State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2019

Name of Facility (as licensed) Salmon Brook Rehab and Nursing		
Address (No. & Street, City, State, Zip Code) 1423 Quinnipiac Ave, Unit 202 New Haven, CT 06513		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 5/1/2019	Report for Year Ending 9/30/2019	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2093			075060

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	20412		

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Salmon Brook Rehab and Nursing	2093	9/30/2019	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Salmon Brook Rehab and Nursing [facility name], for the cost report period beginning May 1, 2019 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.

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Shanique Mightly			Printed Name (Owner) Eliezer Elefant	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Salmon Brook Rehab and Nursing	Period Covered:		From 5/1/2019	To 9/30/2019
Address of Facility 1423 Quinnipiac Ave, Unit 202 New Haven, CT 06513				
Report Prepared By Marcum LLP	Phone Number 203-781-9600		Date 1/9/2019	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-938-2223	9/30/2019	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Salmon Brook Rehab and Nursing	1423 Quinnipiac Ave, Unit 202 New Haven, CT 06513

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2093			075060

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Eliezer Elefant purchased facility on 5/1/19.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Shanique Mightly	002093

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

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

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

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

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Salmon Brook Rehab and Nursing	1423 Quinnipiac Ave, Unit 202 New Haven, CT 06513	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Eliezer Elefant	54 Farview Circle Watertown CT 06795	Owner	100
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Salmon Brook Rehab and Nursing	2093	9/30/2019	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
RegalCare Rehab	26 Firemens Memorial Drive, Suite 205, Pomona, NY 10970	○	⊙		Physical Therapy	Page 13 / Line 5a	181,428	181,428
RegalCare Rehab	26 Firemens Memorial Drive, Suite 205, Pomona, NY 10970	○	⊙		Speech Therapy	Page 13 / Line 9a	41,689	41,689
RegalCare Rehab	26 Firemens Memorial Drive, Suite 205, Pomona, NY 10970	○	⊙		Occupational Therapy	Page 13 / Line 10a	201,940	201,940
Salmon Brook PropCo	5 Barlow Road, Edison, NJ 08817	○	⊙		Rental Property	Page 22 / Line 9	550,000	***550000
		○	⊙		Various Intercompany Loans	Pag 34 / Line B3		
Eliezer Elefant	26 Firemens Memorial Drive, Suite 205, Pomona, NY 10970	○	⊙		Admin Services	Page 16 m11	33,200	33,200
		○	⊙					
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Salmon Brook Rehab and Nursing	2093	9/30/2019	5	37

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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.

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
						Total ***	

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No

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

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General Information and Questionnaire
Accounting Basis

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1	
2	
3	
4	

Services Provided by This Firm (*describe fully*)

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

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

○ Yes ⊙ No

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Treasurer State of CT	860-652-7629
2 Charles Fisher, State Marshal: Mary Scata	
3	
4	
5	

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

1 2143 Main Street Glastonbury, CT 06033
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	Conservatorship (Disallowed)	$	650
2	Statutory representation	$	103
3	Contingency fee real estate tax reduction (Disallowed)	$	3,405
4		$	
5		$	
	Charge for Services Provided	$	4,158

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

⊙ Yes ○ No

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	130	130			130	130			126	126		
B. On last day of THIS report period	126	126			126	126			126	126		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	92	92			92	92			94	94		
B. As of midnight of THIS report period	96	96			94	94			96	96		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,315	2,315			707	707			1,608	1,608		
B. Medicaid (Conn.)	9,459	9,459			3,717	3,717			5,742	5,742		
C. Medicaid (other states)												
D. Private Pay	538	538			309	309			229	229		
E. State SSI for RCH												
F. Other (Specify) HMO/Hospice	2,176	2,176			786	786			1,390	1,390		
G. Total Care Days During Period (3A thru F)	14,488	14,488			5,519	5,519			8,969	8,969		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	89	89			89	89						
B. Other Bed Reserve Days	8	8			8	8						
5. ***Total Resident Days*** **(3G + 4A + 4B)**	14,585	14,585			5,616	5,616			8,969	8,969		

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Schedule of Resident Statistics (Cont'd)

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

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	18	61		17				
Per Diem Rate								
a. One bed rm.	Various	235.00		400.00				
b. Two bed rms.	Various	231.00		265.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	1,184	1,184		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	33	33		
2. Restorative Treatments	296	296		
C. Other	8,561	8,561		
D. ***Total Physical Therapy Treatments***	10,074	10,074		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	278	278		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	10	10		
2. Restorative Treatments	89	89		
C. Other	889	889		
D. ***Total Speech Therapy Treatments***	1,266	1,266		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,366	1,366		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	57	57		
2. Restorative Treatments	517	517		
C. Other	9,269	9,269		
D. ***Total Occupational Therapy Treatments***	11,209	11,209		

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Report of Expenditures - Salaries & Wages

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	51,192	875				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	63,645	2,860				
5. Dietary Service						
a. Head Dietitian	8,867	243				
b. Food Service Supervisor						
c. Dietary Workers	158,511	6,242				
6. Housekeeping Service						
a. Head Housekeeper	14,286	571				
b. Other Housekeeping Workers	116,577	6,843				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	34,900	1,615				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	30,917	1,798				
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	66,604	1,353				
b. RN						
1. Direct Care	332,306	8,072				
2. Administrative**	116,141	395				
c. LPN						
1. Direct Care	412,437	13,208				
2. Administrative**						
d. Aides and Attendants	638,332	34,389				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	38,872	2,177				
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	49,133	1,647				
n. Marketing	5,278	115	Est.			
o. Other (Specify)						
See Attached Schedule	24,720	814				
A-13. Total Salary Expenditures	2,162,718	83,217				

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
	0					
Admissions	$ 24,720	814				
Total	$ 24,720	814	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
	0					
Respiratory Therapist (Disallowed)	$ 1,685	10				
IV Insertions (Disallowed)	$ 3,751	26 insertions				
Total	$ 5,436	10	$ -	-	$ -	-

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

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

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Shanique Mightly	51,192				Management of Center	875	A2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Salmon Brook Rehab and Nursing	2093	9/30/2019	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	2,255	90				
3. Pharmacist	2,173	No Hours				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	181,428	2,519				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	17,000	308				
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	41,689	317				
b. Other						
10. Occupational Therapist						
a. Resident Care	201,940	2,802				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	53,656	190				
2. Administrative***						
b. LPN						
1. Direct Care	3,512	25				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	5,436	10				
B-13 Total Fees Paid in Lieu of Salaries	509,089	6,261				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
LTC Management	Dental Services	○	⊙	N/A
Santo Buccheri, M.D.	Medical Director	○	⊙	N/A
Medwiz	Insertions, Clinical Support	○	⊙	N/A
Technical Gas Products	Respiratory Service; Preventive maintenance and electrical testing	○	⊙	N/A
Regal Care Rehabilitation LLC	PT, ST, OT	○	⊙	N/A
MassTex Imaging, LLC	Swallow study/Consultation	○	⊙	N/A
Deborah A. Hardy	RN	○	⊙	N/A
AAA Nursing Care	RN, LPN	○	⊙	N/A
The Nurse Network	RN, LPN	○	⊙	N/A
Integra Scripts	Pharmacy Review	○	⊙	N/A
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Salmon Brook Rehab and Nursing	2093	9/30/2019		15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	57,569	57,569		
2. Disability Insurance	$				
3. Unemployment Insurance	$	(2,539)	(2,539)		
4. Social Security (F.I.C.A.)	$	210,156	210,156		
5. Health Insurance	$	390,371	390,371		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	64,063	64,063		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	9,023	9,023		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	47,149	47,149		
d. Accounting and Auditing	$				
e. Legal (*Services should be fully described on Page 7)*	$	4,158	4,158		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	7,469	7,469		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	3,194	3,194		
2. Cellular Phones	$	166	166		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	230,779	230,779		
Subtotal	$	1,021,558	1,021,558		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
	0		
Union Training Fund	$ 8,172		
Background Checks	$ 851		
Total	$ 9,023	$ -	$ -

Schedule of Other Taxes

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

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Salmon Brook Rehab and Nursing	2093	9/30/2019	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,021,558	1,021,558		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	3,170	3,170		
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	7,641	7,641		
5. Education Expenses Related to Seminars and Conventions	$	1,273	1,273		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	450	450		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	5,960	5,960		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	1,350	1,350		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$				
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	375	375		
9. Subscriptions	$				
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	132,495	132,495		
12. Administrative Management Services**	$				
13. Other (*Specify*) See Attached Schedule	$	3,820	3,820		
C-14 Total Administrative & General Expenditures	$	1,178,092	1,178,092		

* 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)
	0		
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
	0		
Marketing and Advertising	$ 5,960		
Total Other Advertising	$ 5,960	$ -	$ -

Schedule of Dues

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

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
	0		
Salon/Food/Inspection and Cetificate fee for boiler/water heater	$ 1,441		
Late Fees (Disallowed)	$ 7		
Bank Fees	$ 491		
Employee Food (Disallowed)	$ 1,354		
Employee Relations (Disallowed)	$ 527		
Total Other Administrative and General	$ 3,820	$ -	$ -

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CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Salmon Brook Rehab and Nursing	2093	9/30/2019	17 | 37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

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

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CSP-18 Rev. 9/2018

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

Name of Facility	License No.	Report for Year Ended	Page of
Salmon Brook Rehab and Nursing	2093	9/30/2019	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	90,216	90,216		
2. Non-Food Supplies	$	13,901	13,901		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	33,431	33,431		
c. Other (*Specify*)_____ Other Dietary Supplies	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	137,548	137,548		

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

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

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

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CSP-19 Rev. 9/2018

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

Name of Facility	License No.	Report for Year Ended	Page of
Salmon Brook Rehab and Nursing	2093	9/30/2019	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*					
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $				
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) Supplies	$	2,443	2,443		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	2,443	2,443		

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

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

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

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CSP-20 Rev. 9/2018

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
Salmon Brook Rehab and Nursing	2093	9/30/2019	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
C. Other (*Specify*) Supplies		$	9,023	9,023		
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	9,023	9,023		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	136,071	136,071		
b. Medicine Cabinet Drugs		$	1,527	1,527		
c. Medical and Therapeutic Supplies		$				
d. Ambulance/Limousine***		$	1,895	1,895		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	1,833	1,833		
f. X-rays and Related Radiological Procedures***		$	4,647	4,647		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	17,772	17,772		
i. Recreation		$	9,695	9,695		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	67,327	67,327		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	240,767	240,767		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
	0		
Nursing Supplies	$ 58,259		
Sanitation and Incineration	$ 269		
Equipment Rental	$ 8,799		
Total Other Resident Care	$ 67,327	$ -	$ -

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CSP-21 Rev. 10/2001

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

Name of Facility	License No.	Report for Year Ended	Page	of
Salmon Brook Rehab and Nursing	2093	9/30/2019	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
Healthcare Services Group Inc.	Drive, Bensalem, PA 19020	○	⊙	N/A	Dietary Management Services	33,431			18	2b
All Waste Inc.		○	⊙	N/A	Waste Disposal	11,106			22	6f
LTC Consulting Services	7 Randolph Road, Howell, NJ 07731	○	⊙	N/A	Billing and Fisclal Services	70,250			16	m11
Eliezer Elefant		⊙	○	Owner	Administrative Services	33,200			16	m11
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

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

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CSP-22 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Salmon Brook Rehab and Nursing	2093	9/30/2019	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	24,988	24,988		
b. Heat	$	7,465	7,465		
c. Light & Power	$	85,392	85,392		
d. Water	$	12,315	12,315		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	32,298	32,298		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	162,458	162,458		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$				
d. Movable Equipment	$	2,029	2,029		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	2,029	2,029		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$	33,229	33,229		
b. Mortgage Expense	$				
c. Leasehold Improvements	$	12,738	12,738		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	45,967	45,967		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	550,000	550,000		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	50,758	50,758		
c. Personal property taxes	$	21,605	21,605		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	670,359	670,359		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
	0		
Supplies	$ 3,727		
Sanitation and Incineration	$ 11,106		
Extermination	$ 1,340		
Landscaping	$ 6,996		
Fire Drill	$ 535		
Contracted Service	$ 7,904		
Security	$ 690		
Total Other Repairs and Maintenance	$ 32,298	$ -	$ -

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CSP-23 Rev. 10/2006

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Salmon Brook Rehab and Nursing	2093	9/30/2019	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
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								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period												
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			Var	Var	17,637		17,637		S/L	Various	2,029	
D-3. Subtotal												2,029
E. ***Total Depreciation***												2,029

Schedule of Land In

Acquisition Date
Additions:
Total additions for L
Deletions:
Total deletions for L

***Ties to Page 23, L**

****Ties to Page 23, L**

Schedule of Building

Acquisition Date
Additions:
Total additions for B
Deletions:
Total deletions for B

***Ties to Page 23, L**

****Ties to Page 23, L**

Schedule of Non-Mo

Acquisition Date
Additions:
Total additions for N
Deletions:
Total deletions for N

***Ties to Page 23, L**

****Ties to Page 23, L**

Schedule of Movabl

Acquisition Date	
Additions:	
Total additions for M	
Deletions:	
Total deletions for M	

***Ties to Page 23, L**
****Ties to Page 23, L**

Schedule of Leaseho

Acquisition Date	
Additions:	
Total additions for L	
Deletions:	
Total deletions for L	

***Ties to Page 24, L**
****Ties to Page 24, L**

nprovements Acquired during this report peri

Description of Item
Land Improvement
Land Improvement

ine A3

ine A2

g Improvements Acquired during this report peri

Description of Item
Building Improvement
Building Improvement

ine B3

ine B2

ovable Equipment Acquired during this report peri

Description of Item
Non-Movable Equipmen
Non-Movable Equipmen

ine C3

ine C2

e Equipment Acquired during this report peri

Description of Item
Plumbing & Heating: new toilet
Plumbing & Heating: new sink
HD Supplies: carpet extractor
Coastal Mechanical Services: replace hot water heater
Hector Caraballo: POC Tablets
Capital One: Printer
On-Time IT Solutions, Inc.: Dell Opti Plex x2
Movable Equipmen
Movable Equipmen

ine D2c
ine D2b

ld Improvements Acquired during this report peri

Description of Item
Plumbing & Heating: new water line in refrigerator and new valve and angle in toilet
Commercial Door and Hardware: kitchen door
Coastal Mechanical Services: new pump, bell gasket
Coastal Mechanical Services: replace kitchen compressor
Aldrich Equipment: install actuator
Gas Equipment Service and Repair LLC: emergency repair on gas line- replaced the regulator
BridgeLine Global Solutions: cross connects
Plumbing & Heating: installed faucet handles in kitchen
Coastal Mechanical Services: replaced fuses
Coastal Mechanical Services: replace belt on dishwasher, fix leak on discharge line, charge chiller with R-22, straighten out fins on chiller, blow out drain line and raise tubi
Hartford Sign & Design: new signs
Distinctive Coatings LLC: stainless steel plates under sink area
H&E Enterprize: catch basin repair (cost of materials was about $1346)
Coastal Mechanical Services: installed fan cycling switch and filter on unit
Coastal Mechanical Services: new sensors
Copier
Leasehold Improvemer
Leasehold Improvemen

ine C3
ine C2

Cost	Useful Life	Depreciation	
$ -		$ -	*
$ -		$ -	**

Cost	Useful Life	Depreciation	
$ -		$ -	*
$ -		$ -	**

Cost	Useful Life	Depreciation	
$ -		$ -	*
$ -		$ -	**

Cost	Useful Life	Depreciation	
$ 1,054	20	$ 53	
$ 924	20	$ 46	
$ 2,194	10	$ 219	
$ 9,813	10	$ 981	
$ 1,015	5	$ 203	
$ 775	5	$ 155	
$ 1,862	5	$ 372	
$ 17,637		$ 2,029	*
$ -		$ -	**

Cost	Useful Life	Depreciation	
$ 1,225	20	$ 61	
$ 866	15	$ 58	
$ 1,444	10	$ 144	
$ 3,451	12	$ 288	
$ 1,971	10	$ 197	
$ 1,214	25	$ 49	
$ 1,177	10	$ 118	
$ 560	20	$ 28	
$ 964	15	$ 64	
$ 7,735	10	$ 774	
$ 3,669	10	$ 367	
$ 1,908	10	$ 191	
$ 2,600	15	$ 173	
$ 1,135	15	$ 76	
$ 1,690	15	$ 113	
$ 50,184	5	$ 10,037	
$ 81,793		$ 12,738	*
$ -		$ -	**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Salmon Brook Rehab and Nursing	2093	9/30/2019	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1. Startup Costs	5	2019		92,800		S/L		33,229	
2.									
3.									
A-4. Subtotal									33,229
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				81,793		S/L		12,738	
C-4. Subtotal									12,738
D. ***Total Amortization***									45,967

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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CSP-25 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Salmon Brook Rehab and Nursing	2093	9/30/2019	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	
6. Square Footage	
7. Acquisition Cost	
a. Land	
b. Building	

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

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

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
Salmon Brook ProperCo	Building	05/01/19	Ongoing	550,000

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

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CSP-26 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Salmon Brook Rehab and Nursing	2093	9/30/2019	26 | 37

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

(*Carry Subtotals forward to next page*)

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CSP-27 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Salmon Brook Rehab and Nursing	2093	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*)			$	68,422	68,422		
Other Interest							
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)			$	68,422	68,422		
14. Insurance							
a. Insurance on Property (buildings only)			$	6,697	6,697		
b. Insurance on Automobiles			$				
c. Insurance other than Property (as specified above)							
1. Umbrella (*Blanket Coverage*)			$				
2. Fire and Extended Coverage			$				
3. Other (*Specify*)			$	58,704	58,704		
General Liability/Property							
14d. ***Total Insurance Expenditures (14a + b + c)***			$	65,401	65,401		
15. ***Total All Expenditures (A-13 thru C-14)***			$	5,206,320	5,206,320		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Salmon Brook Rehab and Nursing	2093	9/30/2019	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $	5,278	5,278		
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	10a	Occupational Therapy $	201,940	201,940		
7.			Other - See attached Schedule $	44,156	44,156		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	47,149	47,149		
10.			Accounting $				
10a.			Legal $	4,054	4,054		
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.	16	m2/3	Unallowable Advertising * $	5,960	5,960		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	3,722	3,722		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $				
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	312,259	312,259		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	L12N	Marketing	$ 5,278		
Total Other Salaries Adjustment			$ 5,278	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B12	Respiratory Therapist	$ 1,685		
13	B12	IV Insertions	$ 3,751		
13	B11a1	CHOW Consent Order Contract RN	$ 38,720		
Total Other Fees Adjustments			$ 44,156	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
15	Var	Benefits Associated with Marketing Salary	$ 1,459		
16	m13	Late Fees	7		
16	m13	Employee Food	1,354		
16	m8a	Chamber of Commerce Dues	375		
16	m13	Employee Relations	527		
Total Other A&G Adjustments			$ 3,722	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Salmon Brook Rehab and Nursing	2093	9/30/2019	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	312,259	312,259		
Page 20 - Resident Care Supplies***								
27.	20	5a2	Prescription Drugs	$	136,071	136,071		
28.	20	5d	Ambulance/Limousine	$	1,895	1,895		
29.	20	5f	X-rays, etc	$	4,647	4,647		
30.	20	5h	Laboratory	$	17,772	17,772		
31.			Medical Supplies	$				
32.	20	5e2	Oxygen (non emergency)	$	1,833	1,833		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	21,306	21,306		
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$				
36.			Depreciation on Unallowable Motor Vehicles	$				
37.			Unallowable Property and Real Estate Taxes	$				
38.			Rental of Building Space or Rooms	$				
39.			Other - See Attached Schedule	$				
Page 27 - Insurance								
40.			Mortgage Insurance	$				
41.			Property Insurance	$				
Other - Miscellaneous								
42.			Other - Indirect	$				
43.			Interest Income on Account Rec.	$				
44.			Other - Miscellaneous Administrative	$				
45.			Management Fees Direct	$				
46.			Management Fees Indirect	$				
47.			Other - Direct	$				
Not For Profit Providers Only								
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	$				
49.	***Total Amount of Decrease (Items 1 - 48)***			$	495,783	495,783		

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

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5i	Cable TV	$ 6,132		
20	5l	Nursing Supplies	$ 15,174		
Total Other Ancillary Costs			$ 21,306	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)

Total Other Adjustments			$ -	$ -	$ -

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Salmon Brook Rehab and Nursing	2093	9/30/2019	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	2,218,464	2,218,464		
b. Medicaid Room and Board Contractual Allowance **	$				
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,305,910	1,305,910		
b. Medicare Room and Board Contractual Allowance **	$	(14,806)	(14,806)		
4. a. Private-Pay Residents and Other	$	1,067,745	1,067,745		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$				
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$				
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	194,111	194,111		
b. Physical Therapy - Medicare Contractual Allowance **	$	(165,078)	(165,078)		
c. Physical Therapy - Non-Medicare	$	109,037	109,037		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(93,945)	(93,945)		
4. a. Speech Therapy - Medicare	$	70,353	70,353		
b. Speech Therapy - Medicare Contractual Allowance **	$	(52,157)	(52,157)		
c. Speech Therapy - Non-Medicare	$	45,527	45,527		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(26,869)	(26,869)		
5. a. Occupational Therapy - Medicare	$	221,353	221,353		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(187,552)	(187,552)		
c. Occupational Therapy - Non-Medicare	$	126,249	126,249		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(103,404)	(103,404)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	(121)	(121)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	4,714,817	4,714,817		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	1	1		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	110	110		
V. Total Other Revenue (1 thru 8)	$	111	111		
VI. Total All Revenue (III +V)	$	4,714,928	4,714,928		

* *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)
		0		
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
		0		
30 II 6b	Revenue Adjustment HMO	$ (80)		
30 II 6b	Revenue Adjustment Ancillary	$ (41)		
Total Other Resident Revenue		$ (121)	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
			0		
30 IV 5	Other Revenue Interest		$ 1		
Total Interest Income			$ 1	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
		0		
30 IV 8	Donation to Facility	$ 100		
30 IV 8	Bounced Check Fee	$ 10		
Total Other Revenue		$ 110	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Salmon Brook Rehab and Nursing	2093	9/30/2019	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 109,361
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,897,342
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 311,207
a. Prepaid Expenses				
b. Prepaid insurance				
c. Prepaid Taxes and WC Premiums				
d. See Schedule		311,207		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,317,910
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	81,793		$ 69,055
	Accum. Depreciation	12,738	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	17,637		$ 15,608
	Accum. Depreciation	2,029	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 11,181
F/S vs. C/R Depreciation		11,182		
See Schedule		(1)		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 95,844

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	A5	Prepaid Expenses	$ 21,630
31	A5	Prepaid Insurance	$ 93,191
31	A5	Prepaid Taxes	$ 115,791
31	A5	Prepaid Workers Comp	$ 80,595
Total Prepaid Expenses			$ 311,207

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

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

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

Page Ref	Line Ref	Description	
		Rounding	$ (1)
Total Other Other Fixed Assets (Itemize)			$ (1)

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
32	D7	Due From>Old Owner	$ 603
32	D7	Due To/(From)>Vendor	$ 133
Total Other Assets			$ 736

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

Page Ref	Line Ref	Description	
33	A12	Accrued Expenses	$ 122,286
33	A12	Capital Lease Copier	$ 47,006
33	A12	Insurance - General Liability & Other	$ 79,463
33	A12	Insurance - Property	9,375.00
33	A12	Workers Comp	59,150.00
Total Other Current Liabilities (Itemize)			$ 317,280

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

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Salmon Brook Rehab and Nursing	2093	9/30/2019	32	37

	Account				Amount
			Total Brought Forward:		$ 2,413,754
C.	Leasehold or like property recorded for Equity Purposes.				
	1. Land				$
	2. Land Improvements	*Historical Cost			
		Accum. Depreciation		Net	$
	3. Buildings	*Historical Cost			
		Accum. Depreciation		Net	$
	4. Non-Movable Equipment	*Historical Cost			
		Accum. Depreciation		Net	$
	5. Movable Equipment	*Historical Cost			
		Accum. Depreciation		Net	$
	6. Motor Vehicles	*Historical Cost			
		Accum. Depreciation		Net	$
	7. Minor Equipment-Not Depreciable				$
C-8	***Total Leasehold or Like Properties*** (C1 thru 7)				$
D.	Investment and Other Assets				
	1. Deferred Deposits				$ 500
	2. Escrow Deposits				$
	3. Organization Expense	*Historical Cost	93,803		
		Accum. Depreciation	33,229	Net	$ 60,574
	4. Goodwill (Purchased Only)				$
	5. Investments Related to Resident Care (*itemize*)				$
	6. Loans to Owners or Related Parties (*itemize*)				$ (255,658)
	Name and Address	Amount	Loan Date		
		(255,658)			
	7. Other Assets (*itemize*)				$ 736
	See Schedule		736		
D-8.	***Total Investments and Other Assets*** (Lines D1 thru 7)				$ (193,848)
D-9.	***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 2,219,906

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Salmon Brook Rehab and Nursing	2093	9/30/2019	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 830,798
2. Notes Payable (*itemize*)				$ 1,000,000
LOC		1,000,000		
See Schedule				
3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 30,249
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ (5,607)
7. Medicare Final Settlement Payable				$ 927
8. Medicare Current Financing Payable				$
9. Mortgage Payable (*Current Portion*)				$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
11. Accrued Income Taxes*				$
12. Other Current Liabilities (*itemize*)				$ 317,280
See Schedule		317,280		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 2,173,647

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Salmon Brook Rehab and Nursing	2093	9/30/2019	34	37

Account	Amount
Total Brought Forward:	2,173,647
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ 218,408

Name and Address of Lender	Amount	Loan Date
Management, RC Holdings, NL, EE, FV South Port, Eli Mirlis	218,408	

4. Other Long-Term Liabilities (*itemize*)		$ 308,059
Due To/(From)>Twin Oaks	300,000	
Due To/(From)>HMO	8,059	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 526,467
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 2,700,114

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

Name of Facility	License No.	Report for Year Ended	Page	of
Salmon Brook Rehab and Nursing	2093	9/30/2019	35	37

Account					Amount	
A.	**Reserves**					
	1. Reserve for value of leased land				$	
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized				$	
	3. Reserve for depreciation value of leased personal property (*Equity)*				$	
	4. Reserve for leasehold real properties on which fair rental value is based				$	
	5. Reserve for funds set aside as donor restricted				$	
	6. Total Reserves				$	
B.	**Net Worth**					
	1. Owner's Capital				$	
	2. Capital Stock				$	
	3. Paid-in Surplus				$	
	4. Treasury Stock				$	
	5. Cumulated Earnings				$	
	6. Gain or Loss for Period	5/1/2019	thru	9/30/2019	$	(480,208)
	7. Total Net Worth				$	(480,208)
C.	***Total Reserves and Net Worth***				$	(480,208)
D.	***Total Liabilities, Reserves, and Net Worth***				$	2,219,906

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Salmon Brook Rehab and Nursing	2093	9/30/2019	36	37

	Account	Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2018	$
B.	Total Revenue (*From Statement of Revenue Page 30*)	$ 4,714,928
C.	Total Expenditures (*From Statement of Expenditures Page 27*)	$ 5,195,136
D.	Net Income or Deficit	$ (480,208)
E.	Balance	$ (480,208)
F.	Additions	
	1. Additional Capital Contributed (*itemize*)	
	Expense Pg. 27 $5,206,320	
	Depreciation Diff $(11,184)	
	Total Expenses $5,195,136	
	2. Other (*itemize*)	
F-3.	Total Additions	$
G.	Deductions	
	1. Drawings of Owners/Operators/Partners (*Specify*)	$

Name and Address (*No., City, State, Zip*)	Title	Amount

	2. Other Withdrawings *(Specify)*	$

Purpose	Amount

	3. Total Deductions		$
H.	***Balance at End of Period***	09/30/19	$ (480,208)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Salmon Brook Rehab and Nursing	2093	9/30/2019	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Matthew S. Bavolack

Addres Address	Phone Number
555 Long Wharf Drive, New Haven, CT 06511	203-781-9600

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Yael Zabludowski	732-961-8571

Contact Email Address
yaelz@itccs.com