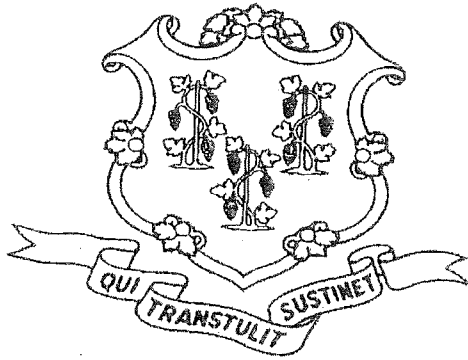


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2019

Name of Facility (as licensed) Riverside Health Care Center, Inc.	
Address (No. & Street, City, State, Zip Code) 745 Main Street, East Hartford, CT 06108	
Type of Facility <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)	
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019

License Numbers:	CCNH 1000c	RHNS	(Specify)	Medicare Provider 07-5257
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Medicaid Provider Numbers:	CCNH 10009	RHNS	ICF-IID
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**For Department Use Only**

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

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**General Information**

Name of Facility (as licensed) Riverside Health Care Center, Inc.	License No. 1000c	Report for Year Ended 9/30/2019	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 Riverside Health Care Center, Inc. [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, 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.

{a} Subject to Desk Audit Review

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) Karen Chadderton			Printed Name (Owner) Marvin Ostreicher		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Riverside Health Care Center, Inc.	Period Covered:	From 10/1/2018	To 9/30/2019	
Address of Facility 745 Main Street, East Hartford, CT 06108				
Report Prepared By Marcum LLP	Phone Number 203-781-9600	Date 2/3/2020		
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. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

**General Information and Questionnaire**  
**Type of Facility - Organization Structure**

Phone No. of Facility 860-289-2791		Report for Year Ended 9/30/2019		Page 2	of 37
Name of Facility (as shown on license) Riverside Health Care Center, Inc.			Address (No. & Street, City, State, Zip) 745 Main Street, East Hartford, CT 06108		
License Numbers:	CCNH 1000c	RHNS	(Specify)	Medicare Provider No. 07-5257	
Type of Facility (Check appropriate box(es))					
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input type="checkbox"/> (Specify)	
Type of Ownership (Check appropriate box)					
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust					
If this facility opened or closed during report year provide:			Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?			<input type="radio"/> Yes <input checked="" type="radio"/> No		If "Yes," explain fully.
N/A					
<b>Administrator</b>					
Name of Administrator Karen Chadderton			Nursing Home Administrator's License No.:	001221	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		
N/A					



## General Information and Questionnaire Corporate Owners

Name of Facility Riverside Health Care Center, Inc.	License No. 1000c	Report for Year Ended 9/30/2019	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation Riverside Health Care Center, Inc.	Business Address 745 Main Street, East Hartford, CT 06108	State(s) in Which Incorporated CT		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Dorris Laufer	1402 59th Street, Brooklyn, NY 11219	President	50	
Marvin Ostreicher	184 Wildacre Avenue, Lawrence, NY 11559	Secretary	200	
Nathan Pollack	2441 Beachwood Road, Beachwood, OH 44122	Director	100	
Agnes Zitter	9 Dogwood Lane, Lawrence, NY 11559	Director	56	
Names of Stockholders Owning at Least 10% of Shares				
Michael Pollack Life Estate Trust	2441 Beachwood Road, Beachwood, OH 44122	Director	100	
H. Ostreicher	1 Lakeside Drive, East Lawrence, NY 11559	Director	166	





**General Information and Questionnaire  
 Related Parties\***

Name of Facility Riverside Health Care Center, Inc.	License No. 1000c	Report for Year Ended 9/30/2019	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?  Yes  No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
National HealthCare Associates	20 E Sunrise Hwy, Valley Stream NY, 11581	<input type="radio"/>	<input checked="" type="radio"/>		Consulting Fees	Page 16 / Line m11	43,929	43,929
National HealthCare Associates	20 E Sunrise Hwy, Valley Stream NY, 11581	<input type="radio"/>	<input checked="" type="radio"/>		Job Placement Consulting Fees	Page 16 / Line m11	7,800	7,800
National HealthCare Associates	20 E Sunrise Hwy, Valley Stream NY, 11581	<input type="radio"/>	<input checked="" type="radio"/>		Interest	Page 27 / Line 12d	10,015	10,015
National HealthCare Associates	20 E Sunrise Hwy, Valley Stream NY, 11581	<input type="radio"/>	<input checked="" type="radio"/>		Shared Expense	Page 16 / Line m12	1,479,325	1,479,325
850 SILAS DEANE	850 Silas Deane Hwy Wethersfield, CT 06109	<input type="radio"/>	<input checked="" type="radio"/>		Rent/Other	Page 16 / Line m12	4,997	4,997
20 Sunrise	20 E Sunrise Hwy, Valley Stream NY, 11581	<input type="radio"/>	<input checked="" type="radio"/>		Rent/Other	Page 16 / Line m12	45,686	45,686
Preferred Therapy Solutions	850 Silas Deane Hwy Wethersfield, CT 06109	<input type="radio"/>	<input checked="" type="radio"/>		PT,OT,ST Services / Consulting	Various	1,811,303	1,762,885
NOA DIAGNOSTICS	6851 Jericho Tpke, Suite 150 Syosset, NY 11791	<input type="radio"/>	<input checked="" type="radio"/>		Radiology	Page 20 / Line 5f	23,547	20,275
See Attached for Continued List	Various	<input type="radio"/>	<input checked="" type="radio"/>		Various	Various	4,202,181	4,152,158

\* Use additional sheets if necessary.

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

**General Information and Questionnaire**  
**Related Parties\***

Name of Facility Riverside Health & Rehab		License No. 1000c			Report for Year Ended 9/30/2019		Page 4a	of 37
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	%**				
PROCARE LTC PHARMACY OF CT	1492 Highland Ave Cheshire CT 06410	<input type="radio"/>	<input checked="" type="radio"/>	0%	Drugs/OTC/RX Consulting	Various	629,306	579,283
National HealthCare Associates-Aetna	850 Silas Deane Hwy Wethersfield, CT 06109	<input type="radio"/>	<input checked="" type="radio"/>	0%	Health Insurance	Page 15 / Line 1a5	2,275,061	2,275,061
National HealthCare Associates	20 E Sunrise Hwy, Valley Stream NY, 11581	<input type="radio"/>	<input checked="" type="radio"/>	0%	Bank Charges	Page 16 / Line m13	29,433	29,433
Riverside Realty Co.	745 Main St. East Hartford CT 06108	<input type="radio"/>	<input checked="" type="radio"/>	0%	Facility Lease	Page 22 / Line 9	1,261,427	***1,261,427
Cambridge Health and Rehabilitation Center	2428 Easton Tpke Fairfield CT 06825	<input type="radio"/>	<input checked="" type="radio"/>	0%	Workers Comp	Page 15 / Line 1a1	6,954	6,954

\* Use additional sheets if necessary.

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

\*\*\* N/A Medicaid reimbursement is based upon fair rental value system. Replaced during rate setting.

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

Name of Facility Riverside Health Care Center, Inc.	License No. 1000c	Report for Year Ended 9/30/2019	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

N/A

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

N/A

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

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

N/A

### General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility			License No.	Report for Year Ended			Page	of
Riverside Health Care Center, Inc.			1000c	9/30/2019			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						
Reliable Health Systems, Nostrand Ave, Brooklyn, NY 11230	<input type="radio"/>	<input checked="" type="radio"/>	Computer Equipment	10/01/08	60 Months / Ongoing	2,956	2,956	
Wescom Solutions, PO Box 674802, Detroit, MI 48267	<input type="radio"/>	<input checked="" type="radio"/>	Software	Ongoing	Ongoing	74,813	74,813	
Pitney Bowes, Inc.	<input type="radio"/>	<input checked="" type="radio"/>	Mailing Machine	Ongoing	Ongoing	3,707	3,707	
Wells Fargo, PO Box 7777, San Francisco, CA 94120	<input type="radio"/>	<input checked="" type="radio"/>	Copier	08/01/16	39 Months	818	818	
Leaf 1720A Crete Street, Moberly, MO 65270	<input type="radio"/>	<input checked="" type="radio"/>	Copier	01/01/16	39 Months	11,716	2,525	
Leaf 1720A Crete Street, Moberly, MO 65270	<input type="radio"/>	<input checked="" type="radio"/>	Copier	10/01/16	39 Months	7,208	7,208	
Leaf 1720A Crete Street, Moberly, MO 65270	<input type="radio"/>	<input checked="" type="radio"/>	Copier	05/01/19	39 Months	22,068	14,725	
Toyota Financial Services	<input type="radio"/>	<input checked="" type="radio"/>	Auto Lease	03/16/15	36 Months	3,914	3,914	
Nissan Motor Acceptance Corp, PO Box 371447, Pittsburgh PA 15250	<input type="radio"/>	<input checked="" type="radio"/>	Auto Lease	08/05/16	35 Months	3,811	3,811	
	<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	<b>Total ***</b>
							114,477	

\* 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.



LEASE AGREEMENT

1720A Crete Street, Moberly, MO 65270
Phone: 800-662-3759, Fax: 800-426-2626

LESSEE LEGAL NAME: Riverside Healthcare dba RIVERSIDE HEALTH & REHABILITAT
Telephone No: 8602892791

Billing Address: 745 MAIN ST, EAST HARTFORD, CT 06108
Equipment Location (if other than Billing Address): 745 Main Street, East Hartford, CT 06108

EQUIPMENT DESCRIPTION: (indicate quantity, new or used and include make, model, serial # and all attachments—see below and/or attached Schedule A)

Table with 5 columns: Unit Quantity, Description of Equipment Leased, Make and Type, Model Number, Serial Number

Table with 4 columns: BASE TERM IN MONTHS (39), TOTAL NUMBER OF LEASE PAYMENTS (32 @ \$1,679.00), END OF LEASE PURCHASE OPTION (Fair market value, 10% of cost, \$1.00), and advance/security/documentation fees totaling \$95.00.

\*\*If more than one lease payment is required as an Advance Payment, the balance will be applied to lease payments in inverse order, starting with the last lease payment. Your obligation to pay all amounts and perform all other obligations is non-cancellable, absolute, unconditional and not subject to abatement, set-off or defense.

In this agreement ("Lease"), "we," "our," and "us" refers to LEAF Capital Funding, LLC as Lessor and "you" and "your" refer to the Lessee. You agree to lease the Equipment upon the following terms and conditions:

- 1. LEASE PAYMENTS AND TERM: The Lease is enforceable on you upon your execution. The term of the Lease shall commence on the date the Equipment is delivered to you...
2. DELIVERY, ACCEPTANCE, USE AND REPAIR: You are responsible for Equipment delivery and installation. You unconditionally accept the Equipment upon the earlier of (a) your oral or written acceptance of the Equipment, or (b) 10 days after delivery of the Equipment...
3. INDEMNIFICATION: You agree to indemnify, defend and hold us harmless from and against any losses, damages, penalties, claims and suits, including attorneys' fees and expenses related to the ordering, manufacture, installation, ownership, condition, use, lease, possession, delivery or return of Equipment...
4. LEASE EXPIRATION, RENEWAL: Unless you notify us at least 90 days prior to the expiration of the Lease of your election to return or purchase the Equipment, this Lease will renew on a month-to-month basis at the same monthly Lease Payment until you either exercise the purchase option or provide us with at least 90 days notice and return the Equipment...
5. LATE FEES AND CHARGES: If any amount is not paid within three (3) days of when due, you agree to pay us a late charge equal to the lesser of 10% of the amount past due or the maximum legal amount...
6. NO WARRANTY: We do not manufacture the Equipment and you have selected the Equipment and the supplier. WE MAKE NO EXPRESS OR IMPLIED WARRANTIES, INCLUDING THOSE OF MERCHANTABILITY OR FITNESS FOR A PURPOSE AND ARE NOT RESPONSIBLE FOR CONSEQUENTIAL OR INCIDENTAL DAMAGES...
7. INSURANCE, RISK OF LOSS: You bear all risk of loss or damage to the Equipment from its order until it is returned in the required condition or purchased by you ("Risk Period")...
8. OWNERSHIP AND TAXES: We own the Equipment (excluding licensed software). If you are deemed to own it, you grant us a security interest in the Equipment...
9. DEFAULT: If you or any guarantor do not pay us any amount within ten (10) days of its due date, or breach any terms of this Lease, any guaranty or any license relating to the Equipment, you will be in default...
10. ASSIGNMENT: You have no right to sell or assign the Equipment or Lease. We may sell or assign our rights in the Lease and/or Equipment and the new owner will have all our rights but will not be subject to any claim or defense you have against us...
11. ARTICLE 2A: You agree this Lease is a "finance lease" as defined in Article 2A of the Uniform Commercial Code. You waive all rights and remedies conferred upon a lessee by Article 2A (508-522) of the UCC...
12. CREDIT INFORMATION: You authorize us or any of our affiliates to obtain credit bureau reports, and make other credit inquiries that we deem necessary...
13. CHOICE OF LAW: THIS LEASE WILL BE GOVERNED BY PENNSYLVANIA LAW. YOU CONSENT TO JURISDICTION IN THE STATE OR FEDERAL COURTS IN PENNSYLVANIA AND WAIVE ANY RIGHT TO A TRIAL BY JURY...
14. MISCELLANEOUS: This Lease is the parties' entire agreement and can be amended only in writing signed by both parties. This Lease may be executed in counterparts (manually or by electronic means) and, when transmitted to us shall be binding upon you for all purposes...

ACCEPTED BY LESSEE: Riverside Healthcare dba RIVERSIDE HEALTH & REHABILITAT
Print Name: MICHAEL BOKOW Title: PURCHASING
Lessee Authorized Signature: [Signature] E-Mail Address: Date:

PERSONAL GUARANTY: Undersigned guarantees that Lessee will make all payments and perform all other obligations under the Lease when due. Undersigned agrees that this is a guaranty of payment and not of collection, and that we can proceed directly against undersigned without first proceeding against Lessee or the Equipment. Undersigned also waives all suretyship defenses and notification if the Lessee is in default and consents to any extensions or modifications granted to Lessee. Undersigned will pay us all expenses (including attorneys' fees) we incur in enforcing our rights against undersigned or Lessee. If more than one person signs this guaranty, each agrees that his/her liability is joint and several. Undersigned authorizes us and our affiliates to obtain credit bureau reports and make inquiries regarding undersigned's personal credit. You consent to jurisdiction in the State or Federal courts in Pennsylvania and expressly waive any right to a trial by jury.

SIGNED X Print Name: E-Mail Address:
Accepted by: LEAF Capital Funding, LLC By: Title: Date:



SCHEDULE A TO LEASE AGREEMENT  
(EQUIPMENT DESCRIPTION)

Lease Application No.: 505542


QNT	Equipment Description	New/Used	Make	Model	Serial Number
-----	-----------------------	----------	------	-------	---------------

Location: 745 Main Street, East Hartford, CT 06108

6	Toshiba E-studio 3018A	New		E-studio 3018A	
1	Toshiba E-studio 3518A	New		E-studio 3518A	
1	Toshiba E-studio 6518A	New		E-studio 6518A	
2	Toshiba E-studio 7518A	New		E-studio 7518A	
1	Toshiba E-studio 4515AC	New		E-studio 4515AC	
1	Kyocera M2040dn	New		M2040dn	

LESSEE: Riverside Healthcare dba RIVERSIDE HEALTH & REHABILITAT

LEAF CAPITAL FUNDING, LLC

BY:   
 PRINT NAME: MICHAEL BOKAN  
 TITLE: PURCHASING  
 DATE: 3/22/19

BY: \_\_\_\_\_  
 PRINT NAME: \_\_\_\_\_  
 TITLE: \_\_\_\_\_  
 DATE: \_\_\_\_\_



**DELIVERY AND ACCEPTANCE CERTIFICATE**

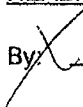
Date of Equipment Delivery: \_\_\_\_\_

Application No.: 505542

Riverside Healthcare dba RIVERSIDE HEALTH & REHABILITAT ("Customer") hereby certifies that all of the equipment, software and other property (collectively, "Equipment") referred to in that certain Agreement related to the above referenced application number (the "Agreement") by and between Customer and **LEAF Capital Funding, LLC** ("LEAF") has been delivered to and been received by Customer at the location(s) set forth in the Agreement, that all installation or other work necessary prior to the use thereof has been completed, that the Equipment has been examined by the Customer and is in good operating order and condition and is in all respects satisfactory to Customer, and that the Equipment is accepted by the Customer for all purposes under the Agreement. Customer represents and warrants that the Date of Equipment Delivery set forth above and the Billing Address and the Equipment Location set forth in the Agreement are correct. By its execution and delivery of this Acceptance Certificate, Customer hereby reaffirms all of the representations, warranties and covenants contained in the Agreement as of the date hereof, and further represents and warrants to LEAF that no Event of Default, and no event or condition which with notice or the passage of time or both would constitute an Event of Default, has occurred and is continuing as of the date hereof. Customer further certifies to LEAF that Customer has selected the Equipment (and to the extent applicable, the vendor of the Equipment) and has received and approved the purchase order, purchase agreement or supply contract under which the Equipment will be acquired for all purposes of the Agreement.

ACCORDINGLY, CUSTOMER AUTHORIZES LEAF TO PURCHASE THE EQUIPMENT FROM THE APPLICABLE SUPPLIER(S).

DO NOT SIGN THIS DELIVERY AND ACCEPTANCE CERTIFICATE UNTIL YOU HAVE RECEIVED ALL OF THE EQUIPMENT.

CUSTOMER: <u>Riverside Healthcare dba RIVERSIDE HEALTH &amp; REHABILITAT</u>	
By: 	_____
Print Name:	_____
Title:	_____
E-Mail Address:	_____
Date:	_____

THE ABOVE SIGNATORY AFFIRMS THAT HE/SHE IS A DULY AUTHORIZED CORPORATE OFFICER OR OFFICIAL, MEMBER, PARTNER OR PROPRIETOR OF THE ABOVE NAMED CUSTOMER.

SALES ORDER

**THE OFFICEWORKS**

The Office Works, Inc.  
 45 Corporate Avenue  
 Plainville, CT 06062  
 1-800-634-4810 1-860-793-9994

Date: March 13, 2019

**BILL TO:**  
 Riverside Health Care  
 745 Main Street  
 East Hartford, CT 06108

**SHIP TO:**  
 Same

ITEM	DESCRIPTION	QTY	SALE / LEASE PRICE
e-Studio 3018A	Toshiba digital multifunction copier	6	
e-Studio 3518A	Toshiba digital multifunction copier	1	39-month lease
e-Studio 6518A	Toshiba digital multifunction copier	1	\$1,679.00 per month
e-Studio 7518A	Toshiba digital multifunction copier	2	
e-Studio 4515AC	Toshiba digital color multifunction copier	1	
MR3031	Document handler	8	
MJ1109B	Console document finisher	1	
MJ6105B	Hole punch unit	1	
KN5005	Finisher bridge kit	1	
KD1059B	Large capacity paper feed pedestal	1	
GD1370N	Fax board	11	
Stand 5005	Cabinet stand		N/A
M2040dn	Kyocera Desktop MFP (1)	<b>DELIVERY</b>	N/C
P6230cdn	Kyocera color printer (1)	<b>SALES TAX</b>	6.35% of monthly payment
P2040dw	Kyocera monochrome printer (3)	<b>TOTAL DUE</b>	N/A

**Notes / Provisions**

- Delivery, installation and training is included at N/C. The office works will remove the currently leased copiers and return them to the leasing company at no charge.

**CUSTOMER:** Riverside Health Care

**The Office Works, Inc.**

Authorized Signature *[Signature]*

Accepted By \_\_\_\_\_

Print Name MICHAEL BOVON

Print Name \_\_\_\_\_

Title PURCHASING

Title \_\_\_\_\_

Date 3/20/19

Phone \_\_\_\_\_

Sales Associate \_\_\_\_\_



**General Information and Questionnaire**  
**Accounting Basis**

Name of Facility Riverside Health Care Center, Inc.	License No. 1000c	Report for Year Ended 9/30/2019	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

- Accrual     Cash     Modified Cash

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

N/A

**Independent Accounting Firm**

Name of Accounting Firm 1 Blum, Shapiro & Company, P.C. 2 3 4	Address (No. & Street, City, State, Zip Code) 2 Enterprise Dr., Shelton, CT 06484
---	--

Services Provided by This Firm (*describe fully*)

1	Compilation, preparation of Medicare and Medicaid cost reports and YE tax services	\$	30,873
2		\$	
3		\$	
4		\$	
			Charge for Services Provided
			\$ 30,873

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

- Yes     No    Page 15 / Line 1d

**Legal Services Information**

Name of Legal Firm or Independent Attorney 1 GOLDMAN GRUDER & WOOD 2 BERCHEM MOSES PC 3 TREASURER STATE OF CONNECTICUT 4 STATEWIDE PROCESS SERVING 5	Telephone Number 203-899-8900 203-783-1200 860-291-7278 N/A
---	---

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

- 1 200 CONNECTICUT AVENUE NORWALK CT 06854  
2 75 Broad Street, Milford, CT 06460  
3 Town Hall, 740 Main Street, East Hartford, CT 06108  
4 34 Connecticut Blvd. Suite #9, East Hartford, CT 06108  
5

Services Provided by This Firm (*describe fully*)

1	Collections (Disallowed on Pg 28)	\$	19,307
2	Labor - CHRO Complaint / Wrongful Discharge (Disallowed on Pg 28)	\$	5,910
3	Conservator (Disallowed on Pg 28)	\$	494
4	Conservator (Disallowed on Pg 28)	\$	200
5		\$	
			Charge for Services Provided
			\$ 25,911

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

- Yes     No    Page 15 / Line 1e

Schedule of Resident Statistics

Name of Facility Riverside Health Care Center, Inc.		License No. 1000c			Report for Year Ended 9/30/2019				Page 8	of 37			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	345	345			345	345			345	345			
B. On last day of THIS report period	345	345			345	345			345	345			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	320	320			320	320			319	319			
B. As of midnight of THIS report period	307	307			319	319			307	307			
3. Total Number of Days Care Provided During Period													
A. Medicare	3,528	3,528			2,826	2,826			702	702			
B. Medicaid (Conn.)	106,014	106,014			78,797	78,797			27,217	27,217			
C. Medicaid (other states)													
D. Private Pay	2,678	2,678			2,006	2,006			672	672			
E. State SSI for RCH													
F. Other (Specify) Managed Care & Hospice	5,257	5,257			4,261	4,261			996	996			
G. Total Care Days During Period (3A thru F)	117,477	117,477			87,890	87,890			29,587	29,587			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days	3	3			2	2			1	1			
B. Other Bed Reserve Days	43	43			28	28			15	15			
5. <b>Total Resident Days (3G + 4A + 4B)</b>	117,523	117,523			87,920	87,920			29,603	29,603			

### Schedule of Resident Statistics (Cont'd)

Name of Facility Riverside Health Care Center, Inc.			License No. 1000c			Report for Year Ended 9/30/2019			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <span style="float: right;"><input type="radio"/> Yes <input checked="" type="radio"/> No</span>													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
N/A													
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	9	273		25									
Per Diem Rate													
a. One bed rm.	Various	254.20		535.00									
b. Two bed rms.	Various	254.20		500.00									
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								7,339	7,339				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								5,000	5,000				
C. Other								17,294	17,294				
D. <b>Total Physical Therapy Treatments</b>								29,633	29,633				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								1,630	1,630				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								497	497				
C. Other								1,687	1,687				
D. <b>Total Speech Therapy Treatments</b>								3,814	3,814				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								18,915	18,915				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								7,293	7,293				
C. Other								18,023	18,023				
D. <b>Total Occupational Therapy Treatments</b>								44,231	44,231				

Annual Report of Long-Term Care Facility

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Riverside Health Care Center, Inc.	1000c	9/30/2019	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
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)	47,633	93				
2. Administrator(s) (Complete also Sec. III of Schedule A1)	189,839	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	133,314	2,080				
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	490,379	19,890				
5. Dietary Service						
a. Head Dietitian	175,343	5,483				
b. Food Service Supervisor	207,651	8,827				
c. Dietary Workers	891,739	53,298				
6. Housekeeping Service						
a. Head Housekeeper	121,225	4,433				
b. Other Housekeeping Workers	1,251,609	67,706				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	80,975	2,080				
b. Other Maintenance Workers	153,256	6,616				
8. Laundry Service						
a. Supervisor	3,683	180				
b. Other Laundry Workers	449,822	23,324				
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	278,856	4,160				
b. RN						
1. Direct Care	1,462,882	36,308				
2. Administrative**	396,764	11,735				
c. LPN						
1. Direct Care	3,513,355	122,170				
2. Administrative**	6,232	175				
d. Aides and Attendants	5,546,258	298,408				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	452,218	19,002				
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	209,850	7,367				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	522,699	15,668				
<i>A-13. Total Salary Expenditures</i>	16,585,582	711,083				

\* 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)

Position	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Admissions	\$ 314,961	8,521				
Medical Records	43,189	2,313				
Respiratory Therapist (Disallowed on Pg 28a)	164,549	4,834				
<b>Total</b>	<b>\$ 522,699</b>	<b>15,668</b>	<b>\$ -</b>	<b>-</b>	<b>\$ -</b>	<b>-</b>

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
IV Nursing Consultant (Disallowed on Pg 28a)	\$ 31,228	416				
Rehab Consultant (Disallowed on Pg 28a)	24,116	481				
<b>Total</b>	<b>\$ 55,344</b>	<b>897</b>	<b>\$ -</b>	<b>-</b>	<b>\$ -</b>	<b>-</b>

**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	
Riverside Health Care Center, Inc.				1000c	9/30/2019			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section I - Operators/Owners</b>										
Marvin J. Ostreicher	47,633			Non Discriminatory	Supervises Operations, Deals with DNS & Other	93	A1	See Attached		
<b>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).</b>										

\* 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.

Riverside Health & Rehab  
 Marvin J Ostreicher Time Study  
 9/30/2019

BEDS	Total w/ Bnft
------	---------------

Bethel	161	66.00
Bloomfield	120	67.00
Bristol	132	60.00
Cambridge	160	73.00
Hebrew Home	257	111.00
Ludlowe	144	60.00
Maple View	120	58.00
Marlborough	120	56.00
Milford	120	60.00
Regency	130	62.00
Riverside	345	93.00
Village Crest	95	58.00
Water's Edge	150	64.00
Augusta	72	57.00
Belair	102	53.00
Brattleboro	80	65.00
Brentwood	78	50.00
Brewer	111	64.00
Catskill	136	58.00
Colony	92	55.00
Country	111	58.00
Dover	112	58.00
Eastside	69	51.00
Eliot	114	62.00
Glen Falls	120	56.00
Huntington	320	94.00
Kennebunk	78	51.00
Maywood	120	65.00
Newton Wellseley	110	58.00
Norway	70	48.00
Poughkeepsie	200	74.00
Reservoir	144	71.00
Rutland	125	64.00
Sachem	111	54.00
Sands Point	180	70.00
Utica	117	53.00
Westgate	104	59.00
Winship	72	50.00

Vacation/PTO  
 Sick  
 Personal  
 Holiday

Total 2,948 1,498.00

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	
Riverside Health Care Center, Inc.			1000c		9/30/2019			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)							
<b>Section III - Administrators***</b>										
Karen Chadderton	189,839			Non Discriminatory	Administrator	2,080	A2			
<b>Section IV - Assistant Administrators</b>										
Michael Bernardi	133,314			Non Discriminatory	Assistant Administrator	2,080	A3			

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

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

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



**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended	Page	of		
Riverside Health Care Center, Inc.	1000c	9/30/2019	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian						
2. Dentist	10,209	184				
3. Pharmacist	33,491	447				
4. Podiatrist	179	2				
5. Physical Therapy						
a. Resident Care	604,555	10,467				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	105,933	317				
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	203,379	3,314				
b. Other						
10. Occupational Therapist						
a. Resident Care	978,795	17,763				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	55,344	897				
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>1,991,885</b>	<b>33,391</b>				

\* 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 Riverside Health Care Center, Inc.		License No. 1000c	Report for Year Ended 9/30/2019	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Gerident Solutions, P.O. Box 290539, Wethersfield, CT 06129	Dentist	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Procure LTC of CT, 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist / IV Nursing Consultant	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
Preferred Thearpy-850 Silas Deane HWY Wethersfield CT	PT, OT, ST / Rehab Consultant	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
Starling Physicians - 2110 Sillas Deane Highway, Rocky Hill, CT 06067	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Bloomfield Foot Specialists, 1 Northwestern Drive Bloomfield CT 06002	Podiatrist	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Mouli Associates - 43 Wood Street, Hartford, CT 06105	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Elmo Villanueva Collins Medical Associates - 506 Cromwell Avenue, Rocky Hill CT 06067	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Swallowing Diagnostics - PO Box 484 Avon CT 06001	Speech Therapy	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
CLIMB MEDICAL GROUP LLC PO Box 23369 Belfast, ME 04915	Nursing Consultant	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
		<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
Riverside Health Care Center, Inc.	1000c	9/30/2019	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 703,385	703,385		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 152,040	152,040		
4. Social Security (F.I.C.A.)	\$ 1,215,884	1,215,884		
5. Health Insurance	\$ 2,275,773	2,275,773		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 79,375	79,375		
8. Uniform Allowance	\$			
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 8,125	8,125		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 370,330	370,330		
d. Accounting and Auditing	\$ 30,873	30,873		
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 25,911	25,911		
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$			
g. Office Supplies	\$ 30,741	30,741		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 26,603	26,603		
2. Cellular Phones	\$ 9,829	9,829		
i. Appraisal ( <i>Specify purpose and         attach copy</i> )*	\$			
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$ 479	479		
k. Other Taxes ( <i>Not related to property - See Page 22</i> )				
1. Income*	\$			
2. Other ( <i>Specify</i> ) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 1,769,171	1,769,171		
<b>Subtotal</b>	<b>\$ 6,698,519</b>	<b>6,698,519</b>		

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

(Carry Subtotals forward to next page)



## Annual Report of Long-Term Care Facility

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

Name of Facility	License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2019	16	37
Item	Total	CCNH	RHNS	(Specify)
<b>Subtotals Brought Forward:</b>	6,698,519	6,698,519		
i. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$ 12,923	12,923		
3. Gifts to Staff and Residents	\$ 33,641	33,641		
4. Employee Travel	\$ 13,168	13,168		
5. Education Expenses Related to Seminars and Conventions	\$ 3,351	3,351		
6. Automobile Expense (not purchase or depreciation)	\$ 1,189	1,189		
7. Other (Specify) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (all such expenses)	\$			
2. Advertising Telephone Directory (all such expenses)***	\$			
3. Advertising Other (Specify)*** See Attached Schedule	\$ 77,039	77,039		
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	\$ 11,222	11,222		
* 8. Dues and Membership Fees to Professional Associations (Specify) See Attached Schedule	\$ 22,964	22,964		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 750	750		
9. Subscriptions	\$ 254	254		
10. Contributions*** See Attached Schedule	\$			
11. Services Provided by Contract (Specify and Complete Schedule C-2, Page 21 for each firm or individual)	\$ 182,983	182,983		
12. Administrative Management Services**	\$ 1,573,937	1,573,937		
13. Other (Specify) See Attached Schedule	\$ 73,042	73,042		
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 8,704,982	8,704,982		

\* 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)
	-		
<b>Total Other Travel and Entertainment</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
	-		
Promotional Advertising (Disallowed on Pg 28)	\$ 77,039		
<b>Total Other Advertising</b>	<b>\$ 77,039</b>	<b>\$ -</b>	<b>\$ -</b>

Schedule of Dues

Description	CCNH	RHNS	(Specify)
	-		
CAHCF Dues	\$ 22,819		
ALTCFM Dues	145		
<b>Total Dues</b>	<b>\$ 22,964</b>	<b>\$ -</b>	<b>\$ -</b>

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
	-		
<b>Total Contributions</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
	-		
Licenses and Permits	\$ 6,573		
Penalties (Disallowed on Pg 28a)	671		
Bank Charges	59,511		
Misc Expenses (Disallowed on Pg 28a)	6,287		
<b>Total Other Administrative and General</b>	<b>\$ 73,042</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule C-1 - Management Services\***

Name of Facility Riverside Health Care Center, Inc.	License No. 1000c	Report for Year Ended 9/30/2019	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 #
National Healthcare	1,573,937	Shared Expenses	Page 16 / Line m12

\* 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 Riverside Health Care Center, Inc.		License No. 1000c	Report for Year Ended 9/30/2019	Page 18	of 37
Item	Total	CCNH	RHNS	(Specify)	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$ 969,794	969,794			
2. Non-Food Supplies	\$ 101,322	101,322			
3. Other (Specify) _____	\$ _____				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 42,960	42,960			
c. Other (Specify) _____	\$ _____				
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 1,114,076</b>	<b>1,114,076</b>			
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 Riverside Health Care Center, Inc.		License No. 1000c	Report for Year Ended 9/30/2019	Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*		Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$	196,584	196,584	
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)		\$	1,561	1,561	
c. Other (Specify) Other Laundry Supplies		\$	22,512	22,512	
<b>3D. Total Laundry Expenditures (3a + b + c)</b>		\$	<b>220,657</b>	<b>220,657</b>	
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	License No.	Report for Year Ended	Page	of	
Riverside Health Care Center, Inc.	1000c	9/30/2019	20	37	
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care					
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	88,261	88,261		
b. Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )	Sq. Ft. Serviced by Personnel				
	Amt. \$				
c. Other ( <i>Specify</i> )	\$				
<b>4D. Total Housekeeping Expenditures (4a + b + c)</b>	\$	<b>88,261</b>	<b>88,261</b>		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$	553,271	553,271		
2. Purchased from	\$				
b. Medicine Cabinet Drugs	\$	37,601	37,601		
c. Medical and Therapeutic Supplies	\$	438,084	438,084		
d. Ambulance/Limousine***	\$	32,508	32,508		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	22,363	22,363		
f. X-rays and Related Radiological Procedures***	\$	23,733	23,733		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$	47,716	47,716		
i. Recreation	\$	57,689	57,689		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (Specify)**** See Attached Schedule	\$	86,475	86,475		
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	<b>1,299,440</b>	<b>1,299,440</b>		

\* 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.



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

Name of Facility Riverside Health Care Center, Inc.			License No. 1000c		Report for Year Ended 9/30/2019			Page of 21   37		
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
MJ Daly	110 Mattatuck Heights, Waterbury, CT, 06705	<input type="radio"/>	<input checked="" type="radio"/>	N/A	HVAC	76,822			22	6f
Otis Elevator	PO Box 13716 Newark, NJ 07188	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Elevator Service	34,083			22	6f
Fire Protection Testing	1701 Highland Ave #4, Cheshire, CT 06410	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Alarm Maintenance and Monitoring	21,212			22	6f
Kone Inc.	47-36 36th Street, Long Island City, NY 11101	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Elevator Maintenance	14,281			22	6f
ADM Environmental	1317 Coney Island Ave, Brooklyn, NY 11230	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Trash Removal / Recycling Service	54,043			22	6f
ADP	Philadelphia, PA 19170-0372	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Payroll Processing	45,576			16	m11
Intergrated Health Systems	PO Box 23072 Overland Park, KS 66283	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Computer Maintenance Sytems	21,632			16	m11
Smartlinx	333 Thornall St. 4th Floor Edison, NJ 08837	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Time & Attendance	19,530			16	m11
		<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"/>							

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2019			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$					
b. Heat	\$ 167,928	167,928				
c. Light & Power	\$ 534,690	534,690				
d. Water	\$ 166,049	166,049				
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 114,477	114,477				
f. Other ( <i>itemize</i> )	\$ 353,628	353,628				
See Attached Schedule						
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$ 1,336,772	1,336,772				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 164,761	164,761				
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$ 164,761	164,761				
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 214,713	214,713				
d. Other ( <i>Specify</i> )	\$					
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$ 214,713	214,713				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 1,261,427	1,261,427				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 322,064	322,064				
c. Personal property taxes	\$ 44,027	44,027				
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$ 2,006,992	2,006,992				

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



### Depreciation Schedule

Name of Facility Riverside Health Care Center, Inc.		License No. 1000c			Report for Year Ended 9/30/2019			Page 23	of 37				
Property Item		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals				
<b>A. Land Improvements</b>													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal													
<b>B. Building and Building Improvements</b>													
1. Acquired prior to this report period		20,614,833		20,614,833	(Equity Purposes)								
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal													
<b>C. Non-Movable Equipment</b>													
1. Acquired prior to this report period		1,048,608		1,048,608	(Equity Purposes)								
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal													
		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								
<b>D. Movable Equipment</b>													
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				Var	Var	2,073,919		2,073,919	1,327,339	S/L	Various	148,651	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)				Var	Var	150,182		150,182		S/L	Various	16,110	
D-3. Subtotal													164,761
<b>E. Total Depreciation</b>													164,761

Schedule of Land Improvements Acquired during this report period

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

\*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
<b>Additions:</b>				
<b>Total additions for Building Improvements</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ - **

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2





6/25/2019	MJ Daly-Thermostat valve	1,417	20	71
6/25/2019	MJ Daly-Valves	1,405	20	70
6/30/2019	MJ Daly-Fan Motor	2,212	20	111
10/31/2018	MJ Daly - 2 Heat Pumps	9,065	20	453
11/30/2018	MJ Daly - 2 Heat Pumps	9,065	20	453
<b>Total additions for Leaschold Improvement</b>		<b>\$ 101,263</b>		<b>\$ 5,668 *</b>
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		<b>\$ -</b>		<b>\$ - **</b>

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Amortization Schedule\***

Name of Facility Riverside Health Care Center, Inc.			License No. 1000c		Report for Year Ended 9/30/2019			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							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period	Var	Var	Various	2,996,100	2,098,481	S/L	Various	209,045	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	Var	Var	Various	101,263		S/L	Various	5,668	
C-4. Subtotal									214,713
<b>D. Total Amortization</b>									214,713

\* 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.

Riverside Health & Rehab  
FIXED ASSET / DEPRECIATION SCHEDULE

Asset Type	Description	Date In Service	Method	Life	Historical Cost	2018 A/D	2019 Deprec.	2019 A/D	NBV
<b>LEASEHOLD IMPROVEMENTS</b>									
LI	Prior Period Acquisitions (Per 9/30/18 CR)	Various	S/L	Various	2,996,100	2,098,481	209,045	2,307,526	688,574
<b>2019 Additions</b>									
LI	Magnum Ind - Entry Tile	10/12/2018	S/L	10	2,320	-	232	232	2,088
LI	Junga Electric-ballards	11/16/2018	S/L	15	2,746	-	183	183	2,563
LI	Magnum Ind-Sheet Vinyl	12/31/2018	S/L	10	1,133	-	113	113	1,020
LI	OTIS-Power unit/Starter	12/21/2018	S/L	20	28,117	-	1,406	1,406	26,711
LI	MJ Daly-pipes, fittings	1/31/2019	S/L	20	8,777	-	439	439	8,338
LI	MJ Daly-couplers, diverters	1/31/2019	S/L	20	3,024	-	151	151	2,873
LI	MJ Daly-Module Control	1/31/2019	S/L	20	2,767	-	138	138	2,629
LI	MJ Daly-pipes, valves	1/31/2019	S/L	20	2,183	-	109	109	2,074
LI	MJ Daly-Misc	2/28/2019	S/L	20	4,207	-	210	210	3,997
LI	Magnum Ind-door kickplates	3/12/2019	S/L	10	1,617	-	162	162	1,455
LI	MJ Daly-Penthouse Pump	1/13/2019	S/L	10	2,226	-	223	223	2,003
LI	MJ Daly-Faucets/Valves	2/28/2019	S/L	20	2,190	-	109	109	2,081
LI	WestReach-Door	4/30/2019	S/L	10	1,571	-	157	157	1,414
LI	Lingard Cabinet Co-countertops	5/30/2019	S/L	15	3,988	-	266	266	3,722
LI	MJ Daly	5/31/2019	S/L	20	3,011	-	151	151	2,860
LI	MJ Daly-water heater parts	5/31/2019	S/L	20	2,056	-	103	103	1,953
LI	Westreach-Door	7/31/2019	S/L	10	999	-	100	100	899
LI	MJ Daly- Chiller Leak Install	6/30/2019	S/L	20	5,166	-	258	258	4,908
LI	MJ Daly-Thermostat valve	6/25/2019	S/L	20	1,417	-	71	71	1,346
LI	MJ Daly-Valves	6/25/2019	S/L	20	1,405	-	70	70	1,335
LI	MJ Daly-Fan Motor	6/30/2019	S/L	20	2,212	-	111	111	2,101
LI	MJ Daly - 2 Heat Pumps	10/31/2018	S/L	20	9,065	-	453	453	8,612
LI	MJ Daly - 2 Heat Pumps	11/30/2018	S/L	20	9,065	-	453	453	8,612
<b>TOTAL LEASEHOLD IMPROVEMENTS</b>					<b>3,097,363</b>	<b>2,098,481</b>	<b>214,713</b>	<b>2,313,194</b>	<b>784,169</b>
<b>MOVABLE EQUIPMENT</b>									
MME	Prior Period Acquisitions (Per 9/30/18 CR)	Various	S/L	Various	2,073,919	1,327,339	148,651	1,475,990	597,929
<b>2019 Additions</b>									
MME	Starling Physicians-ApneaLink	10/11/2018	S/L	7	1,604	-	229	229	1,375
MME	TriState Surg-Bariatric Beds	10/10/2018	S/L	15	2,334	-	156	156	2,178
MME	Culinary Depot-Waring CB15	10/17/2018	S/L	10	1,138	-	114	114	1,024
MME	TriState-Bariatric Wheelchair	11/6/2018	S/L	5	798	-	160	160	638
MME	Cul Depot-shipp on Asset 1212	11/30/2018	S/L	10	36	-	4	4	32
MME	Culinary Depot-Ice Maker	11/30/2018	S/L	10	2,989	-	299	299	2,690
MME	Cul Depot-Merid Water Dispense	11/6/2018	S/L	10	4,057	-	406	406	3,651
MME	Smart Care-blower motor	11/12/2018	S/L	8	1,925	-	241	241	1,684
MME	Daniel's Equip-UniMacWasher	11/1/2018	S/L	10	4,844	-	484	484	4,360
MME	MLK Lock-Security Cameras	11/14/2018	S/L	5	3,551	-	710	710	2,841
MME	RVH Millwork-Cabinet/Sink	1/3/2019	S/L	20	5,583	-	279	279	5,304
MME	Dir Supply-Dig Chair Seale	1/21/2019	S/L	10	1,308	-	131	131	1,177
MME	Cul Depot-Meat Chopper	1/20/2018	S/L	10	5,115	-	511	511	4,604
MME	Daniel's Equip-UniMacWasher	2/25/2019	S/L	10	19,377	-	1,938	1,938	17,439
MME	SupplyWorks-window coverings	2/4/2019	S/L	5	1,849	-	370	370	1,479
MME	SupplyWorks-window coverings	2/14/2019	S/L	5	1,308	-	262	262	1,046
MME	SmartCare - Thermostat	2/1/2019	S/L	5	1,407	-	281	281	1,126
MME	McKesson-Trapeze Bed	3/25/2019	S/L	15	499	-	33	33	466
MME	Direct Supply-Vacuum	3/13/2019	S/L	8	635	-	79	79	556
MME	Direct Supply-Cabinets/Chests	3/1/2019	S/L	15	4,822	-	321	321	4,501
MME	Culinary Depot - Ice Dispenser	4/22/2019	S/L	10	3,766	-	377	377	3,389
MME	Supply Works-Cellular shades	4/8/2019	S/L	5	2,460	-	492	492	1,968
MME	Direct Supply-Dig Chair Seale	5/7/2019	S/L	10	1,368	-	137	137	1,231
MME	TriState-Bariatric Wheel Chair	5/29/2019	S/L	5	798	-	160	160	638
MME	Direct Supply-Floor Machine	5/24/2019	S/L	10	670	-	67	67	603
MME	MLK Lock-cameras	4/2/2019	S/L	5	1,752	-	350	350	1,402
MME	MJ Daly- Chiller	5/31/2019	S/L	10	64,859	-	6,486	6,486	58,373
MME	TriState Surg-Elec Actuator	8/21/2019	S/L	10	541	-	54	54	487
MME	Cul Dep-Mobile dish dispenser	9/24/2019	S/L	10	7,796	-	780	780	7,016
MME	McKesson-Defibrillator	4/18/2019	S/L	5	995	-	199	199	796
<b>TOTAL MOVABLE EQUIPMENT</b>					<b>2,224,101</b>	<b>1,327,339</b>	<b>164,761</b>	<b>1,492,100</b>	<b>732,001</b>
<b>TOTAL ASSETS PER CR SCHEDULE</b>					<b>5,321,465</b>	<b>3,425,820</b>	<b>379,474</b>	<b>3,805,294</b>	<b>1,516,171</b>
<b>TOTAL ASSETS PER TRIAL BALANCE</b>					<b>5,321,465</b>	<b>-</b>	<b>379,474</b>	<b>3,805,294</b>	<b>1,516,171</b>
<b>ROUNDING</b>									
<b>VARIANCE</b>					<b>(0)</b>	<b>3,425,820</b>	<b>-</b>	<b>-</b>	<b>(0)</b>

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

Name of Facility Riverside Health Care Center, Inc.	License No. 1000c	Report for Year Ended 9/30/2019	Page 25	of 37	
<b>11. Property Questionnaire</b>					
<b>Part A</b>					
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description	Total				
1. Date Land Purchased					
2. Date Structure Completed					
3. If <b>NOT</b> Original Owner, Date of Purchase	09/08/80				
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	345				
6. Square Footage	144,794				
7. Acquisition Cost					
a. Land	365,846				
b. Building	19,933,873				
<b>Part B - Owner and Related Parties</b>		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)	Fixed				
b. Date Mortgage Obtained	04/03/03				
c. Interest Rate for the Cost Year	3.75%				
d. Term of Mortgage (number of years)	34 Years, 6 Months				
e. Amount of Principal Borrowed	18,891,400				
f. Principal balance outstanding as of 9/30/19	14,112,935				
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>					
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					
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>					
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 Riverside Health Care Center, Inc.		License No. 1000c	Report for Year Ended 9/30/2019		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. <b>Total Building Interest Expense</b> (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Riverside Health Care Center, Inc.		1000c		9/30/2019		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) Admin / Computer Loan / Property Interest				\$	11,552	11,552	
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>				\$	11,552	11,552	
14. Insurance							
a. Insurance on Property (buildings only)				\$	77,960	77,960	
b. Insurance on Automobiles				\$	9,662	9,662	
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$	27,123	27,123	
2. Fire and Extended Coverage				\$			
3. Other (Specify) Crime / Liability				\$	155,577	155,577	
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$	270,322	270,322	
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$	33,630,521	33,630,521	

**D. Adjustments to Statement of Expenditures**

Name of Facility			License No.	Report for Year Ended	Page	of	
Riverside Health Care Center, Inc.			1000c	9/30/2019	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 227,541	227,541		
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$ 978,795	978,795		
7.			Other - See attached Schedule	\$ 55,523	55,523		
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 370,330	370,330		
10.			Accounting	\$			
10a.	15	1c	Legal	\$ 25,911	25,911		
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 7,669	7,669		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	L3	Gifts, flowers and coffee shops	\$ 33,641	33,641		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.	16	L4	Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$ 12,899	12,899		
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m2/3	Unallowable Advertising *	\$ 77,039	77,039		
19.	15	1j	Income Tax / Corporate Business Tax	\$ 229	229		
20.			Fund Raising / Contributions	\$			
21.	16	m12	Unallowable Management Fees	\$ 745,103	745,103		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 60,670	60,670		
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 2,595,350	2,595,350		

\* All except "Help Wanted".

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

(Carry Subtotal forward to next page)



## Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	12m	Admissions Salary Associated with Marketing	\$ 62,992		
10	12o	Respiratory Therapist	164,549		
<b>Total Other Salaries Adjustment</b>			\$ 227,541	\$ -	\$ -

## Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	12o	IV Nursing Consultant	\$ 31,228		
13	12o	Rehab Consultant	24,116		
13	B4	Podiatrist	179		
<b>Total Other Fees Adjustments</b>			\$ 55,523	\$ -	\$ -

## Schedule of Other A&amp;G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
15	Var	Benefits Associated with Marketing Salary	\$ 16,812		
16	m8a	Chamber of Commerce Dues	750		
16	m13	Penalties	671		
16	m13	Miscellaneous Expenses	6,287		
15	Var	Benefits Associated with Respiratory Therapist Salary	36,150		
<b>Total Other A&amp;G Adjustments</b>			\$ 60,670	\$ -	\$ -

**National Health Care Associates, Inc. (CT)**  
**Disallowance Schedule for Cell Phones**  
**September 30, 2019**

	<u>Amount</u>	
Total Cell Phone Expense	9,829	TB Linked
Cell Phone Allowed Based on Bed Capacity	6	
Monthly Allowable amount per Cell Phone	\$ 30	
Months in Cost Report Year	<u>12</u>	
Total Allowable Cost	\$ 2,160	
Days in Cost Report (365out of 365 Days)	365	
Days in Cost Report Year	<u>365</u>	
Partial Year Allowable %	100%	
Revised Allowable Cost	\$ 2,160	
<b>Disallowed Cell Phone (Page 28, Line 12)</b>	<b><u><u>\$ 7,669</u></u></b>	

**Riverside Health & Rehab  
 Calculation of Allowable Management Fee  
 September 30, 2019**

<u>Description</u>	<u>Amount</u>	
Management fees Charged	1,573,937	Page 16, Line m12
Accounting Charges	30,873	Page 15, Line 1d
Total Management Fees Per Agreement	<u>1,604,810</u>	
Patient Days	117,523	Page 8 of C/R
Imputed Days - 90% Occupancy (365/365 Days)	<u>113,333</u>	Calculation
<b>Amount Per Patient Day (Greater of 90% or Actaul Days)</b>	<b>\$ 14.16</b>	
PPD Allowance Per Client 2018	7.81	J.01a
2019 CPI Increase %	<u>1.01%</u>	
PPD Allowance 9/30/2019	<u>7.82</u>	
<b>Amount over (Under)</b>	<b>\$ 6.3401</b>	
Total Days	<u>117,523</u>	Page 8 of C/R
<b>Disallowed Management Fee</b>	<b><u><u>\$ 745,103</u></u></b>	

**Respiratory Therapist Benefits Disallowance**

Respiratory Therapist Salary	164,549	Page 10
Total Salaries	<u>16,585,582</u>	TB Linked
Percent to Total Salaries	0.99%	
Total Benefits (Pg 15, Line 1a3 - 1a6)	3,643,697	TB Linked
Respiratory Therapist Benefits Disallowed	<b>36,150</b>	Page 28 attachment

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

Name of Facility				License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.				1000c	9/30/2019	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 2,595,350	2,595,350		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5a2	Prescription Drugs	\$ 553,271	553,271		
28.	20	5d	Ambulance/Limousine	\$ 32,508	32,508		
29.	20	5f	X-rays, etc	\$ 23,733	23,733		
30.	20	5h	Laboratory	\$ 47,716	47,716		
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 22,363	22,363		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 137,266	137,266		
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 11,050	11,050		
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	\$ 17,387	17,387		
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$ 29,494	29,494		
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 3,470,138	3,470,138		

\*\*\* 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	5i	Cable Television Disallowance (See Attached)	\$ 17,367		
20	5l	IV Thy Supplies - Rehab Tpy and Ancllr	12,077		
20	5l	Equip Rental - Nursing	21,568		
20	5l	Equip Rental - Rehab Tpy and Anclry	11,746		
20	5l	Equip Rental - Respiratory	39,144		
20	5c	Med B Nursing Supplies	35,364		
<b>Total Other Ancillary Costs</b>			<b>\$ 137,266</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Excess Movable Equipment Depreciation**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7b	Non Allowable Depreciation on Various Fixed Assets	\$ 11,050		
<b>Total Excess Movable Equipment Depreciation</b>			<b>\$ 11,050</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Property Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14b	Insurance on Automobiles	\$ 9,662		
22	6e	Leases on Automobiles	7,725		
<b>Total Other Property Adjustments</b>			<b>\$ 17,387</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other - Indirect Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)

<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	12d	Interest Expense on Late Fees	\$ 537		
30	IV 8	Sales of Equipment	744		
30	IV 8	Medical Records Revenue	594		
30	IV 8	Miscellaneous Revenue	27,619		
<b>Total Other Adjustments</b>			<b>\$ 29,494</b>	<b>\$ -</b>	<b>\$ -</b>

Schedule of Unallowable Building Interest

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



**National Health Care Associates, Inc. (CT)**  
**Cable TV Disallowance**  
**September 30, 2019**

**Pg. 29b**

Total Cable TV Expense	20,967	TB Linked
Total Monthly Fee Allowed	\$ 300	
Total Months	12	
Total Allowable Expense	<u>\$ 3,600</u>	
Partial Year Cost Report (365 out of 365 Days)	\$ 365	
Days in Cost Report Year	<u>365</u>	
Partial Year Allowable %	100.00%	
Revised Allowable Cost	\$ 3,600	
<b>Disallowed Expense</b>	<u><u>\$ 17,367</u></u>	{a}

**Tickmark**  
{a}

Ties to page 29a

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended			Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2019			30	37
Item	Total	CCNH	RHNS	(Specify)		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 42,933,564	42,933,564				
b. Medicaid Room and Board Contractual Allowance **	\$ (18,041,881)	(18,041,881)				
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 1,730,932	1,730,932				
b. Medicare Room and Board Contractual Allowance **	\$ 391,620	391,620				
4. a. Private-Pay Residents and Other	\$ 6,458,842	6,458,842				
b. Private-Pay Room and Board Contractual Allowance **	\$ (1,608,939)	(1,608,939)				
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 202,800	202,800				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (202,800)	(202,800)				
c. Prescription Drugs - Non-Medicare	\$ 283,742	283,742				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (297,952)	(297,952)				
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	\$ 545,054	545,054				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (404,570)	(404,570)				
c. Physical Therapy - Non-Medicare	\$ 618,190	618,190				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (516,775)	(516,775)				
4. a. Speech Therapy - Medicare	\$ 134,113	134,113				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (68,178)	(68,178)				
c. Speech Therapy - Non-Medicare	\$ 201,105	201,105				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (136,816)	(136,816)				
5. a. Occupational Therapy - Medicare	\$ 752,788	752,788				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (460,694)	(460,694)				
c. Occupational Therapy - Non-Medicare	\$ 1,034,501	1,034,501				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (716,926)	(716,926)				
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 50,830	50,830				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 75,677	75,677				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 32,958,227	32,958,227				
<b>IV. Other Revenue*</b>						
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> )	\$ 459	459				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$ 221,373	221,373				
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 221,832	221,832				
<b>VI. Total All Revenue</b> (III + V)	\$ 33,180,059	33,180,059				

\* 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 II 6a	Medicare Pt A IV Therapy	\$ 28,096		
30 II 6a	Medicare Pt A Lab	20,099		
30 II 6a	Medicare Pt A X-Ray	10,743		
30 II 6a	Medicare Pt B Prior Period	(8,108)		
<b>Total Other Resident Revenue - Medicare</b>		<b>\$ 50,830</b>	<b>\$ -</b>	<b>\$ -</b>

## Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
		-		
30 II 6b	Medicaid Lab	\$ 3,310		
30 II 6b	MCR Pt A Chargeable Med Supp	1,026		
30 II 6b	MCR Pt A Charge Med Supp Contra	(1,026)		
30 II 6b	Medicare Pt A Settlement	12,098		
30 II 6b	Medicare Pt B Flu/Pneumonia	4,339		
30 II 6b	Comm Ins IV Therapy	12,246		
30 II 6b	Comm Ins Lab	2,787		
30 II 6b	Comm Ins X-Ray	1,068		
30 II 6b	Mgd Medicare IV Therapy	10,463		
30 II 6b	Mgd Medicare Lab	17,230		
30 II 6b	Mgd Medicare Glucose	(1,110)		
30 II 6b	Mgd Medicare X-Ray	9,934		
30 II 6b	Mgd Medicare Flu/Pneumonia	6,203		
30 II 6b	Mgd Medicare Prior Period	(2,891)		
<b>Total Other Resident Revenue</b>		<b>\$ 75,677</b>	<b>\$ -</b>	<b>\$ -</b>

## Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
			-		
30 IV 5	Interest Expense on Money Market Account	338,470	\$ 459		
<b>Total Interest Income</b>			<b>\$ 459</b>	<b>\$ -</b>	<b>\$ -</b>

## Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
		-		
30 IV 8	Prior Period Revenue	\$ 47,743		
30 IV 8	Lawsuit Settlement Revenue (No CY Expense)	625		
30 IV 8	Sales of Equipment (Disallowed on Pg 29a)	744		
30 IV 8	Medical Records Revenue (Disallowed on Pg 29a)	594		
30 IV 8	UHC Income	124,292		
30 IV 8	Write Off of PY Outstanding Checks	19,681		
30 IV 8	Miscellaneous Revenue (Disallowed on Pg 29a)	27,619		
30 IV 8	Void of Legal Expense (No CY Expense)	75		
<b>Total Other Revenue</b>		<b>\$ 221,373</b>	<b>\$ -</b>	<b>\$ -</b>

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2019	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	918,754
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	3,488,564
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	546,784
4. Inventories			\$	52,264
5. Prepaid Expenses			\$	533,541
a. _____				
b. _____				
c. _____				
d. See Schedule		533,541		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	63,488
CT PET Deferred Tax		63,488		
_____				
_____				
See Schedule				
<b>A-9. Total Current Assets (Lines A1 thru 8)</b>			<b>\$</b>	<b>5,603,395</b>
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
4. Leasehold Improvements	*Historical Cost <u>3,097,363</u>		\$	784,169
	Accum. Depreciation <u>2,313,194</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>2,224,101</u>		\$	732,001
	Accum. Depreciation <u>1,492,100</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
_____				
See Schedule				
<b>B-10. Total Fixed Assets (Lines B1 thru 9)</b>			<b>\$</b>	<b>1,516,171</b>

\* 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
Riverside Health Care Center, Inc.	1000c	9/30/2019	32	37
Account			Amount	
Total Brought Forward:			\$	7,119,566
<b>C. Leasehold or like property recorded for Equity Purposes.</b>				
1. Land			\$	
2. Land Improvements			*Historical Cost _____	
Accum. Depreciation _____			Net \$	
3. Buildings			*Historical Cost 20,614,833	
Accum. Depreciation _____			Net \$ 20,614,833	
4. Non-Movable Equipment			*Historical Cost 1,048,608	
Accum. Depreciation _____			Net \$ 1,048,608	
5. Movable Equipment			*Historical Cost _____	
Accum. Depreciation _____			Net \$	
6. Motor Vehicles			*Historical Cost _____	
Accum. Depreciation _____			Net \$	
7. Minor Equipment-Not Depreciable			\$	
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$ 21,663,441	
<b>D. Investment and Other Assets</b>				
1. Deferred Deposits			\$	491,239
2. Escrow Deposits			\$	466,591
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> )			\$	33,978
Security Deposits 33,978				
See Schedule				
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$ 991,808	
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$ 29,774,815	

\* 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
Riverside Health Care Center, Inc.		1000c	9/30/2019	33	37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	5,701,054
2. Notes Payable ( <i>itemize</i> )				\$	
See Schedule					
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$	27,541
Name of Lender		Purpose	Amount	Date Due	
		Equipment Lease ST	27,541		
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$	1,388,194
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable ( <i>Current Portion</i> )				\$	
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities ( <i>itemize</i> )				\$	1,331,796
See Schedule					1,331,796
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>				\$	<b>8,448,585</b>

\* 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 Riverside Health Care Center, Inc.		License No. 1000c	Report for Year Ended 9/30/2019	Page 34	of 37
Account				Amount	
Total Brought Forward:				8,448,585	
<b>Liabilities (cont'd)</b>					
B. Long-Term Liabilities					
1. Loans Payable-Equipment ( <i>itemize</i> )					
				\$	142,157
Name of Lender	Purpose	Amount	Date Due		
	Equipment Lease LT				
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$	422,570
Name and Address of Lender	Amount	Loan Date			
Due to Related / Other	422,570				
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$	
_____					
_____					
See Schedule					
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$	564,727
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$	9,013,312

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	A5	Prepaid Expenses	\$ 2,687
31	A5	Prepaid Workers Comp	44,048
31	A5	Prepaid Gen. Ins	63,015
31	A5	Prepaid Expense Other	36,909
31	A5	Prepaid Real Estate Taxes	247,018
31	A5	Prepaid Personal Property Taxes	32,394
31	A5	Prepaid Mgmt Assets	107,470
<b>Total Prepaid Expenses</b>			<b>\$ 533,541</b>

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

Page Ref	Line Ref	Description	
<b>Total Other Current Assets (Itemize)</b>			<b>\$ -</b>

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

Page Ref	Line Ref	Description	
<b>Total Other Other Fixed Assets (Itemize)</b>			<b>\$ -</b>

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
<b>Total Other Assets</b>			<b>\$ -</b>

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
<b>Total Notes Payable</b>			<b>\$ -</b>

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

Page Ref	Line Ref	Description	
33	A12	Loans and Exchange	\$ (946)
33	A12	Unclaimed ADP checks	4,270
33	A12	Due to Medicaid	464,750
33	A12	Patients Fund	134,728
33	A12	Voluntary Ded. Exchange	13,823
33	A12	Accrued Expenses	499,417
33	A12	Accrued Pension	79,375
33	A12	Accrued Worker's Comp	110,089
33	A12	Accrued Purchase	26,290
<b>Total Other Current Liabilities (Itemize)</b>			<b>\$ 1,331,796</b>

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

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			<b>\$ -</b>



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

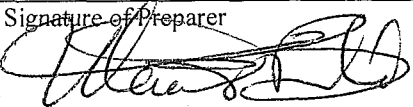
Name of Facility	License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2019	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	20,614,833
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	1,048,608
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			\$	21,663,441
<b>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	5,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(456,476)
6. Gain or Loss for Period			\$	(450,462)
7. Total Net Worth			\$	(901,938)
<b>C. Total Reserves and Net Worth</b>			\$	20,761,503
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	29,774,815

### H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2019	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2018			\$	(238,817)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	33,180,059
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	33,630,521
D. Net Income or Deficit			\$	(450,462)
E. Balance			\$	(689,279)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
Rounding (3)				
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	(3)
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	212,656
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
Partner Drawings			212,656	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	212,656
H. <b>Balance at End of Period</b>			\$	(901,938)
09/30/19				

① Prior year adjusted for filing error

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

Name of Facility Riverside Health Care Center, Inc.	License No. 1000c	Report for Year Ended 9/30/2019	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)		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer 	Title PRINCIPAL	Date Signed 2/13/20		
Printed Name of Preparer Matthew S. Bavolack				
Address Address 555 Long Wharf Drive, New Haven, CT 06511		Phone Number 203-781-9600		
Contacted Person Regarding Additional Information Needed Regarding This Report John Phelps		Phone Number 516-705-4813		
Contact Email Address jphelps@nathealthcare.com				

## ACCOUNTANTS' CONSULTING REPORT

Management is responsible for the accompanying Annual Report of Long-Term Care Facility (the "Cost Report") for Riverside Health Care Center, Inc. for the year ended September 30, 2019, included in the accompanying prescribed form. We have prepared the Cost Report in accordance with the American Institute of Certified Public Accountants' Statements on Standards for Consulting Services. The Cost Report was prepared in conformity with regulations prescribed by The State of CT Department of Social Services (DSS) from data provided to us by the management of Riverside Health Care Center, Inc. We did not audit or review the Cost Report included in the accompanying prescribed form, nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any form of assurance on the Cost Report included in the accompanying prescribed form.

Management is responsible for maintaining its records in accordance with accounting principles generally accepted in the United States of America and in accordance with reimbursement regulations set forth by DSS. Management is also responsible for designing, implementing, and maintaining internal control relevant to the preparation and fair presentation of the financial data and supplemental information included in the Cost Report.

This report is intended solely for the information and use of the management of Riverside Health Care Center, Inc. and DSS and is not intended to be, and should not be, used by anyone other than these specified parties.

**MARCUM LLP**

New Haven, CT  
February 10, 2020

# Annual Report of Long-Term Care Facility Cost Year 2019 Checklist

This checklist is not required to be submitted with the Annual Report

**Facility Name** Riverside Health Care Center, Inc.

Complete the following check list. **Provide an explanation for any "No" answers.** Attach additional sheets to explain further, if necessary.

Yes No  
  1. Have all related parties been properly disclosed on Pages 4, 11, 12, 14, 17 and 21?

**Explanation:** \_\_\_\_\_  
\_\_\_\_\_

Yes No  
  2. Are the methods of allocating costs consistent with prior year? If not, explain the reporting change.

**Explanation:** \_\_\_\_\_  
\_\_\_\_\_

Yes No  
  3. Are costs allocated based on the methods prescribed on Page 5 of the Annual Report? If not, provide the basis of your allocation.

**Explanation:** \_\_\_\_\_  
\_\_\_\_\_

Yes No  
  4. Do equipment leases listed on Page 6 agree with equipment leases reported on Page 22, Line 6e? If not, state where these costs are included in the Annual Report.

**Explanation:** \_\_\_\_\_  
\_\_\_\_\_

Yes  No

5. Do accounting and legal fees reported on Page 7 agree with Page 15, Lines 1d and 1e, respectively?

Explanation: \_\_\_\_\_  
\_\_\_\_\_

Yes  No

6. During cost year, did you report all certified bed changes on Page 9? Do the bed change dates agree to the license issued by the Department of Health?

Explanation: \_\_\_\_\_  
\_\_\_\_\_

Yes  No

7. If there has been a change in Administrators, have the dates of employment and applicable hours for each Administrator been reported on Page 12?

Explanation: \_\_\_\_\_  
\_\_\_\_\_

Yes  No

8. Have hours been reported for all expenses claimed on Page 13? Hours must be actual rather than estimated.

Explanation: \_\_\_\_\_  
\_\_\_\_\_

Yes  No

9. Has resident day user fee expense been properly reported on Page 15, Line 1k3?

Explanation: \_\_\_\_\_  
\_\_\_\_\_

Yes  No

10. Have purchased services greater than \$10,000 reported on Pages 16, 18, 19, 20 and 22 been detailed on Page 21?

Explanation: \_\_\_\_\_  
\_\_\_\_\_

Yes No

11. Have the dietary and laundry questionnaires on Pages 18 and 19 been completed?

Explanation: \_\_\_\_\_  
\_\_\_\_\_

Yes No

12. Has the personal use portion of automobile expense been disallowed, including, depreciation, lease payments, insurance and taxes?

Explanation: \_\_\_\_\_  
\_\_\_\_\_

Yes No

13. Does historical cost and accumulated depreciation of all assets reported on Pages 23 and 24 roll forward from the prior cost year?

Explanation: \_\_\_\_\_  
\_\_\_\_\_

Yes No

14. Does the net book value of all assets reported on Pages 23 and 24 agree with the net book value reported on Pages 31 and 32?

Explanation: \_\_\_\_\_  
\_\_\_\_\_

Yes No

15. Has asset useful life been reported in accordance with the 2013 edition of the American Hospital Association guidelines?

Explanation: \_\_\_\_\_  
\_\_\_\_\_

Yes No

16. Have all assets been categorized between movable and fixed in accordance with the 2013 edition of the American Hospital Association guidelines?

Explanation: \_\_\_\_\_  
\_\_\_\_\_

Yes No

17. Have all contractual allowances been properly reported on Page 30?

Explanation: \_\_\_\_\_  
\_\_\_\_\_

Yes No

18. Were all discrepancies on the Error Page addressed?

Explanation: \_\_\_\_\_  
\_\_\_\_\_

Yes No

19. Have Pages 1 and 37 been signed? *Cost reports without a signed Page 1 and 37 will not be accepted.*

Explanation: \_\_\_\_\_  
\_\_\_\_\_

Yes No

20. Have detailed schedules been provided for all "other" line items, fixed asset and movable equipment additions? *If detail is not provided, appropriate disallowances will be made.*

Explanation: \_\_\_\_\_  
\_\_\_\_\_

Yes No

21. Have all costs associated with non-nursing home businesses (i.e., Adult Daycare, Meals on Wheels, Outpatient Therapy Services, etc.) been disallowed on Pages 28 and/or 29 of the Annual Report?

Explanation: \_\_\_\_\_  
\_\_\_\_\_

Yes No

22. Has all required documentation been submitted to the Annual Report review and audit contractor?

Explanation: \_\_\_\_\_  
\_\_\_\_\_