

State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2019

Name of Facility (as licensed) Gardner Heights Health Care Center	
Address (No. & Street, City, State, Zip Code) 172 Rocky Rest Rd. Shelton, CT 06484	
Type of Facility <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019

License Numbers:	CCNH 2296-C	RHNS	(Specify)	Medicare Provider 07-5368
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Medicaid Provider Numbers:	CCNH 9969	RHNS 91520	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) Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2019	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Gardner Heights Health Care Center [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) Janet Shahen			Printed Name (Owner) Brian J. Foley		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Gardner Heights Health Care Center		Period Covered:	From 10/1/2018	To 9/30/2019
Address of Facility 172 Rocky Rest Rd. Shelton, CT 06484				
Report Prepared By Apple Health Care, Inc.		Phone Number (860) 678-9755	Date	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire

Type of Facility - Organization Structure

	Phone No. of Facility 203-929-1481	Report for Year Ended 9/30/2019	Page 2	of 37
Name of Facility (as shown on license) Gardner Heights Health Care Center		Address (No. & Street, City, State, Zip) 172 Rocky Rest Rd. Shelton, CT 06484		
License Numbers:	CCNH 2296-C	RHNS	(Specify)	Medicare Provider No. 07-5368
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?				
<input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Janet Shahan		Nursing Home Administrator's License No.:	001551	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

**General Information and Questionnaire
 Corporate Owners**

Name of Facility Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2019	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address	State(s) in Which Incorporated		
Gardner Heights Health Care Center	172 Rocky Rest Rd. Shelton, CT 06484	Connecticut		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Brian J. Foley	21 Waterville Road Avon, CT 06001	President	100	
Ryan Vess	21 Waterville Road Avon, CT 06001	Secretary		
Names of Stockholders Owning at Least 10% of Shares				
Brian J. Foley	21 Waterville Road Avon, CT 06001	President	100	

Annual Report of Long-Term Care Facility

**General Information and Questionnaire
Related Parties***

Name of Facility Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2019	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Brian J. Foley	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Real Estate Rental	Pg. 22 Line 9	432,000	432,000
Apple Heath Care	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Management & Accounting Services	Pg. 16 Line m12	371,721	371,721
Corporate Employees	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	118,177	118,177
Employees @ various Apple Facilities		<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	50,900	50,900
Apple Heath Care	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Pension Plan (401K)	Pg. 15 Line 1a7	34,705	34,705
Aetna	PO Box 88860 Chicago, IL 60695	<input checked="" type="radio"/>	<input type="radio"/>		Group Medical	Pg. 15 Line 1a5	472,130	
Delta Dental	PO Box 222 Parsippany, NJ 07054	<input checked="" type="radio"/>	<input type="radio"/>		Group Dental	Pg. 15 1a5	8,015	
Metlife	PO Box 360229 Pittsburgh, PA 15251	<input checked="" type="radio"/>	<input type="radio"/>		Group Dental	Pg. 15 1a5	20,838	
USI	PO Box 62937 Virginia Beach, VA 23466	<input checked="" type="radio"/>	<input type="radio"/>		Property, Liability, & Umbrella Insurance	Pg. 27 Line 14a	137,525	

* 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 Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2019	Page 5	of 37
If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:				
Item		Method of Allocation		
Dietary		Number of meals served to residents		
Laundry		Number of pounds processed		
Housekeeping		Number of square feet serviced		
Nursing		Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants		
Direct Resident Care Consultants		Number of hours of resident care provided by EACH specialist (See listing page 13)		
Maintenance and operation of plant		Square feet		
Property costs (depreciation)		Square feet		
Employee health and welfare		Gross salaries		
Management services		Appropriate cost center involved		
All other General Administrative expenses		Total of Direct and Allocated Costs		
The preparer of this report must answer the following questions applicable to the cost information provided.				
1. In the preparation of this Report, were all costs allocated as required? <input checked="" type="radio"/> Yes <input type="radio"/> 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. The costs incurred by Apple Health Care, Inc. (a related party) to provide accounting and managerial services to each facility owned by Brian J. Foley are allocated on a per bed basis.				
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.)				
<input type="radio"/> Yes <input checked="" type="radio"/> No If "No," explain fully why such allocation was not made.				
N/A				

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

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

Name of Facility Gardner Heights Health Care Center			License No. 2296-C	Report for Year Ended 9/30/2019			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						
	<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 checked="" type="radio"/> Yes <input type="radio"/> No	Total ***

* 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 Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2019	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:
 Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Blum Shapiro & Co. PC	29 South Main St. West Hartford, CT 06127
2 Brazee & Huban	35 Wendell Ave. Pittsfield, MA 10202
3 Blum Shapiro & Co. PC	29 South Main St. West Hartford, CT 06127
4	

Services Provided by This Firm (*describe fully*)

1 Preparation of audited financials (disallow Pg. 28)	\$ 14,756
2 Preparation of tax returns	\$ 2,394
3 Audit - 401K	\$ 636
4	\$
	Charge for Services Provided
	\$ 17,786

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

Legal Services Information

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

Address (*No. & Street, City, State, Zip Code*)
 1
 2
 3
 4
 5

Services Provided by This Firm (*describe fully*)

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

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

Schedule of Resident Statistics

Name of Facility Gardner Heights Health Care Center			License No. 2296-C			Report for Year Ended 9/30/2019				Page 8	of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	130	130			130	130			130	130		
B. On last day of THIS report period	130	130			130	130			130	130		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	98	98			98	98			102	102		
B. As of midnight of THIS report period	102	102			102	102			102	102		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,161	1,161			672	672			489	489		
B. Medicaid (Conn.)	32,986	32,986			24,962	24,962			8,024	8,024		
C. Medicaid (other states)												
D. Private Pay	2,324	2,324			1,627	1,627			697	697		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	36,471	36,471			27,261	27,261			9,210	9,210		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	36,471	36,471			27,261	27,261			9,210	9,210		

Schedule of Resident Statistics (Cont'd)

Name of Facility Gardner Heights Health Care Center			License No. 2296-C			Report for Year Ended 9/30/2019			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH (1)	RHNS (2)	(Specify) (3)	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.													
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	2	85		15									
Per Diem Rate													
a. One bed rm.				370.00									
b. Two bed rms.	various RUG	224.74		383.00									
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									4,668	4,668			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									4,517	4,517			
D. Total Physical Therapy Treatments									9,185	9,185			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									328	328			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									693	693			
D. Total Speech Therapy Treatments									1,021	1,021			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									2,596	2,596			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									3,760	3,760			
D. Total Occupational Therapy Treatments									6,356	6,356			

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Gardner Heights Health Care Center	2296-C	9/30/2019	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	103,672	2,086				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	64,337	3,893				
5. Dietary Service						
a. Head Dietitian	55,560	1,755				
b. Food Service Supervisor	47,675	2,040				
c. Dietary Workers	304,757	21,132				
6. Housekeeping Service						
a. Head Housekeeper	43,119	1,996				
b. Other Housekeeping Workers	163,516	12,081				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	95,832	4,291				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	30,559	2,393				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants	129,856	4,640				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	186,718	4,044				
b. RN						
1. Direct Care	446,444	11,813				
2. Administrative**	152,611	4,624				
c. LPN						
1. Direct Care	728,591	25,621				
2. Administrative**						
d. Aides and Attendants	1,414,871	80,928				
e. Physical Therapists	301,870	7,503				
f. Speech Therapists	61,930	1,589				
g. Occupational Therapists	151,150	4,015				
h. Recreation Workers	102,055	5,572				
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	97,583	3,352				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	4,682,707	205,368				

* 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
Total	\$ -	-	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Purchasing Consultant	\$ 2,000	40				
Data Integrity Auditor	\$ 1,650	33				
A&D Fee	\$ 2,193	44				
Total	\$ 5,843	117	\$ -	-	\$ -	-

**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
Gardner Heights Health Care Center				2296-C	9/30/2019				11	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

** Include all employment worked during the cost year.

**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	
Gardner Heights Health Care Center				2296-C	9/30/2019			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Marc Lei	70,678				Administrator 10/1/18-6/20/19	1,474	A2	Apple Rehab Watertown	611	34,241
Janet Shahen	32,994				Administrator 6/21/19-9/30/19	611	A2	Apple Rehab Watertown	1,474	81,134
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		
Gardner Heights Health Care Center	2296-C	9/30/2019	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	11,830	313				
3. Pharmacist	8,447	70				
4. Podiatrist	35	1				
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	29,090	194				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
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						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	5,843	117				
B-13 Total Fees Paid in Lieu of Salaries	55,245	695				

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

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

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

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

Name of Facility Gardner Heights Health Care Center		License No. 2296-C	Report for Year Ended 9/30/2019	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
PatientPing 10 Post Office Square, Boston, MA 02109	Admissions & Discharge Fee	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Laura C. Brenes Dorso 464 Wolcott Rd. Wolcott, CT 06716	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Brijesh Chandwani 3200 Park Ave. 10D2 Bridgeport, CT 06604	Dentist	<input type="radio"/>	<input checked="" type="radio"/>		
Pointright Inc 150 Cambridge Park Dr, Cambridge, MA 02140	Data Integrity Audit	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Gardner Heights Health Care Center	2296-C	9/30/2019	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 125,023	125,023		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 66,090	66,090		
4. Social Security (F.I.C.A.)	\$ 333,818	333,818		
5. Health Insurance	\$ 372,960	372,960		
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 32,258	32,258		
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 34,705	34,705		
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*	\$ 160,879	160,879		
d. Accounting and Auditing	\$ 17,786	17,786		
e. Legal (Services should be fully described on Page 7)	\$			
f. Insurance on Lives of Owners and Operators (Specify)*	\$			
g. Office Supplies	\$ 8,812	8,812		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 28,103	28,103		
2. Cellular Phones	\$			
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*	\$ (9,468)	(9,468)		
2. Other (Specify) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 734,858	734,858		
Subtotal	\$ 1,905,823	1,905,823		

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Gardner Heights Health Care Center	2296-C	9/30/2019	16	37
Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	1,905,823	1,905,823		
l. Travel and Entertainment				
1. Resident Travel and Entertainment	\$ 9,306	9,306		
2. Holiday Parties for Staff	\$ 2,545	2,545		
3. Gifts to Staff and Residents	\$ 8,657	8,657		
4. Employee Travel	\$ 6,698	6,698		
5. Education Expenses Related to Seminars and Conventions	\$ 2,399	2,399		
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>)	\$			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$			
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 14,876	14,876		
4. Fund-Raising***	\$			
5. Medical Records	\$ 674	674		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$			
7. Postage	\$ 4,518	4,518		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 9,525	9,525		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 640	640		
9. Subscriptions	\$ 1,532	1,532		
10. Contributions*** See Attached Schedule	\$			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$			
12. Administrative Management Services**	\$ 371,721	371,721		
13. Other (<i>Specify</i>) See Attached Schedule	\$ 137,883	137,883		
C-14 Total Administrative & General Expenditures	\$ 2,476,798	2,476,798		

* Do not include Subscriptions, which should go in item 9.

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Advertising - Public Relations	\$ 14,871		
Advertising - PR sales tax	\$ 5		
Total Other Advertising	\$ 14,876	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 9,525		
Total Dues	\$ 9,525	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Corporate Fees Non Reimburable	\$ 55,731		
Licenses & Fees	\$ 11,837		
Pre Employment Screenings	\$ 6,727		
System License & Subscription Fee	\$ 23,867		
Bank Service Charges	\$ 12,101		
Legal Fees - Collections, Probate, Conservator	\$ 837		
Account W/O	\$ 699		
Resident Expenses	\$ 210		
Survey Fines & Citations	\$ -		
Internet & Cable/Satellite TV	\$ 20,105		
IT Service Fee	\$ 5,769		
Total Other Administrative and General	\$ 137,883	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2019	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Apple Health Care, Inc.	371,721	Accounting & Management Services	Pg. 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.**

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

Name of Facility Gardner Heights Health Care Center		License No. 2296-C	Report for Year Ended 9/30/2019	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 219,520	219,520		
2.	Non-Food Supplies	\$ 26,287	26,287		
3.	Other (Specify) _____	\$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$ 2,029	2,029		
c. Other (Specify) _____		\$			
2D. Total Dietary Expenditures (2a + b + c + d)		\$ 247,835	247,835		
2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F.	Resident Meals: Total no. of meals served per day:*	299	299		
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 Gardner Heights Health Care Center		License No. 2296-C	Report for Year Ended 9/30/2019		Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)	
3. Laundry						
a. In-House Processing*		Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$	3,671	3,671		
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. \$	6,246	6,246		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	90,247	90,247		
c. Other (Specify)		\$				
3D. Total Laundry Expenditures (3a + b + c)		\$	100,164	100,164		
3E. Laundry Questionnaire						
F.	Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
H.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
I.	Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
K.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
 All allocations should add to total recorded in 3D.
 *** Pounds of Laundry only required for multi-level facilities.

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

Name of Facility		License No.	Report for Year Ended		Page	of
Gardner Heights Health Care Center		2296-C	9/30/2019		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
1.	Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	37,346	37,346		
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$				
C.	Other (<i>Specify</i>)	\$				
4D.	Total Housekeeping Expenditures (4a + b + c)	\$	37,346	37,346		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from Neighborcare	\$	98,591	98,591		
b.	Medicine Cabinet Drugs	\$				
c.	Medical and Therapeutic Supplies	\$	152,549	152,549		
d.	Ambulance/Limousine***	\$				
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	15,223	15,223		
f.	X-rays and Related Radiological Procedures***	\$	7,615	7,615		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	7,141	7,141		
i.	Recreation	\$	26,018	26,018		
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	38,414	38,414		
5M.	Total Resident Care Expenditures (5a - 5j)	\$	345,552	345,552		

* 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)
Nursing Station Supplies	\$ 1,295		
Rehab Service Supplies	\$ 21,650		
IV Therapy	\$ 15,389		
Supplies - Social Service	\$ 80		
Total Other Resident Care	\$ 38,414	\$ -	\$ -

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

Name of Facility Gardner Heights Health Care Center			License No. 2296-C		Report for Year Ended 9/30/2019			Page of 21 37		
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
CWPM, LLC	25 Norton Place Plainville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		refuse removal	22,438			22	6f
Unitex Textile Rental	Mount Vernon, NY 10550	<input type="radio"/>	<input checked="" type="radio"/>		laundry service	89,996			19	3b
Sadicks Landscaping, LLC	938 Howe Ave Shelton, CT 06484	<input type="radio"/>	<input checked="" type="radio"/>		landscaping/snow removal	22,658			22	6a
Saucier Mechanical Services	148 Norton St Plantsville, CT 06479	<input type="radio"/>	<input checked="" type="radio"/>		HVAC/electrical contractor	18,167			22	6a
		<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"/>							

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Gardner Heights Health Care Center	2296-C	9/30/2019			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 126,464	126,464				
b. Heat	\$ 72,618	72,618				
c. Light & Power	\$ 92,222	92,222				
d. Water	\$ 31,074	31,074				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$					
f. Other (<i>itemize</i>)	\$ 24,582	24,582				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 346,960	346,960				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$ 415	415				
d. Movable Equipment	\$ 22,223	22,223				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 22,638	22,638				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 62,404	62,404				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 62,404	62,404				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 432,000	432,000				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 46,857	46,857				
c. Personal property taxes	\$ 3,983	3,983				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 567,881	567,881				

* 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)
Refuse Removal	\$ 24,582		
Total Other Repairs and Maintenance	\$ 24,582	\$ -	\$ -

Depreciation Schedule

Name of Facility Gardner Heights Health Care Center			License No. 2296-C			Report for Year Ended 9/30/2019			Page 23	of 37			
Property Item			Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals			
A. Land Improvements													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal													
B. Building and Building Improvements													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal													
C. Non-Movable Equipment													
1. Acquired prior to this report period			10,294		10,294	9,551	S/L	Var	415				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal										415			
		Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
		Yes	No	Month	Year								
D. Movable Equipment													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a.													
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period						707,798		707,798	625,715	S/L	Var	20,662	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)						16,736		16,736		S/L	Var	1,561	
D-3. Subtotal													22,223
E. Total Depreciation													22,638

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:				
Total additions for Building Improvement		\$ -		\$ - *
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 period

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

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
8/8/2017	deposit For Generator Service	\$ 1,806	5	\$ 271
9/22/2017	Balance Generator Service	\$ 1,806	5	\$ 271
10/12/2018	Temp Generator	\$ 3,776	5	\$ 566
10/26/2018	CAP #15166 5 Wireless APs	\$ 2,361	3	\$ 287
10/28/2018	Countertop Steamer	\$ 4,166	10	\$ 125
1/28/2019	Patient Lift	\$ 2,822	10	\$ 41
Total additions for Movable Equipmen		\$ 16,736		\$ 1,561 *
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 period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
3/8/2018	Replace Fire Doors	\$ 1,673		\$ 105
8/2/2018	Basement Mitigation Deposit	\$ 3,555		\$ 444
8/2/2018	Basement Mitigation Balance	\$ 3,555		\$ 444
9/26/2018	Pipe Lining	\$ 1,550		\$ 194
10/25/2018	Oil Line Foot Valves	\$ 1,872		\$ 281
10/30/2018	EMS Response & Dry out	\$ 17,076		\$ 1,423
3/28/2019	Facility Sign Deposit	\$ 1,850		\$ 62
3/28/2019	New Signage	\$ 3,334		\$ 112
7/24/2019	Replace broken sewer piping	\$ 7,275		\$ 156
8/28/2019	Replace Fire Alarm Panel Emergency	\$ 5,887		\$ 80
Total additions for Leasehold Improvermen		\$ 47,626		\$ 3,302 *
Deletions:				
Total deletions for Leasehold Improvermen		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility Gardner Heights Health Care Center			License No. 2296-C		Report for Year Ended 9/30/2019			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period				1,217,624	755,838	A		59,102	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				47,626		A		3,302	
C-4. Subtotal									62,404
D. Total Amortization									62,404

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2019	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description		Total		
1. Date Land Purchased				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity		130		
6. Square Footage		64,365		
7. Acquisition Cost				
a. Land				
b. Building				
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)		Variable		
b. Date Mortgage Obtained		12/07/16		
c. Interest Rate for the Cost Year		4.48%		
d. Term of Mortgage (number of years)		5		
e. Amount of Principal Borrowed		4,119,992		
f. Principal balance outstanding as of 09/30/2019		3,828,650		
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
Part C - Arms-Length Leases for Real Property Improvements Only				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Gardner Heights Health Care Center		2296-C	9/30/2019		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Gardner Heights Health Care Cent		2296-C		9/30/2019		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$			
12. D. Other Interest Expense (Specify)				\$			
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$			
14. Insurance							
a. Insurance on Property (buildings only)				\$ 137,525	137,525		
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. Total Insurance Expenditures (14a + b + c)				\$ 137,525	137,525		
15. Total All Expenditures (A-13 thru C-14)				\$ 8,998,014	8,998,014		

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Gardner Heights Health Care Center				2296-C	9/30/2019	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	A12g	Occupational Therapy	\$ 151,150	151,150		
4.			Other - See attached Schedule	\$ 9,758	9,758		
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 160,879	160,879		
10.	15	1d	Accounting	\$ 14,756	14,756		
10a.			Legal	\$ 837	837		
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m2/3	Unallowable Advertising *	\$ 14,876	14,876		
19.	15	1k1	Income Tax / Corporate Business Tax	\$ (9,468)	(9,468)		
20.	16	m10	Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 92,158	92,158		
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)				\$ 434,947	434,947		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	A12m	Social Services - Marketing	\$ 9,758		
Total Other Salaries Adjustment			\$ 9,758	\$ -	\$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Corp Fees Nonreimbursable	\$ 55,731		
16	1.3	Employee Recognition/Gifts/Parties	\$ 8,657		
16	8a	Chamber of Commerce	\$ 640		
16	m13	Bank Charges	\$ 12,101		
16	m13	Account W/O	699.00		
16	m13	Resident Reimbursements	\$ 210		
30	IV8	Account W/O	\$ 6,822		
30	IV8	Settlement	\$ 7,027		
30	IV8	Refund	\$ 273		
Total Other A&G Adjustments			\$ 92,158	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
Gardner Heights Health Care Center				2296-C	9/30/2019	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 434,947	434,947		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 89,928	89,928		
28.	16	L1	Ambulance/Limousine	\$ 9,306	9,306		
29.	20	h	X-rays, etc	\$ 7,615	7,615		
30.	20	f	Laboratory	\$ 7,141	7,141		
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 11,127	11,127		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 37,039	37,039		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.	30	IV5	Interest Income on Account Rec.	\$ 8	8		
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 597,112	597,112		

*** 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.

Total Other Adjustments			\$ -	\$ -	\$ -

Schedule of Other - Miscellaneous Administrative Adjustments

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Gardner Heights Health Care Center	2296-C	9/30/2019			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 7,119,091	7,119,091				
b. Medicaid Room and Board Contractual Allowance **	\$					
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents(<i>all inclusive</i>)	\$ 506,131	506,131				
b. Medicare Room and Board Contractual Allowance **	\$ 100,694	100,694				
4. a. Private-Pay Residents and Other	\$ 1,405,210	1,405,210				
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 62,580	62,580				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (60,280)	(60,280)				
c. Prescription Drugs - Non-Medicare	\$ 18,166	18,166				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ 10,119	10,119				
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	\$ 265,091	265,091				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (142,449)	(142,449)				
c. Physical Therapy - Non-Medicare	\$ 56,383	56,383				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (35,070)	(35,070)				
4. a. Speech Therapy - Medicare	\$ 37,846	37,846				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (26,766)	(26,766)				
c. Speech Therapy - Non-Medicare	\$ 8,100	8,100				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (3,060)	(3,060)				
5. a. Occupational Therapy - Medicare	\$ 242,326	242,326				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (154,634)	(154,634)				
c. Occupational Therapy - Non-Medicare	\$ 43,685	43,685				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (26,820)	(26,820)				
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 9,426,341	9,426,341				
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ 8	8				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 57,279	57,279				
V. Total Other Revenue (1 thru 8)	\$ 57,287	57,287				
VI. Total All Revenue (III +V)	\$ 9,483,628	9,483,628				

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
Total Other Resident Revenue		\$ -	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30	Interest Income	698,376	\$ 8		
Total Interest Income			\$ 8	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV8	Account W/O	\$ 6,822		
30 IV8	Settlement	\$ 7,027		
30 IV8	Dividends [Optum]	\$ 43,157		
30 IV8	Refund	\$ 273		
Total Other Revenue		\$ 57,279	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Gardner Heights Health Care Center	2296-C	9/30/2019	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	698,376
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	33,645
5. Prepaid Expenses			\$	12,904
a. _____				
b. _____				
c. _____				
d. See Schedule		12,904		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	553,544

See Schedule		553,544		
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,298,469
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
4. Leasehold Improvements	*Historical Cost <u>1,265,251</u>		\$	447,009
	Accum. Depreciation <u>818,242</u>	Net		
5. Non-Movable Equipment	*Historical Cost <u>10,294</u>		\$	329
	Accum. Depreciation <u>9,965</u>	Net		
6. Movable Equipment	*Historical Cost <u>724,535</u>		\$	76,597
	Accum. Depreciation <u>647,938</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	523,935

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2019	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$ 1,822,404	
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements			\$	
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings			\$	
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Non-Movable Equipment			\$	
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
5. Movable Equipment			\$	
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
6. Motor Vehicles			\$	
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense			\$	
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$ 1,000	

See Schedule			1,000	
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ 1,000	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 1,823,404	

* 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 Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2019	Page 34	of 37
Account			Amount	
Total Brought Forward:			1,198,574	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				
\$				
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 891,361

See Schedule		891,361		
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 891,361
C. Total All Liabilities (Lines A-13 + B-5)				\$ 2,089,935

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

Name of Facility	License No.	Report for Year Ended	Page	of
Gardner Heights Health Care Center	2296-C	9/30/2019	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	1,470,000
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(2,223,145)
6. Gain or Loss for Period			\$	485,614
	10/1/2018	thru	9/30/2019	
7. Total Net Worth			\$	(266,531)
C. Total Reserves and Net Worth			\$	(266,531)
D. Total Liabilities, Reserves, and Net Worth			\$	1,823,404

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Gardner Heights Health Care Center	2296-C	9/30/2019	36	37		
Account			Amount			
A. Balance at End of Prior Period as shown on Report of 09/30/2018			\$	(995,833)		
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	9,483,628		
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	8,998,014		
D. Net Income or Deficit			\$	485,614		
E. Balance			\$	(510,219)		
F. Additions						
1. Additional Capital Contributed <i>(itemize)</i>						
Brian Foley	250,000					
2. Other <i>(itemize)</i>						
F-3. Total Additions					\$	250,000
G. Deductions						
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	6,312		
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount			
Brian Foley		President	6,312			
2. Other Withdrawings <i>(Specify)</i>			\$			
Purpose		Amount				
3. Total Deductions			\$	6,312		
H. <i>Balance at End of Period</i>		09/30/19	\$	(266,531)		

I. Preparer's/Reviewer's Certification

Name of Facility Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2019	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Robert Gwizdak				
Address Address			Phone Number	
21 Waterville Rd. Avon, CT 06001			(860) 678-9755	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Susan Southey			(860) 470-7542	
Contact Email Address				
ssouthey@apple-rehab.com				