State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2017

Name of Facility (as licensed) Cheshire House Nursing & Rehabilitation Center		
Address (No. & Street, City, State, Zip Code) 3396 East Main Street, Waterbury, CT 06705		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2141c			07-5373

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	6577		

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

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Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2017	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 Cheshire House Nursing & Rehabilitation Center [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, 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
	2/13/18		2/13/18
Printed Name (Administrator) Carol Salvietta		Printed Name (Owner) Martin Sbriglio	

Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires
Michelle A.S. Joyner	CT	2/13/18		MICHELLE A. SNEAD-JOYNER NOTARY PUBLIC State of Connecticut My Commission Expires 12/31/2022

Address of Notary Public
184 Orange St. Stratford CT

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Cheshire House Nursing & Rehabilitation Center	Period Covered:		From 10/1/2016	To 9/30/2017
Address of Facility 3396 East Main Street, Waterbury, CT 06705				
Report Prepared By Ryders Health Management	Phone Number 203-381-327		Date 1/4/2018	

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
203-381-1327	9/30/2017	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Cheshire House Nursing & Rehabilitation Center	3396 East Main Street, Waterbury, CT 06705

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2141c			07-5373

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Carol Salvietta	001389

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

Name	License No.:
N/A	N/A

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2017	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
N/A		

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

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Cer	2141c	9/30/2017	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Cheshire House Nursing & Rehabilitation Center	3396 East Main Street, Waterbury, CT 06705	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Martin Sbriglio	3396 East Main Street, Waterbury, CT 06705	Owner	100
Names of Stockholders Owning at Least 10% of Shares			
Martin Sbriglio	3396 East Main Street, Waterbury, CT 06705	Owner	100

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General Information and Questionnaire
Individual Proprietorship

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

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Ryders Health Management	88 Ryders Lane, Stratford, CT 06641	○	⊙		Financial Management Support	16, m12	240,810	240,810
Cheshire House Properties LLC	3396 East Main St., Waterbury, CT 06705	○	⊙		Rental Real Estate	22, 9	480,000	480,000
RHM (CT W/C Trust)	PO Box 30393, Hartford, CT 06150	○	⊙		Workers Compensation	15, 1a1	160,192	160,192
RHM (C N A Healthpro)		○	⊙		Property Insurance	27, 14a	11,653	11,653
RHM (One Beacon)	199 Scott Swamp Road, Farmington, CT 06032	○	⊙		Liability Insurance	27, 14c1	30,173	30,173
RHM (IHP, Guardian Dental, PBS)		⊙	○		Health Insurance	15, 1a5	283,070	283,070
RHM (ADP Retirement Services)	4801 Olympia Plaza Drive, Suite 2000, Louisville, KY 40241	○	⊙		401k Plan	15, 1a7	11,208	
		○	○					
		○	○					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

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

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

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

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

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
GE Capital, PO Box 642111, Pittsburgh, PA 15264-2111	O	O	Copy Machines	06/01/15	12 Months	15,036	15,036
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
						Total ***	15,036

Is a Mileage Log Book Maintained for All Leased Vehicles ? O Yes O 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 Marcum Advisors, LLP	555 Long Wharf Drive, New Haven, CT 06511
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Tax returns, annual review of financial statements	$ 11,073
2		$
3		$
4		$
		Charge for Services Provided $ 11,073

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
⊙ Yes ○ No 15, 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Waterbury Probate Court	
2 Murtha Cullina LLP	860-240-6000
3 Joe D'Agostino	
4 Partners Pharmacy	
5	

Address (*No. & Street, City, State, Zip Code*)
1 49 Leavenworth St., Waterbury, CT
2 PO Box 150435, Hartford, CT 06115
3 88 Ryders Lane, Stratford, CT
4
5

Services Provided by This Firm (*describe fully*)

1	Probate Fees - Disallowed	$ 64
2	Health care regulatory issues, general matters - refund	$ (6,105)
3	Corporate matters - disallowed	$ 3,720
4	Settlement - disallowed	$ 82,857
5		$
		Charge for Services Provided $ 80,536

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
⊙ Yes ○ No 15, 1e

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Schedule of Resident Statistics

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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	75	75			75	75			75	75		
B. On last day of THIS report period	75	75			75	75			75	75		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	72	72			72	72			72	72		
B. As of midnight of THIS report period	73	73			72	72			73	73		
3. Total Number of Days Care Provided During Period												
A. Medicare	7,422	7,422			5,711	5,711			1,711	1,711		
B. Medicaid (Conn.)	12,862	12,862			9,813	9,813			3,049	3,049		
C. Medicaid (other states)												
D. Private Pay	3,907	3,907			2,672	2,672			1,235	1,235		
E. State SSI for RCH												
F. Other (Specify) Hospice, Managed Care	1,459	1,459			1,066	1,066			393	393		
G. Total Care Days During Period (3A thru F)	25,650	25,650			19,262	19,262			6,388	6,388		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	255	255			225	225			30	30		
B. Other Bed Reserve Days	167	167			88	88			79	79		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	26,072	26,072			19,575	19,575			6,497	6,497		

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Schedule of Resident Statistics (Cont'd)

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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	10	35		27				
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.								
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	2,787	2,787		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	20,718	20,718		
D. ***Total Physical Therapy Treatments***	23,505	23,505		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	109	109		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	498	498		
D. ***Total Speech Therapy Treatments***	607	607		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	874	874		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	21,242	21,242		
D. ***Total Occupational Therapy Treatments***	22,116	22,116		

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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? O Yes O No

Item	Total Cost and Hours					
	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)	114,561	2,288				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	175,047	10,115				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	42,949	1,745				
c. Dietary Workers	268,473	21,175				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	185,055	16,172				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	72,138	2,050				
b. Other Maintenance Workers	41,035	2,222				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	55,034	3,661				
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	91,421	2,292				
b. RN						
1. Direct Care	640,143	16,462				
2. Administrative**	224,232	5,692				
c. LPN						
1. Direct Care	863,708	30,334				
2. Administrative**						
d. Aides and Attendants	1,136,622	83,411				
e. Physical Therapists	560,448	15,257				
f. Speech Therapists	26,385	398				
g. Occupational Therapists	342,582	9,104				
h. Recreation Workers	84,726	4,318				
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	145,224	5,349				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	13,293	808				
A-13. Total Salary Expenditures	5,083,076	232,850				

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

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH		RHNS		(Specify)	
	$	Hours	$	Hours	$	Hours
Medical Records	$ 13,293	808				
Total	$ 13,293	808	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	$	Hours	$	Hours	$	Hours
Rehab Management Fee	$ 41,664	835				
Total	$ 41,664	835	$ -	-	$ -	-

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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										
Martin Sbriglio, RN, NHA								Ryders Health Management, 88 Ryders Lane, Suite 88, Stratford, CT 06614	2,056	130,000
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* **										
Stanley DeCosts	114,561			Non-Discriminatory	Administrative	2,288				
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
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	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian	36,410	730				
2. Dentist	8,170	160				
3. Pharmacist	6,817	70				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	853	17				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	36,000	360				
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)						
Medical Staff	700	7				
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care	23,200	464				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	41,664	835				
B-13 Total Fees Paid in Lieu of Salaries	153,813	2,643				

* 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	
Healthdrive Dental Group, 888 Worchester St., Wellesley, MA 02482	Dental Consultant	○	◉	
Elizabeth Meisel, 72 Basswood Road, Farmington, CT 06032	Dietician	○	◉	
Partners Pharmacy of CT, PO Box 9689, Uniondale, NY 11555	Pharmacy Consultant	○	◉	
Dr. Peter Giacomazzi, 509 Wolcott Road, Wolcott, CT 06716	Medical Director	○	◉	
Dr. George Barchini, 19 Waterbury Road, Thomaston, CT 06787	Medical Staff	○	◉	
Dr. Alex Deshields, 270 Farmington Ave., Farmington, CT 06032	Medical Staff	○	◉	
HealthPro, 307 International Circle, Suite 100, Hunt Valley, MD 21030	Rehab Consultant, Therapy Consultant	○	◉	
		○	○	
		○	○	
		○	○	
		○	○	
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		○	○	

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

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CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2017		15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	160,192	160,192		
2. Disability Insurance	$				
3. Unemployment Insurance	$				
4. Social Security (F.I.C.A.)	$	464,983	464,983		
5. Health Insurance	$	283,070	283,070		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	11,208	11,208		
8. Uniform Allowance	$	25,251	25,251		
9. Other (*Specify*) See Attached Schedule	$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	181,269	181,269		
d. Accounting and Auditing	$	11,073	11,073		
e. Legal (*Services should be fully described on Page 7*)	$	80,536	80,536		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	16,367	16,367		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	15,078	15,078		
2. Cellular Phones	$	1,883	1,883		
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	$	382,145	382,145		
Subtotal	$	1,633,056	1,633,056		

* 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

Cheshire House Nursing & Rehabilitation Center
9/30/2017

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2017	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,633,056	1,633,056		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	9,785	9,785		
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	4,574	4,574		
5. Education Expenses Related to Seminars and Conventions	$	5,074	5,074		
6. Automobile Expense (*not purchase or depreciation*)	$	3,768	3,768		
7. Other (*Specify*) See Attached Schedule	$	971	971		
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	4,229	4,229		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$	77,944	77,944		
4. Fund-Raising***	$				
5. Medical Records	$	10,800	10,800		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	4,510	4,510		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	5,953	5,953		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	412	412		
9. Subscriptions	$				
10. Contributions*** See Attached Schedule	$	3,750	3,750		
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual*)	$	57,546	57,546		
12. Administrative Management Services**	$	240,810	240,810		
13. Other (*Specify*) See Attached Schedule	$	31,742	31,742		
C-14 Total Administrative & General Expenditures	$	2,094,923	2,094,923		

* 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)
Meals & Entertainment	$ 971		
Total Other Travel and Entertainment	$ 971	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Adv. & Pub. Rel Donations	$ 77,944		
Total Other Advertising	$ 77,944	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 5,468		
ACHCA	$ 310		
National Fire Protection	$ 175		
Total Dues	$ 5,953	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Charitable Donations	$ 3,750		
Total Contributions	$ 3,750	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Fees & Licenses	$ 2,274		
Physician Care - Employees	$ 20,912		
Bank Charges	$ 484		
A/R Solutions - Billing Assistance	$ 3,884		
Unemployment Tax Management	$ 1,390		
Managed Care Contract Consulting	$ 2,749		
American Express	$ 49		
Total Other Administrative and General	$ 31,742	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Cheshire House Nursing & Rehabilitation	License No. 2141c	Report for Year Ended 9/30/2017	Page 17 of 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Ryders Health Management	240,810	Financial and Management Services	16, m12

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

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CSP-18 Rev. 9/2002

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
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2017	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	146,806	146,806		
2. Non-Food Supplies	$	17,054	17,054		
3. Other (*Specify*) Food - Café	$	12,386	12,386		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	176,246	176,246		

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

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
P.	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.
** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Name of Facility Cheshire House Nursing & Rehabilitation Center	License No. 2141c	Report for Year Ended 9/30/2017		Page 19 of 37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry				
a. In-House Processing* — Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.*** — Amt. $	7,082	7,082		
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)* — $	141	141		
c. Management Services** — $				
d. Other (*Specify*) Laundry Supplies — $	5,898	5,898		
3E. ***Total Laundry Expenditures*** (3a + b + c + d) — $	13,121	13,121		

3F. Laundry Questionnaire			
G. Is cost of employee laundry included in 3E?	○ Yes	⊙ No	If yes, specify cost.
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 laundry provided to persons other than employees or residents included in 3E?	○ Yes	⊙ No	If yes, specify cost.
K. Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
L. 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 3E.

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Cent	2141c	9/30/2017	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.	$	31,022	31,022		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	31,022	31,022		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	249,205	249,205		
b. Medicine Cabinet Drugs		$	36,113	36,113		
c. Medical and Therapeutic Supplies		$				
d. Ambulance/Limousine***		$	4,613	4,613		
e. Oxygen						
1. For Emergency Use		$	43,723	43,723		
2. Other***		$				
f. X-rays and Related Radiological Procedures***		$	17,211	17,211		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***		$	33,748	33,748		
i. Recreation		$	24,475	24,475		
j. Other (Specify)**** See Attached Schedule		$	198,839	198,839		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	607,927	607,927		

* 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)
Physician Care - Patients	$ 24,584		
Medical Supplies	$ 122,633		
Medical Supplements	$ 6,508		
Medical Waste	$ 10,794		
Medical Equipment	$ 1,811		
Medical Equipment Rental	$ 4,524		
PT Supplies	$ 27,984		
Total Other Resident Care	$ 198,839	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2017	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
ADP Fees	1 ADP Plaza, Milford, CT 06460	○	⊙		Payroll service	18,619			16	m11
Point Click Care	Unit 4, Mississauga, ON L5N 8E9	○	⊙		Software Services	16,238			16	m11
Environmental Systems Corporation	18 Jansen Court, West Hartford, CT 06110	○	⊙		HVAC Servicing	14,352			22	6c
Winter Bros Waste Systems CT	307 White St., Danbury, CT 06810	○	⊙		Disposal of Garbage	18,146			22	6c
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Cheshire House Nursing & Rehabilitation Cen	2141c	9/30/2017			22	37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	139,345	139,345		
b. Heat	$	6,234	6,234		
c. Light & Power	$	108,095	108,095		
d. Water	$	13,880	13,880		
e. Equipment Lease (*Provide detail on page 6*)	$	15,036	15,036		
f. Other (*itemize*)	$				
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	282,590	282,590		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	188,443	188,443		
b. Building & Building Improvements	$	9,744	9,744		
c. Non-Movable Equipment	$	34,198	34,198		
d. Movable Equipment	$	33,740	33,740		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	266,125	266,125		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$				
9. Rental payments on leased real property less real estate taxes included in item 10b	$	480,000	480,000		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	141,795	141,795		
c. Personal property taxes	$	21,414	21,414		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	909,334	909,334		

* 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)
Total Other Repairs and Maintenance	$ -	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
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Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	385,350		385,350	49,285	S/L	Various	188,443	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								188,443
B. **Building and Building Improvements**								
1. Acquired prior to this report period	7,184,234		7,184,234	1,616,103	S/L	Various	9,693	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	11,907						51	
B-4. Subtotal								9,744
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	380,105		380,105	292,327	S/L	Various	29,775	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	47,285						4,423	
C-4. Subtotal								34,198

	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. Jeep	X		12	1995	22,963		22,963	22,963	200DB	5 Years		
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					946,278		946,278	780,759	Various	Various	32,480	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					12,233						1,260	
D-3. Subtotal												33,740
E. ***Total Depreciation***												266,125

Cheshire House Nursing & Rehabilitation Center
9/30/2017

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3
**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
7/31/2017	Sewer Project	$ 11,907	39	$ 51	
Total additions for Building Improvement		$ 11,907		$ 51	*
Deletions:					
Total deletions for Building Improvement		$ -		$ -	**

*Ties to Page 23, Line B3
**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/27/2016	Electric motor	$ 3,356	5	$ 615	
11/29/2017	Maglocks	10,443	39	$ 223	
1/10/2017	Generator	1,559	5	$ 234	
1/24/2017	Magnetic door locks	1,914	5	$ 255	
1/31/2017	Walk in freezer	1,581	5	$ 211	
1/5/2017	Generator board	2,060	5	$ 309	
2/23/2017	Annunciator	3,619	5	$ 422	
4/21/2017	Coil chemical	3,563	5	$ 297	
4/28/2017	Compressor	4,488	5	$ 374	
8/31/2017	HVAC	2,731	5	$ 46	
8/28/2017	Boiler	7,564	7	$ 90	
10/28/2016	Gerimenu	4,408	3	1346.74	
Total additions for Non-Movable Equipmer		$ 47,285		$ 4,423	*
Deletions:					

Total deletions for Non-Movable Equipmen		$ -		$ -	**

***Ties to Page 23, Line C3**
****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
11/14/2016	Ultracare bed	$ 2,205	5	$ 404	
3/24/2017	Chair lift	1,428	5	$ 143	
3/20/2017	Scale	2,328	5	232.76	
3/31/2017	Ultracare bed	2,115	5	211.53	
4/13/2017	Mattress	1,214	5	121.38	
6/8/2017	Chair lift	1,472	5	98.12	
8/14/2017	Chair lift	1,472	5	49.06	
Total additions for Movable Equipmen		$ 12,233		$ 1,260	*
Deletions:					
Total deletions for Movable Equipmen		$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report peri

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

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
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Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1. Covenants not to Compete	3	94	15 Years	70,563	70,000				
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitat	2141c	9/30/2017	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	03/01/94
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	75
6. Square Footage	23,431
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)	Fixed	Fixed		
b. Date Mortgage Obtained	10/26/05	05/01/12		
c. Interest Rate for the Cost Year	400.00%	400.00%		
d. Term of Mortgage (number of years)	12	5		
e. Amount of Principal Borrowed	2,189,859	4,731,035		
f. Principal balance outstanding as of 9/30/2017				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended			Page of
Cheshire House Nursing & Rehabilita	2141c	9/30/2017			26 | 37

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page of
Cheshire House Nursing & Rehabili	2141c	9/30/2017	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				
12. C. Movable Equipment				
1. Automotive Equipment $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*) $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
B. Item / Rate / Amount				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $				
12. D. Other Interest Expense (*Specify*) $	11,316	11,316		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	11,316	11,316		
14. Insurance				
a. Insurance on Property (buildings only) $	11,653	11,653		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	30,173	30,173		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	41,826	41,826		
15. ***Total All Expenditures (A-13 thru C-14)*** $	9,405,194	9,405,194		

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D. Adjustments to Statement of Expenditures

Name of Facility: Cheshire House Nursing & Rehabilitation Center	License No. 2141c	Report for Year Ended 9/30/2017	Page 28 of 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.	10	12g	Occupational Therapy $	342,582	342,582		
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	B10a	Occupational Therapy $	23,200	23,200		
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	181,269	181,269		
10.	15	1e	Accounting & Legal $	80,536	80,536		
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.	16	l7	Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $	971	971		
17.			Automobile Expense (e.g. personal use) $				
18.	16	m3	Unallowable Advertising * $	77,944	77,944		
19.			Income Tax / Corporate Business Tax $				
20.	16	m10	Fund Raising / Contributions $	3,750	3,750		
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	412	412		
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) $	710,664	710,664		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m8a	Chamber of Commerce	$ 412		
Total Other A&G Adjustments			$ 412	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2017	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	710,664	710,664		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $	249,205	249,205		
28.	20	5d	Ambulance/Limousine $	4,613	4,613		
29.	20	5f	X-rays, etc $	17,211	17,211		
30.	20	5h	Laboratory $	33,748	33,748		
31.			Medical Supplies $				
32.			Oxygen (non emergency) $				
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $				
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Research or Experimental Activities $				
43.			Radio and Television Revenue $				
44.			Vending Machine Revenue $				
45.			Purchase Discounts and Allowances $				
46.			Duplications of functions or services $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest $				
48.			Interest Income on Accounts Rec $				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $				
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.	***Total Amount of Decrease (Items 1 - 50)***		$	1,015,441	1,015,441		

*** 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

Cheshire House Nursing & Rehabilitation Center
9/30/2017

Schedule of Other Ancillary Costs

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

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Schedule of Other 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
Cheshire House Nursing & Rehabilitation	2141c	9/30/2017	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	4,219,888	4,219,888		
b. Medicaid Room and Board Contractual Allowance **	$	(1,056,664)	(1,056,664)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	3,318,507	3,318,507		
b. Medicare Room and Board Contractual Allowance **	$	998,901	998,901		
4. a. Private-Pay Residents and Other	$	2,216,483	2,216,483		
b. Private-Pay Room and Board Contractual Allowance **	$	(601,058)	(601,058)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	175,434	175,434		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(175,434)	(175,434)		
c. Prescription Drugs - Non-Medicare	$	87,228	87,228		
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	$	542,223	542,223		
b. Physical Therapy - Medicare Contractual Allowance **	$	(542,223)	(542,223)		
c. Physical Therapy - Non-Medicare	$	376,829	376,829		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	28,821	28,821		
b. Speech Therapy - Medicare Contractual Allowance **	$	(28,821)	(28,821)		
c. Speech Therapy - Non-Medicare	$	27,979	27,979		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	616,425	616,425		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(616,425)	(616,425)		
c. Occupational Therapy - Non-Medicare	$	305,840	305,840		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	0	0		
b. Other *(Specify)* - Non-Medicare	$	91,621	91,621		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	9,985,553	9,985,553		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	13,101	13,101		
V. Total Other Revenue (1 thru 8)	$	13,101	13,101		
VI. Total All Revenue (III +V)	$	9,998,654	9,998,654		

* *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)
	Oxygen	$ 1,933		
	Oxygen C/A	$ (1,933)		
	X-Ray	$ 14,195		
	X-Ray C/A	$ (14,195)		
	Lab	$ 20,250		
	Lab - C/A	$ (20,250)		
Total Other Resident Revenue - Medicare		$ 0	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Remedy Shared Savings	$ 82,511		
	X-Ray - Private Ins	$ (259)		
	X-Ray - Managed Care	$ 3,901		
	Oxyfen - Managed Care	$ 202		
	Lab - Private Ins	$ 31		
	Lab - Managed Care	$ 5,234		
Total Other Resident Revenue		$ 91,621	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Income	516			
Total Interest Income			$ -	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Café Income	$ 13,101		
Total Other Revenue		$ 13,101	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitati	2141c	9/30/2017	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 533,805
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 896,307
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 3,838
a. Prepaid Expenses		2,835		
b. Prepaid Insurance		1,003		
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 253,983
Loans & Exchanges		(4,118)		
Refunds		9,574		
15 Bed Purchase		248,527		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,687,933
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	385,350		$ 326,324
	Accum. Depreciation	59,026	Net	
3. Buildings	*Historical Cost	7,196,141		$ 5,401,980
	Accum. Depreciation	1,794,160	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	427,390		$ 91,475
	Accum. Depreciation	335,915	Net	
6. Movable Equipment	*Historical Cost	958,512		$ 143,018
	Accum. Depreciation	815,494	Net	
7. Motor Vehicles	*Historical Cost	22,963		$
	Accum. Depreciation	22,963	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 5,962,797

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

(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
Cheshire House Nursing & Rehabilitati	2141c	9/30/2017	32	37

Account				Amount
			Total Brought Forward:	$ 7,650,730
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost	75,563		
	Accum. Depreciation	70,000	Net	$ 5,563
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 165,495
Due from Aaron Manor		(120)		
Due from Greentree Manor		81,184		
Due from LC & Mystic Healthcare		84,431		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 171,057
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 7,821,787

* 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
Cheshire House Nursing & Rehabilitation Cen	2141c	9/30/2017	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 418,161
2. Notes Payable (*itemize*)	$
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*)	$ 98,093
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$
7. Medicare Final Settlement Payable	$
8. Medicare Current Financing Payable	$
9. Mortgage Payable (*Current Portion*)	$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)	$
11. Accrued Income Taxes*	$
12. Other Current Liabilities (*itemize*)	$ 205,390

Patient Fund	15,590	AFLAC - Group	181
Accrued Expenses	512	Accrued PTO	80,539
Accrued User Fee	96,335		
AFLAC - Individual	12,233		

A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 721,645

* 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
Cheshire House Nursing & Rehabilitation C	2141c	9/30/2017	34	37

Account	Amount
Total Brought Forward:	721,645
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ 7,679,646
Due to Bel-Air Manor	288,394	
Due to Chamberlain Manor	713,529	
Due to Lord Chamberlain	173,598	
Due to CH Realty	6,504,125	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 7,679,646
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 8,401,291

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

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitati	2141c	9/30/2017	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		$ (89,373)
2. Capital Stock		$
3. Paid-in Surplus		$
4. Treasury Stock		$
5. Cumulated Earnings		$ (1,095,674)
6. Gain or Loss for Period	10/1/2016 thru 9/30/2017	$ 605,543
7. Total Net Worth		$ (579,503)
C. ***Total Reserves and Net Worth***		$ (579,503)
D. ***Total Liabilities, Reserves, and Net Worth***		$ 7,821,787

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitatio	2141c	9/30/2017	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2016			$
B.	Total Revenue (*From Statement of Revenue Page 30*)			$
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$
D.	Net Income or Deficit			$
E.	Balance			$
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings (*Specify*)			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period*** 09/30/17			$

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation	2141c	9/30/2017	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
Elizabeth Maglio	Controller	2/14/18

Printed Name of Preparer

Elizabeth Maglio

Address	Phone Number
88 Ryders Lane, Stratford, CT 06614	203-381-1327