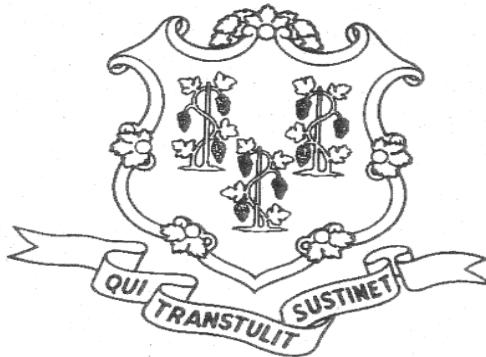


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) Gladeview Health Care Center	
Address (No. & Street, City, State, Zip Code) 60 Boston Post Road Old Saybrook, CT 06475	
Type of Facility  Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)      Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH 2024C	RHNS	(Specify)	Medicare Provider 07-5313
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Medicaid Provider Numbers:	CCNH 2024C	RHNS	ICF-IID
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### For Department Use Only

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

## General Information

Name of Facility (as licensed) Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021	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 Gladeview Health Care Center [facility name], for the cost report period beginning October 1, 2020 and ending September 30, 2021, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)	Date	Signed (Owner)	Date
Printed Name (Administrator) Paul Knutsen		Printed Name (Owner) Linda Silberstein	
Subscribed and Sworn to before me:	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public			

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Gladeview Health Care Center	Period Covered:		From 10/1/2020	To 9/30/2021
Address of Facility 60 Boston Post RoadOld Saybrook, CT 06475				
Report Prepared By Gladeview Health Care Center	Phone Number 860-388-6696	Date 2/2/2022		
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**

## **General Information and Questionnaire Partners/Members**

**General Information and Questionnaire**  
**Corporate Owners**

Name of Facility Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021	Page of 3A   37
If this facility is owned or operated as a corporation, provide the following information:			
Legal Name of Corporation Gladeview Health Care Center	Business Address 60 Boston Post Road Old Saybrook, CT 06475	State(s) in Which Incorporated CT	
Name of Directors, Officers Linda Silberstein	Business Address 60 Boston Post Road Old Saybrook, CT 06475	Title President	No. Shares Held by Each 100
Names of Stockholders Owning at Least 10% of Shares Same as above			

State of Connecticut

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

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**General Information and Questionnaire**  
**Individual Proprietorship**

Name of Facility Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021	Page of 3B   37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

N/A

## General Information and Questionnaire

### Related Parties\*

Name of Facility Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input checked="" type="radio"/> Yes <input type="radio"/> No				If "Yes," provide the Name/Address and complete the information on Page 11 of the report.				
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?				<input checked="" type="radio"/> Yes <input type="radio"/> No <span style="float: right;">If "Yes," provide the following information:</span>				
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party	
		Yes	No	%**				Description of Goods/Services Provided
Gladeview LLC	60 Boston Post Road Old Saybrook, CT 06475	<input type="radio"/>	<input checked="" type="radio"/>		Lease of Real Property	Pg 22, Line 9	1,093,687	1,093,687
Linda Silberstein	60 Boston Post Road Old Saybrook, CT 06475	<input type="radio"/>	<input checked="" type="radio"/>		Salaries and Benefits	Pg 10, line A3Pg 15, lin	191,467	191,467
Dawn Ra Corp	225 Boston Post Road Orange, CT 06477	<input type="radio"/>	<input checked="" type="radio"/>		Shared Salaries and Benefits (reduced from	Pg 10, line A3Pg 15, lin	53,270	53,270
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

\* Use additional sheets if necessary.

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

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021	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

State of Connecticut

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

CSP-6 Rev. 9/2002

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

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

Name of Facility Gladeview Health Care Center		License No. 2024C		Report for Year Ended 9/30/2021			Page 6      of 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					
Wells Fargo Leasing, PO Box 6434, Carol Stream, IL 60197	<input type="radio"/>	<input checked="" type="radio"/>	Copier	10/04/20	48 months	14,021	14,598
Neopost, PO Box 6813, Carol Stream, IL 60197-6813	<input type="radio"/>	<input checked="" type="radio"/>	Postage machine	04/25/19	39 Months	1,100	886
	<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"/>					
Is a Mileage Log Book Maintained for All Leased Vehicles ?		<input type="radio"/> Yes		<input checked="" type="radio"/> No		Total ***	15,484

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

\*\* Attach copies of newly acquired leases.

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

## General Information and Questionnaire

### Accounting Basis

Name of Facility Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual     Cash     Modified Cash

Is the accounting basis for this

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

#### Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1 401k Audit, tax return	\$ 24,359
2 Medicare Cost report	\$ 2,300
3	\$
4	\$
	Charge for Services Provided \$ 26,659

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

Yes     No    |PG 15 Line 1d

#### Legal Services Information

Name of Legal Firm or Independent Attorney 1 Shipman & Goodwin 2 Murtha Cullina 3 Jackson Lewis 4 5	Telephone Number 860-251-5000 203-772-7700 914-872-8060
--	--

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

1 One Constitution Plaza, Hartford, CT 06103	
2 265 Church St. New Haven, CT 06510	
3 44 South Broadway, 14th floor, White Plains, NY 10601	
4	
5	

Services Provided by This Firm (*describe fully*)

1 Employee matters	\$ 852
2 HIPPA matters/Resident will	\$ 127
3 Supervisory labor issues	\$ 2,250
4	\$
5	\$
	Charge for Services Provided \$ 3,229

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

Yes     No    |PG 15 Line 1e

## Schedule of Resident Statistics

Name of Facility Gladeview Health Care Center			License No. 2024C				Report for Year Ended 9/30/2021				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					132	132						
A. On last day of PREVIOUS report period	132	132										
B. On last day of THIS report period	132	132							132	132		
2. Number of Residents					110	110						
A. As of midnight of PREVIOUS report period	110	110										
B. As of midnight of THIS report period	80	80							80	80		
3. Total Number of Days Care Provided During Period					4,578	4,578			757	757		
A. Medicare	5,335	5,335										
B. Medicaid (Conn.)	20,291	20,291			14,958	14,958			5,333	5,333		
C. Medicaid (other states)												
D. Private Pay	4,820	4,820			3,404	3,404			1,416	1,416		
E. State SSI for RCH												
F. Other (Specify) Managed care and other	1,457	1,457			1,107	1,107			350	350		
G. Total Care Days During Period (3A thru F)	31,903	31,903			24,047	24,047			7,856	7,856		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds					17	17			10	10		
A. Medicaid Bed Reserve Days	27	27										
B. Other Bed Reserve Days												
5. <b>Total Resident Days (3G + 4A + 4B)</b>	<b>31,930</b>	<b>31,930</b>			<b>24,064</b>	<b>24,064</b>			<b>7,866</b>	<b>7,866</b>		

## Schedule of Resident Statistics (Cont'd)

Name of Facility Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?  Yes  No

If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	3	59		18				
Per Diem Rate								
a. One bed rm.	Various	291.00		415.00				
b. Two bed rms.		291.00		375.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B	2,751	2,751	(Specify)
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments	53	53	
C. Other	5,839	5,839	
<b>D. Total Physical Therapy Treatments</b>	<b>8,643</b>	<b>8,643</b>	

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	447	447	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	614	614	
<b>D. Total Speech Therapy Treatments</b>	<b>1,061</b>	<b>1,061</b>	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	2,016	2,016	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments	32	32	
C. Other	5,658	5,658	
<b>D. Total Occupational Therapy Treatments</b>	<b>7,706</b>	<b>7,706</b>	

## Report of Expenditures - Salaries &amp; Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		2024C	9/30/2021	10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes		<input type="radio"/> No	
		Total Cost and Hours			
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	200,204	2,152			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	191,467	2,096			
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	337,396	8,899			
5. Dietary Service					
a. Head Dietitian	45,540	1,390			
b. Food Service Supervisor	83,581	2,956			
c. Dietary Workers	430,844	25,709			
6. Housekeeping Service					
a. Head Housekeeper	56,093	2,283			
b. Other Housekeeping Workers	196,335	11,262			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	43,839	1,407			
b. Other Maintenance Workers	51,716	2,200			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers	56,470	3,223			
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	298,821	3,979			
b. RN					
1. Direct Care	695,547	19,777			
2. Administrative**	232,155	6,226			
c. LPN					
1. Direct Care	569,955	18,218			
2. Administrative**					
d. Aides and Attendants	1,669,537	74,693			
e. Physical Therapists	336,214	6,473			
f. Speech Therapists	54,368	1,384			
g. Occupational Therapists	142,445	3,836			
h. Recreation Workers	166,718	8,374			
i. Physicians					
1. Medical Director					
2. Utilization Review					
3. Resident Care***					
4. Other (Specify)					
Respiratory therapist	652	17			
j. Dentists					
k. Pharmacists					
l. Podiatrists					
m. Social Workers/Case Management	194,393	5,797			
n. Marketing					
o. Other (Specify)					
See Attached Schedule					
<i>A-13. Total Salary Expenditures</i>	6,054,290	212,351			

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

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

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

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

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

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

State of Connecticut

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

CSP-11 Rev. 10/2005

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

Name of Facility Gladerview Health Care Center			License No. 2024C		Report for Year Ended 9/30/2021			Page 11	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section I - Operators/Owners</b>										
<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.

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

CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
Gladerview Health Care Center				2024C		9/30/2021			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>										
Paul Knutsen	200,204			Health & Life insurance. Payroll taxes	Day to day operations of the nursing home	2,152	A2			
<b>Section IV - Assistant Administrators</b>										
Linda Silberstein	191,467			Health & Life insurance. Payroll taxes	Day to day operations of the nursing home	2,096	A3			

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

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

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

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

Name of Facility Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021		Page 13	of 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</b> (For all such services complete Schedule B1)					
1. Dietitian					
2. Dentist	13,794	55			
3. Pharmacist					
4. Podiatrist	1,291	13			
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	48,000	612			
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**	11,768	147			
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					
b. Other					
10. Occupational Therapist					
a. Resident Care					
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care					
2. Administrative***					
b. LPN					
1. Direct Care	386,712	5,996			
2. Administrative***					
c. Aides	77,159	1,695			
d. Other					
12. Other (Specify)					
See Attached Schedule					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	538,724	8,518			

\* 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\***

\* Use additional sheets if necessary.

\*\* Refer to Page 4 for definition of related.

**C. Expenditures Other Than Salaries - Administrative and General**

Name of Facility Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021	Page 15	of 37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 117,420	117,420		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 45,173	45,173		
4. Social Security (F.I.C.A.)	\$ 371,392	371,392		
5. Health Insurance	\$ 537,184	537,184		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 22,073	22,073		
8. Uniform Allowance	\$			
9. Other (Specify) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 180,000	180,000		
d. Accounting and Auditing	\$ 28,909	28,909		
e. Legal (Services should be fully described on Page 7)	\$ 979	979		
f. Insurance on Lives of Owners and Operators (Specify)*	\$ 11,062	11,062		
g. Office Supplies	\$ 23,462	23,462		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 27,853	27,853		
2. Cellular Phones	\$ 5,582	5,582		
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*	\$ 38,186	38,186		
2. Other (Specify) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 556,673	556,673		
<b>Subtotal</b>	\$ 1,965,948	1,965,948		

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

(Carry Subtotals forward to next page)

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

Attachment Page 15

## **Schedule of Other Employee Benefits**

### Schedule of Other Taxes

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

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

Name of Facility Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
<b><i>Subtotals Brought Forward:</i></b>		1,965,948	1,965,948		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$	5,803	5,803		
4. Employee Travel	\$				
5. Education Expenses Related to Seminars and Conventions	\$	2,625	2,625		
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$				
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$	28,635	28,635		
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	79,270	79,270		
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	\$	3,002	3,002		
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	11,214	11,214		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	341	341		
9. Subscriptions	\$	1,248	1,248		
10. Contributions*** See Attached Schedule	\$	1,110	1,110		
11. Services Provided by Contract ( <i>Specify and Complete     Schedule C-2, Page 21 for each firm or individual</i> )	\$	180,824	180,824		
12. Administrative Management Services**	\$				
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	10,549	10,549		
<b><i>C-14 Total Administrative &amp; General Expenditures</i></b>	\$	2,290,569	2,290,569		

\* 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	\$ 79,270		
<b>Total Other Advertising</b>	<b>\$ 79,270</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
Academy of Nutrition and Diet	\$ 136		
ALTCFM	\$ 85		
CAHCF	\$ 9,333		
Other	\$ 60		
Connecticut River Area Health District	\$ 280		
American Health Care Association	\$ 1,320		
<b>Total Dues</b>	<b>\$ 11,214</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
Bacon Academy	\$ 500		
Exchange Club	\$ 260		
Old Saybrook Ambulance	\$ 350		
<b>Total Contributions</b>	<b>\$ 1,110</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
Employee physicals	\$ 4,725		
Bank charges	\$ 5,824		
<b>Total Other Administrative and General</b>	<b>\$ 10,549</b>	<b>\$ -</b>	<b>\$ -</b>

State of Connecticut

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

CSP-17 Rev. 10/97

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

Name of Facility Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021	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 #
N/A			

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

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

Name of Facility Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021	Page 18	of 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 245,210	245,210		
2. Non-Food Supplies	\$ 53,713	53,713		
3. Other (Specify) _____ Supplements	\$ 17,652	17,652		
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	\$			
c. Other (Specify) _____	\$			
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 316,575</b>	<b>316,575</b>		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	240	240		
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 Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021		Page of 19   37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$			
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.			
	Amt. \$			
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.			
	Amt. \$			
4. Repair and/or purchase of linens.***	Lbs.			
	Amt. \$			
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$			
c. Other (Specify) Laundry Supplies	\$	8,841	8,841	
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	\$	8,841	8,841	
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 Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021		Page 20	of 37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 43,649	43,649		
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )					
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel				
	Amt.	\$			
C. Other (Specify)		\$ 571	571		
<b>4D. Total Housekeeping Expenditures (4a + b + c )</b>		\$ 44,220	44,220		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Pharmerica	\$	171,342	171,342		
b. Medicine Cabinet Drugs	\$				
c. Medical and Therapeutic Supplies	\$	215,961	215,961		
d. Ambulance/Limousine***	\$	7,383	7,383		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	18,096	18,096		
f. X-rays and Related Radiological Procedures***	\$	3,328	3,328		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$	24,546	24,546		
i. Recreation	\$	11,283	11,283		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (Specify)**** See Attached Schedule	\$	24,180	24,180		
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>		\$ 476,119	476,119		

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

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

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

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

## **Schedule of Other Resident Care**

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

Name of Facility Gladeview Health Care Center				License No. 2024C	Report for Year Ended 9/30/2021				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.***				Pg	Line
		Yes	No			CCNH	RHNS	(Specify)			
PointClickCare	Suite 4, Mississauga, ON L5N 8E9	<input type="radio"/>	<input checked="" type="radio"/>		Computer services					16	M11
Paycom	Oklahoma City, OK 73142	<input type="radio"/>	<input checked="" type="radio"/>		Payroll processing					16	M11
CT Waste Processing	PO Box 99, Plainville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		Rubbish removal					22	6f
Sullivan Lawn Service	8 Piney Branch Road, Ivorytown, CT	<input type="radio"/>	<input checked="" type="radio"/>		Groundskeeping					22	6f
Trans-Ad	130 Pond View Terrace. Branford, CT 06405	<input type="radio"/>	<input checked="" type="radio"/>		Advertising - Promotional					16	m3
Septic Works	PO Box 401, Niantic, CT 06357	<input type="radio"/>	<input checked="" type="radio"/>		Septic cleaning					22	6a
Patient Ping	PO Box 391757, Pittsburgh, PA 15251	<input type="radio"/>	<input checked="" type="radio"/>		Resident tracking software					16	m11
Outfront Media	185 US Highway 46, Fairfield, NJ 07004	<input type="radio"/>	<input checked="" type="radio"/>		Advertising - Promotional					16	m3
Pharmerica	PO Box 409251, Atlanta, GA 30384-9251	<input type="radio"/>	<input checked="" type="radio"/>		Pharmacy supplies and service					20	5a2
		<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 Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	128,621	128,621			
b. Heat	\$	29,476	29,476			
c. Light & Power	\$	98,283	98,283			
d. Water	\$	59,983	59,983			
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$	15,484	15,484			
f. Other <i>(itemize)</i>	\$	96,652	96,652			
See Attached Schedule						
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$	428,499	428,499			
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$	7,916	7,916			
d. Movable Equipment	\$	34,360	34,360			
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$	42,276	42,276			
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$	10,202	10,202			
c. Leasehold Improvements	\$	11,853	11,853			
d. Other <i>(Specify)</i>	\$					
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$	22,055	22,055			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	1,093,687	1,093,687			
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	106,313	106,313			
c. Personal property taxes	\$	125	125			
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$	1,264,456	1,264,456			

\* 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**



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

\*Ties to Page 23, Line A3

\*\*Ties to Page 23, Line A2

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

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

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

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
1/25/2021	Dishwasher	\$ 17,871	5	\$ 894
11/4/2020	Refidgeratot	\$ 745	10	\$ 75
<b>Total additions for Non-Movable Equipment</b>		\$ 18,616		\$ 969 *
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ - ***

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2

## Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
10/15/2020	Hi-lo mat - rehab	\$ 5,514	10	\$ 551
10/30/2020	Commercial refrigerator	\$ 4,270	10	\$ 427
12/3/2020	Ice Machine	\$ 3,490	10	\$ 349
1/19/2021	Overbed tables	\$ 5,176	5	\$ 1,035
2/10/2021	Nursing cart laptops	\$ 3,229	3	\$ 1,076
3/15/2021	Nursing cart laptops	\$ 1,274	3	\$ 425
3/10/2021	Shredder	\$ 2,190	5	\$ 438
6/22/2021	Electric beds	\$ 4,871	12	\$ 406
6/23/2021	Bed actuator	1336	10	\$ 134
6/23/2021	Mattresses	2018	5	\$ 404
<b>Total additions for Movable Equipment</b>		\$ 33,368		\$ 5,245 *
<b>Deletions:</b>				
<b>Total deletions for Movable Equipment</b>		\$ -		\$ - **

\*Ties to Page 23, Line D2c

\*\*Ties to Page 23, Line D2b

## Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
3/19/2021	Drapes	\$ 3,371	10	\$ 169
5/27/2021	Air conditioner upgrades	\$ 6,124	10	\$ 306
4/1/2021	LED upgrade	4406	10	\$ 220
3/19/2021	Deposit on sewer replacement (Not in service at 9/30/21)	3800	10	0
<b>Total additions for Leasehold Improvements</b>		\$ 17,701		\$ 695 *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvements</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

## Amortization Schedule\*

Name of Facility Gladeview Health Care Center			License No. 2024C		Report for Year Ended 9/30/2021			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1. Mortgage cost	12	2011	10	106,134	98,168			10,202	
2.									
3.									
B-4. Subtotal									10,202
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	9	2019		926,638	869,220			11,158	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				17,701				695	
C-4. Subtotal									11,853
D. Total Amortization									22,055

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

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

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

Name of Facility Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021	Page 25	of 37
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#### 11. Property Questionnaire

##### Part A

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

Yes

No

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

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

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

##### Part B - Owner and Related Parties

	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	12/27/14			
c. Interest Rate for the Cost Year	3.72%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	9,670,400			
f. Principal balance outstanding as of 9/30/21	8,638,094			

##### Complete if Mortgage was Refinanced

###### During Current Cost Year

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

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

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

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

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

Name of Facility Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021			Page 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. <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 Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021			Page 27	of 37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		\$				
12. D. Other Interest Expense (Specify)		\$				
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)		\$				
14. Insurance						
a. Insurance on Property (buildings only)		\$	13,262	13,262		
b. Insurance on Automobiles		\$				
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$				
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$				
14d. <b>Total Insurance Expenditures</b> (14a + b + c)		\$	13,262	13,262		
15. <b>Total All Expenditures</b> (A-13 thru C-14)		\$	11,435,555	11,435,555		

## **D. Adjustments to Statement of Expenditures**

Name of Facility Gladeview Health Care Center			License No. 2024C	Report for Year Ended 9/30/2021		Page 28	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b><i>Page 10 - Salaries and Wages</i></b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	A12g	Occupational Therapy	\$ 142,445	142,445		
4.			Other - See attached Schedule	\$			
<b><i>Page 13 - Professional Fees</i></b>							
5.	13	B8c	Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b><i>Pages 15 &amp; 16 - Administrative and General</i></b>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 180,000	180,000		
10.			Accounting	\$			
10a.			Legal	\$ 979	979		
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 4,502	4,502		
13.	15	1f	Life insurance premiums on the life of Owners, Partners, Operators	\$ 11,062	11,062		
14.	16	L3	Gifts, flowers and coffee shops	\$ 5,803	5,803		
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	M3	Unallowable Advertising *	\$ 79,270	79,270		
19.			Income Tax / Corporate Business Tax	\$			
20.	16	M10	Fund Raising / Contributions	\$ 1,110	1,110		
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$			
<b><i>Page 18 - Dietary Expenditures</i></b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b><i>Page 19 - Laundry Expenditures</i></b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b><i>Page 20 - Housekeeping Expenditures</i></b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$ 425,171	\$ 425,171			

\* 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)
<b>Total Other Salaries Adjustment</b>			\$ -	\$ -	\$ -

### **Schedule of Fees Adjustments**

### **Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other A&amp;G Adjustments</b>			\$ -	\$ -	\$ -

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

Name of Facility Gladeview Health Care Center			License No. 2024C	Report for Year Ended 9/30/2021		Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 425,171	425,171		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5a2	Prescription Drugs	\$ 171,342	171,342		
28.	20	5d	Ambulance/Limousine	\$ 7,383	7,383		
29.	20	5f	X-rays, etc	\$ 3,328	3,328		
30.	20	5h	Laboratory	\$ 24,546	24,546		
31.	20	5c	Medical Supplies	\$ 10,798	10,798		
32.	20	5e2	Oxygen (non emergency)	\$ 18,096	18,096		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 24,180	24,180		
<b>Page 22 - Maintenance and Property</b>							
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	\$			
<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	\$ 23,277	23,277		
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<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>				\$ 708,121	708,121		

\*\*\* 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**

### Schedule of Excess Movable Equipment Depreciation

### **Schedule of Other Property Adjustments**

### **Schedule of Other - Indirect Adjustments**

Attachment Page 29

### **Schedule of Other - Miscellaneous Administrative Adjustments**

### **Schedule of Other - Direct Adjustments**

## Schedule of Unallowable Building Interest

**F. Statement of Revenue**

Name of Facility Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021			Page 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> )	\$ 7,768,543	7,768,543			
b. Medicaid Room and Board Contractual Allowance **	\$ (2,308,029)	(2,308,029)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 3,635,807	3,635,807			
b. Medicare Room and Board Contractual Allowance **	\$ (1,131,576)	(1,131,576)			
4. a. Private-Pay Residents and Other	\$ 2,958,337	2,958,337			
b. Private-Pay Room and Board Contractual Allowance **	\$ (122,699)	(122,699)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 85,312	85,312			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (85,312)	(85,312)			
c. Prescription Drugs - Non-Medicare	\$ 74,219	74,219			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (74,219)	(74,219)			
2. a. Medical Supplies - Medicare	\$ 13,636	13,636			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (13,636)	(13,636)			
c. Medical Supplies - Non-Medicare	\$ 11,712	11,712			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (11,712)	(11,712)			
3. a. Physical Therapy - Medicare	\$ 410,579	410,579			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (301,094)	(301,094)			
c. Physical Therapy - Non-Medicare	\$ 151,214	151,214			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (151,214)	(151,214)			
4. a. Speech Therapy - Medicare	\$ 133,241	133,241			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (97,847)	(97,847)			
c. Speech Therapy - Non-Medicare	\$ 32,403	32,403			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (32,403)	(32,403)			
5. a. Occupational Therapy - Medicare	\$ 377,154	377,154			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (326,016)	(326,016)			
c. Occupational Therapy - Non-Medicare	\$ 181,326	181,326			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (181,326)	(181,326)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 10,996,400	10,996,400			
<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> )	\$ 820	820			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 722,579	722,579			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 723,399	723,399			
<b>VI. Total All Revenue</b> (III +V)	\$ 11,719,799	11,719,799			

\* 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)
<b>Total Other Resident Revenue - Medicare</b>		\$ -	\$ -	\$ -

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

## Related Exp

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

## Interest Income

## Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30 IV5	Interest Employee loan	\$ 820			
<b>Total Interest Income</b>		\$ 820	\$ -	\$ -	

### Schedule of Other Revenue

**G. Balance Sheet**

Name of Facility Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021	Page 31   37
Account		Amount	
<b>Assets</b>			
A. Current Assets			
1. Cash ( <i>on hand and in banks</i> )		\$ 1,749,676	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)		\$ 1,285,125	
3. Other Accounts Receivable (Excluding Owners or Related Parties)		\$ 758,216	
4. Inventories		\$ 24,951	
5. Prepaid Expenses		\$ 226,351	
a. Taxes	213,670		
b. Insurance	10,145		
c. Other	2,536		
d. See Schedule			
6. Interest Receivable		\$	
7. Medicare Final Settlement Receivable		\$	
8. Other Current Assets ( <i>itemize</i> )		\$	
See Schedule			
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)		\$ 4,044,319	
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 582,859 Accum. Depreciation 519,593 Net	\$ 63,266	
5. Non-Movable Equipment	*Historical Cost 264,233 Accum. Depreciation 216,362 Net	\$ 47,871	
6. Movable Equipment	*Historical Cost 470,146 Accum. Depreciation 362,807 Net	\$ 107,339	
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</b> (Lines B1 thru 9)		\$ 218,476	

\* 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

<b>Total Prepaid Expenses</b>		\$ -

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

Page Ref Line Ref Description

<b>Total Other Current Assets (Itemize)</b>		\$ -

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

Page Ref Line Ref Description

<b>Total Other Other Fixed Assets (Itemize)</b>		\$ -

## Schedule of Other Assets Page 32 Line D7

Page Ref Line Ref Description

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

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

Page Ref Line Ref Description

<b>Total Notes Payable</b>		\$ -

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

Page Ref Line Ref Description

<b>Total Other Current Liabilities (Itemize)</b>		\$ -

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

Page Ref Line Ref Description

<b>Total Other Current Liabilities (Itemize)</b>		\$ -

## G. Balance Sheet (cont'd)

Name of Facility Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021	Page 32	of 37
Account		Amount		
		Total Brought Forward:		\$ 4,262,795
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			\$	
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense	*Historical Cost _____ Accum. Depreciation _____	Net	\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	
Name and Address	Amount	Loan Date		
7. Other Assets ( <i>itemize</i> )			\$	4,965
Finance fees	4,965			
See Schedule				
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$	4,965
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$	4,267,760

\* 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 Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021	Page 33	of 37
Account				Amount
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable				\$ 391,173
2. Notes Payable ( <i>itemize</i> )				\$
See Schedule				
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$
Name of Lender		Purpose	Amount	Date Due
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$ 423,275
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$
6. Accrued Payroll Taxes Payable				\$ 7,101
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> )				\$ 177,051
Deferred revenue		14,563		
Accrued expenses		13,330		
Provider fee payable		149,158		
				See Schedule
A-13. <b>Total Current Liabilities</b> (Lines A1 thru 12)				\$ 998,600

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

**G. Balance Sheet (cont'd)**

Name of Facility Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021	Page 34	of 37
Account			Amount	
Total Brought Forward:			998,600	
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )			\$	
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable			\$	
3. Loans from Owners or Related Parties ( <i>itemize</i> )			\$	
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities ( <i>itemize</i> )			\$	
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)			\$	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)			\$	998,600

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

Name of Facility Gladerview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021	Page 35	of 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			\$	
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
<b>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	2,983,916
6. Gain or Loss for Period	10/1/2020	thru	9/30/2021	\$ 284,244
7. Total Net Worth			\$	3,269,160
<b>C. Total Reserves and Net Worth</b>				\$ 3,269,160
<b>D. Total Liabilities, Reserves, and Net Worth</b>				\$ 4,267,760

## H. Changes in Total Net Worth

Name of Facility Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2020			\$ 2,983,916	
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$ 11,719,799	
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$ 11,435,555	
D. Net Income or Deficit			\$ 284,244	
E. Balance			\$ 3,268,160	
F. Additions				
1. Additional Capital Contributed ( <i>itemize</i> )				
2. Other ( <i>itemize</i> )				
F-3. Total Additions			\$	
G. Deductions			\$	
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )			\$	
Name and Address (No., City, State, Zip )		Title	Amount	
2. Other Withdrawings ( <i>Specify</i> )			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <b>Balance at End of Period</b>			\$ 3,268,160	

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

Name of Facility Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2021	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		

### Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
Printed Name of Preparer		
Gladeview Health Care Center		
Address	Phone Number	
60 Boston Post Rd. Old Saybrook, CT 06475	860-388-6696	
Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number	
Jason Moore	860-388-6686	
Contact Email Address		
jmoore@gladeviewcares.com		