

# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2020

Name of Facility (as licensed) Senior Philanthropy of Stamford d/b/a Long Ridge Post-Acute Care	
Address (No. & Street, City, State, Zip Code) 710 Long Ridge Rd., Stamford, CT 06902	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020

License Numbers:	CCNH 2408	RHNS	(Specify)	Medicare Provider 07-5394
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Medicaid Provider Numbers:	CCNH 21197	RHNS	ICF-IID
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### For Department Use Only

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

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## General Information

Name of Facility (as licensed) Senior Philanthropy of Stamford d/b/a Long Ridge Pos	License No. 2408	Report for Year Ended 9/30/2020	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 Senior Philanthropy of Stamford d/b/a Long Ridge Post-Acute Care [facility name], for the cost report period beginning October 1, 2019 and ending September 30, 2020, 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) Marion Najamy		Printed Name (Owner)	
Subscribed and Sworn to before me:	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public			

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Senior Philanthropy of Stamford d/b/a Long Ridge Post-Acute Care	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 710 Long Ridge Rd., Stamford, CT 06902				
Report Prepared By CJLC LLC	Phone Number 860-610-9009	Date 2/2/2021		
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	\$			
<b>6. Total Wages Paid</b>	<b>\$</b>			
7. Total salaries paid	\$			
<b>8. Total Wages and Salaries Paid (As per page 10 of Report)</b>	<b>\$</b>			

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	Report for Year Ended	Page	of
203-329-4026	9/30/2020	2	37

Name of Facility (as shown on license)	Address (No. & Street, City, State, Zip )		
Senior Philanthropy of Stamford d/b/a Long Ridge Post-Acute	710 Long Ridge Rd., Stamford, CT 06902		

License Numbers:	CCNH 2408	RHNS	(Specify)	Medicare Provider No. 07-5394
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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
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Has there been any change in ownership  
or operation during this report year?       Yes       No      If "Yes," explain fully.

**Administrator**

Name of Administrator Marion Najamy	Nursing Home Administrator's License No.: 1548
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Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name N/A	License No.:

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

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

Name of Facility Senior Philanthropy of Stamford d/b/a Long R	License No. 2408	Report for Year Ended 9/30/2020	Page of 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	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
RB Bridges	24641 US Hwy 19 N., Clearwater, FL 33763-5007	CEO	
Gene Rensch	24641 US Hwy 19 N., Clearwater, FL 33763-5007	VP, Secretary	
Kimberly Justiniano	24641 US Hwy 19 N., Clearwater, FL 33763-5007	CFO	
Names of Stockholders Owning at Least 10% of Shares			
N/A			

State of Connecticut

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

CSP-3B Rev. 10/2005

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

Name of Facility Senior Philanthropy of Stamford d/b/a Long Ridge	License No. 2408	Report for Year Ended 9/30/2020	Page 3B	of 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

N/A

## General Information and Questionnaire

### Related Parties\*

Name of Facility Senior Philanthropy of Stamford d/b/a Long Ridge Pos		License No. 2408	Report for Year Ended 9/30/2020			Page 4	of 37	
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," provide the Name/Address and complete the information on Page 11 of the report.		
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?				<input checked="" type="radio"/> Yes	<input type="radio"/> No	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	%**				
Eagle Lake Foundation, Inc.	24641 US Hwy 19 N., Clearwater, FL 33763-8007	<input type="radio"/>	<input checked="" type="radio"/>		AHT Fees, Health Ins., Accounting Fees	Various	1,190,896	1,190,896
Golden Hill Rehab	2028 Bridgeport Avenue, Milford, CT 06460	<input type="radio"/>	<input checked="" type="radio"/>		Shared Staff – Respiratory Therapist, COVID	Various	23,635	23,635
Cheshire Regional Rehab Center	745 Highland Ave., Cheshire, CT 06410	<input type="radio"/>	<input checked="" type="radio"/>		Shared Staff - Regional Admissions	Various	7,730	7,730
Newington Rapid Recovery	240 Church Street, Newington, CT 06111	<input type="radio"/>	<input checked="" type="radio"/>		Loan Interest, MDS Shared Staff, Bank Fees	Various	1,513,459	1,513,459
Traditions Senior Management	24641 US Hwy 19 N., Clearwater, FL 33763-8007	<input type="radio"/>	<input checked="" type="radio"/>		Internet, Recruitment, IT Support	Various	191,099	191,099
Western Rehab Care Center	107 Osborne Street, Danbury, CT 06810	<input type="radio"/>	<input checked="" type="radio"/>		Note Interest	Various	41,097	41,097
West River Rehab Center	245 Orange Avenue, Milford, CT 06461	<input type="radio"/>	<input checked="" type="radio"/>		Shared Staff – Regional Educator	Various	25,551	25,551
Traditions Senior Management	24641 US Hwy 19 N., Clearwater, FL 33763-8007	<input type="radio"/>	<input checked="" type="radio"/>		Management Company	16/m12	281,834	281,834
Westport Rehabilitation Complex	1 Burr Rd., Westport, CT 06880	<input type="radio"/>	<input checked="" type="radio"/>		COVID Supplies	Various	2,751	2,751

\* 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 Senior Philanthropy of Stamford d/b/a Long Rid	License No. 2408	Report for Year Ended 9/30/2020	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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.

# **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.

### Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

○ 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 Senior Philanthropy of Stamford d/b/a	License No. 2408	Report for Year Ended 9/30/2020	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual     Cash     Modified Cash

Is the accounting basis for this

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

#### Independent Accounting Firm

Name of Accounting Firm 1 CJLC LLC 2 Marcum LLP 3 Barbara Clark & Company, PA 4	Address (No. & Street, City, State, Zip Code) 225 Pitkin St., East Hartford, CT 06108 555 Long Wharf Drive, 8th Fl., New Haven, CT 06511 PO Box 13723, Saint Petersburg, FL 33733
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Services Provided by This Firm (*describe fully*)

1 Medicaid Cost Report Preparation	\$ 2,848
2 Accrued Accounting Expenses	\$ 25,883
3 Audit Services	\$ 7,052
4	\$
	Charge for Services Provided \$ 35,783

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 1 See schedule. 2 3 4 5	Telephone Number
---	------------------

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

1 2 3 4 5	
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Services Provided by This Firm (*describe fully*)

1	\$ 31,789
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided \$ 31,789

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 Senior Philanthropy of Stamford d/b/a Long Ridge Post-Acute Care			License No. 2408				Report for Year Ended 9/30/2020				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					120	120			120	120		
A. On last day of PREVIOUS report period	120	120							120	120		
B. On last day of THIS report period	120	120			120	120			120	120		
2. Number of Residents					110	110			77	77		
A. As of midnight of PREVIOUS report period	110	110							81	81		
B. As of midnight of THIS report period	81	81			77	77			81	81		
3. Total Number of Days Care Provided During Period					3,509	3,509			921	921		
A. Medicare	4,430	4,430										
B. Medicaid (Conn.)	28,160	28,160			22,716	22,716			5,444	5,444		
C. Medicaid (other states)												
D. Private Pay	1,593	1,593			1,145	1,145			448	448		
E. State SSI for RCH												
F. Other (Specify) HMO,HOS,INS,VA, HMA	1,530	1,530			1,303	1,303			227	227		
G. Total Care Days During Period (3A thru F)	35,713	35,713			28,673	28,673			7,040	7,040		
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												
<b>5. Total Resident Days (3G + 4A + 4B)</b>	<b>35,713</b>	<b>35,713</b>			<b>28,673</b>	<b>28,673</b>			<b>7,040</b>	<b>7,040</b>		

## Schedule of Resident Statistics (Cont'd)

Name of Facility Senior Philanthropy of Stamford d/b/a Long R	License No. 2408	Report for Year Ended 9/30/2020	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?

 Yes No

If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	9	62		5			5	
Per Diem Rate								
a. One bed rm.		308.34		585.42				
b. Two bed rms.				521.48				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B	284	284	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments	2,711	2,711	
2. Restorative Treatments			
C. Other	20,438	20,438	
<b>D. Total Physical Therapy Treatments</b>	<b>23,433</b>	<b>23,433</b>	

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	33	33	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments	615	615	
2. Restorative Treatments			
C. Other	2,650	2,650	
<b>D. Total Speech Therapy Treatments</b>	<b>3,298</b>	<b>3,298</b>	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	593	593	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments	2,430	2,430	
2. Restorative Treatments			
C. Other	22,759	22,759	
<b>D. Total Occupational Therapy Treatments</b>	<b>25,782</b>	<b>25,782</b>	

## Report of Expenditures - Salaries &amp; Wages

Name of Facility Senior Philanthropy of Stamford d/b/a Long Ridge Post-Acut	License No. 2408	Report for Year Ended 9/30/2020		Page 10	of 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)	147,165	2,110				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	172,420	5,857				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	636,967	30,405				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	331,258	18,368				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	101,036	3,976				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	64,829	3,457				
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	401,342	7,631				
b. RN						
1. Direct Care	1,035,302	18,103				
2. Administrative**	173,957	2,911				
c. LPN						
1. Direct Care	1,114,707	38,536				
2. Administrative**						
d. Aides and Attendants	1,670,895	94,155				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	89,983	3,851				
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	105,732	2,905				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	76,388	2,125				
<b>A-13. Total Salary Expenditures</b>	<b>6,241,109</b>	<b>239,778</b>				

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

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

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

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

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

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

State of Connecticut

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

CSP-11 Rev. 10/2005

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

Name of Facility Senior Philanthropy of Stamford d/b/a Long Ridge Post-Acute Care			License No. 2408		Report for Year Ended 9/30/2020			Page 11	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section I - Operators/Owners</b>										
<b>Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).</b>										

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

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

State of Connecticut

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

CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
Senior Philanthropy of Stamford d/b/a Long Ridge Post-Acute Care				2408		9/30/2020			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section III - Administrators***</b>										
Marion Najamy (10/1/19 to 9/30/20)	147,165			Non-Discrim.	Administrator	2,110	A2			
<b>Section IV - Assistant Administrators</b>										

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

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

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
	2408	9/30/2020		13	37
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary</b> (For all such services complete Schedule B1)					
1. Dietitian					
2. Dentist	13,032	65			
3. Pharmacist	26,097	120			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	416,696	Contract			
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	23,231	480			
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**	(8,039)	(32)			
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	215,981	Contract			
b. Other					
10. Occupational Therapist					
a. Resident Care	481,678	Contract			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	(331)	11			
2. Administrative***	79,479	1,023			
b. LPN					
1. Direct Care					
2. Administrative***					
c. Aides					
d. Other					
12. Other (Specify)					
See Attached Schedule					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	1,247,824	1,667			

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

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

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

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

\* Use additional sheets if necessary.

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2020		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 238,411	238,411			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 19,459	19,459			
4. Social Security (F.I.C.A.)	\$ 461,804	461,804			
5. Health Insurance	\$ 1,292,364	1,292,364			
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 4,765	4,765			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 354,520	354,520			
8. Uniform Allowance	\$ 9,735	9,735			
9. Other (Specify) See Attached Schedule	\$ 18,762	18,762			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 41,381	41,381			
d. Accounting and Auditing	\$ 35,783	35,783			
e. Legal (Services should be fully described on Page 7)	\$ 31,789	31,789			
f. Insurance on Lives of Owners and Operators (Specify)*	\$				
g. Office Supplies	\$ 10,264	10,264			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 70,594	70,594			
2. Cellular Phones	\$ 1,040	1,040			
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	\$ 642,981	642,981			
<b>Subtotal</b>	\$ 3,233,652	3,233,652			

\* 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**

Senior Philanthropy of Stamford d/b/a Long Ridge Post-Acute Care  
9/30/2020

Attachment Page 15

**Schedule of Other Employee Benefits**

Description	CCNH	RHNS	(Specify)
Employee Expense-Nursing Admn	\$ 912		
Drug Free Expense-Nursing	\$ 450		
Employee Expense-Nursing	\$ 6,769		
Employee Benefits/Expense- Admin	\$ 10,631		
<b>Total</b>	\$ 18,762	\$ -	\$ -

**Schedule of Other Taxes**

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2020		16	37
Item		Total	CCNH	RHNS	(Specify)
	<b><i>Subtotals Brought Forward:</i></b>	3,233,652	3,233,652		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	2,817	2,817		
5. Education Expenses Related to Seminars and Conventions	\$	890	890		
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> )	\$	6,501	6,501		
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	796	796		
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$	4,424	4,424		
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	14,366	14,366		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	11,353	11,353		
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> )	\$	213,745	213,745		
12. Administrative Management Services**	\$	281,834	281,834		
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	80,269	80,269		
<b><i>C-14 Total Administrative &amp; General Expenditures</i></b>	\$	<b>3,850,647</b>	<b>3,850,647</b>		

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

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

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

**Schedule of Other Travel and Entertainment**

Description	CCNH	RHNS	(Specify)
<b>Total Other Travel and Entertainment</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
Promo Items-Mkt	\$ 796		
<b>Total Other Advertising</b>	<b>\$ 796</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
CT Association of Health Care Facilities	\$ 14,366		
<b>Total Dues</b>	<b>\$ 14,366</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Contributions**

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

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
Background Checks-Nursing Admn	\$ 106		
Software Expense - Nursing Adm	\$ 3,648		
Licenses/Permits-Nursing Admn	\$ 626		
Background Checks-Nursing	\$ 851		
Licenses/Permits-Dietary	\$ 379		
Licenses/Permits	\$ 1,131		
Patient Trust Bond	\$ 804		
Resident Reimburse on Lost/Stolen Items	\$ 137		
Hurricane/Emergency Costs	\$ 1,200		
Equipment Minor-Adm	\$ 2,278		
Internet Access-Adm	\$ 31,501		
Records Storage - Adm	\$ 6,414		
Equipment Rental-Adm	\$ 1,217		
Collection Fees/Credit Card Fees	\$ 3,861		
Late fees/Fines/Finance Charges-Adm	\$ 7,075		
Bank Service Charges-Adm	\$ 19,041		
<b>Total Other Administrative and General</b>	<b>\$ 80,269</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility Senior Philanthropy of Stamford d/b/a Lo	License No. 2408	Report for Year Ended 9/30/2020	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 #
Traditions Senior Management, 24641 US Hwy 19 N, Clearwater, FL, 33763	281,834	Handles all the operations and financial functions directly related to the facility.	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	License No.	Report for Year Ended		Page of
		9/30/2020		18   37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 249,519	249,519		
2. Non-Food Supplies	\$ 59,587	59,587		
3. Other (Specify) _____	\$ _____			
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ _____			
c. Other (Specify) _____ Supplies	\$ 16,249	16,249		
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 325,355</b>	<b>325,355</b>		
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? <input type="radio"/> Yes <input checked="" type="radio"/> No				
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
L. Is any revenue collected from these people? <input checked="" type="radio"/> Yes <input type="radio"/> No				If yes, specify amt. \$1,350
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)				30/IV1
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> 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.

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

Name of Facility Senior Philanthropy of Stamford d/b/a Long Ridge Post-	License No. 2408	Report for Year Ended 9/30/2020	Page of 19   37	
Item	Total	CCNH	RHNS	(Specify)
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$			
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.			
	Amt. \$			
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.			
	Amt. \$			
4. Repair and/or purchase of linens.***	Lbs.			
	Amt. \$			
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$	168,137	168,137	
c. Other (Specify) Supplies	\$	1,635	1,635	
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	\$	169,772	169,772	
3F. Laundry Questionnaire				
G. Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
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 laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K. Did you receive revenue 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)	

\* 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.

\*\*\* 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
		9/30/2020		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced				
a. In-House Care	by Personnel				
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$				
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel				
	Amt. \$	73,942	73,942		
C. Other ( <i>Specify</i> )	\$	138	138		
<b>4D. Total Housekeeping Expenditures (4a + b + c )</b>	\$	<b>74,080</b>	<b>74,080</b>		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	166,827	166,827		
b. Medicine Cabinet Drugs	\$	22,794	22,794		
c. Medical and Therapeutic Supplies	\$	162,728	162,728		
d. Ambulance/Limousine***	\$	1,507	1,507		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	17,031	17,031		
f. X-rays and Related Radiological Procedures***	\$	9,470	9,470		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$	17,682	17,682		
i. Recreation	\$	1,817	1,817		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other ( <i>Specify</i> )**** See Attached Schedule	\$	90,241	90,241		
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	<b>490,097</b>	<b>490,097</b>		

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

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

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

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

**Schedule of Other Resident Care**

Description	CCNH	RHNS	(Specify)
Equipment Minor	\$ 241		
Minor Equipment & Supplies - Therapy	\$ 4,049		
IV Supplies - Medicaid	\$ 616		
IV Drugs - Medicare	\$ 12,763		
IV Supplies - Medicare	\$ 39		
Medical Equipment Rental	\$ 30,728		
Minor Equipment - Nursing	\$ 19,283		
IV Drugs - Managed Care	\$ 1,626		
IV Supplies - Managed Care	\$ 30		
IV Drugs - Medicaid	\$ 2,701		
Medical Waste Disposal	\$ 1,054		
Utilities-Cable TV	\$ 17,111		
<b>Total Other Resident Care</b>	<b>\$ 90,241</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility Senior Philanthropy of Stamford d/b/a Long Ridge Post-Acute Care				License No. 2408	Report for Year Ended 9/30/2020				Page of 21   37		
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				Pg	Line
		Yes	No			CCNH	RHNS	(Specify)			
Davis Disposal Service Inc.	127 Orchard St., Stamford, CT 06902	<input type="radio"/>	<input checked="" type="radio"/>		Trash Removal Services	32,524				22	6f
Brian Capone Land Services LLC	27 Diamondcrest Lane, Stamford, CT 06903	<input type="radio"/>	<input checked="" type="radio"/>		Grounds Maintenance	52,161				22	6f
Healthcare Services Group	300, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Laundry	63,393				19	3b
Healthcare Services Group	300, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Houskeeping	73,942				20	4b
Healthcare Services Group	300, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Dietary	16,249				18	2b
Rinaldi Linen Service	47 Commons Court, Waterbury, CT 06704	<input type="radio"/>	<input checked="" type="radio"/>		Laundry	104,744				19	3b
		<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
		9/30/2020		22   37
Item		Total	CCNH	RHNS
6. Maintenance & Operation of Plant				
a. Repairs & Maintenance	\$	26,071	26,071	
b. Heat	\$	38,181	38,181	
c. Light & Power	\$	121,017	121,017	
d. Water	\$	76,933	76,933	
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$			
f. Other <i>(itemize)</i>	\$	167,111	167,111	
See Attached Schedule				
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$	429,313	429,313	
7. Depreciation <i>(complete schedule page 23*)</i>				
a. Land Improvements	\$			
b. Building & Building Improvements	\$	31,637	31,637	
c. Non-Movable Equipment	\$			
d. Movable Equipment	\$	86,700	86,700	
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$	118,337	118,337	
8. Amortization <i>(Complete att. Schedule Page 24*)</i>				
a. Organization Expense	\$			
b. Mortgage Expense	\$			
c. Leasehold Improvements	\$			
d. Other <i>(Specify)</i>	\$			
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	1,406,619	1,406,619	
10. Property Taxes				
a. Real estate taxes paid by owner	\$			
b. Real estate taxes paid by lessor	\$	114,057	114,057	
c. Personal property taxes	\$	8,728	8,728	
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$	1,647,741	1,647,741	

\* 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)
Electrical-Maint	\$ 2,077		
Plumbing-Maint	\$ 10,801		
HVAC/Boiler Maint	\$ 20,360		
Paint-Maint	\$ 808		
Alarm Inspection-Maint	\$ 6,553		
Alarm Repairs-Maint	\$ 9,707		
Grounds Maintenance-Maint	\$ 52,161		
Sprinklers-Maint	\$ 3,450		
Elevator-Maint	\$ 10,770		
Pest Control-Maint	\$ 2,241		
Maint Contracts- Generator	\$ 5,781		
Equipment Minor-Maint	\$ 4,381		
Waste Disposal -Grease/Trash	\$ 32,524		
Copier- Maintenance Agreement	\$ 5,497		
<b>Total Other Repairs and Maintenance</b>	<b>\$ 167,111</b>	<b>\$ -</b>	<b>\$ -</b>

## Depreciation Schedule

Name of Facility Senior Philanthropy of Stamford d/b/a Long Ridge Post-Acute Care				License No. 2408			Report for Year Ended 9/30/2020				Page 23	of 37	
Property Item				Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals		
<b>A. Land Improvements</b>													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
<b>A-4. Subtotal</b>													
<b>B. Building and Building Improvements</b>				476,540		476,540	66,477	S/L	Various	28,819			
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)				28,180						2,818			
<b>B-4. Subtotal</b>											31,637		
<b>C. Non-Movable Equipment</b>													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
<b>C-4. Subtotal</b>													
	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals	
	Yes	No	Month	Year									
<b>D. Movable Equipment</b>													
1. Motor Vehicles (Specify name, model and year of each vehicle)			7	15	40,257		40,257	36,230	S/L	5			
a. 2015 Ford Transit 250 - 10 Passenger													
b. Corporate Fleet - taxable sales taxes			5	16	1,110		1,110	888	S/L	5			
c. Corporate Fleet - taxable sales taxes			9	17	1,693		1,693	1,017	S/L	5			
d. Transfer of Van to BR			7	15	(43,060)		(43,060)	(17,224)	S/L	5			
2. Movable Equipment													
a. Acquired prior to this report period			Var	Var	1,399,859		1,399,859	1,200,752	S/L	Various	84,165		
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)					29,358						6,559		
<b>D-3. Subtotal</b>											86,700		
<b>E. Total Depreciation</b>											118,337		

Senior Philanthropy of Stamford d/b/a Long Ridge Post-Acute Care  
9/30/2020

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

\*Ties to Page 23, Line A3

\*\*Ties to Page 23, Line A2

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

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
6/11/2020	Replace elevator door edges and power supply	\$ 13,252	10	\$ 1,325
6/29/2020	Transformer	\$ 6,888	10	\$ 689
7/26/2020	Hydraulic Jack for Elevator	\$ 8,040	10	\$ 804
<b>Total additions for Building Improvement</b>		\$ 28,180		\$ 2,818 *
<b>Deletions:</b>				
<b>Total deletions for Building Improvement</b>		\$ -		\$ - ***

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

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

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2

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

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
2/1/2020	CDW Laptops	\$ 5,153	3	\$ 1,718
6/12/2020	Exhaust Fan Motors	\$ 6,125	5	\$ 1,225
6/18/2020	2 RTUs	\$ 18,080	5	\$ 3,616
<b>Total additions for Movable Equipment</b>		\$ 29,358		\$ 6,559 *
<b>Deletions:</b>				
<b>Total deletions for Movable Equipment</b>		\$ -		\$ - **

\*Ties to Page 23, Line D2c

\*\*Ties to Page 23, Line D2b

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

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

\*\*Ties to Page 24, Line C2

**Amortization Schedule\***

Name of Facility Senior Philanthropy of Stamford d/b/a Long Ridge Post-Acut			License No. 2408		Report for Year Ended 9/30/2020			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
<b>A-4. Subtotal</b>									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
<b>B-4. Subtotal</b>									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
<b>C-4. Subtotal</b>									
<b>D. Total Amortization</b>									

\* Straight-line method must be used.

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

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

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

Name of Facility Senior Philanthropy of Stamford d/b/a	License No. 2408	Report for Year Ended 9/30/2020	Page 25	of 37
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#### 11. Property Questionnaire

##### Part A

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

Yes

No

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

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

Description	Total			
1. Date Land Purchased				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	120			
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building				

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

	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				

##### Complete if Mortgage was Refinanced

###### During Current Cost Year

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

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

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
710 Long Ridge Rd. LLC, 710 Long Ridge Rd., Stamford, CT 06902	Building	04/01/15	10 yrs	1,406,077

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 Senior Philanthropy of Stamford d/b/a	License No. 2408	Report for Year Ended 9/30/2020			Page 26	of 37
Item		Total	CCNH	RHNS	(Specify)	
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
2. Second Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
3. Third Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
4. Fourth Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount	\$					
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
<b>12 B7. Total Building Interest Expense (A1 - A4 + B5)</b>	\$					

(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 9/30/2020			Page 27	of 37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		\$				
12. D. Other Interest Expense (Specify)		\$	147,863	147,863		
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)		\$	147,863	147,863		
14. Insurance						
a. Insurance on Property (buildings only)		\$	24,543	24,543		
b. Insurance on Automobiles		\$				
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$	62,901	62,901		
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$				
14d. <b>Total Insurance Expenditures</b> (14a + b + c)		\$	87,444	87,444		
15. <b>Total All Expenditures</b> (A-13 thru C-14)		\$	14,711,245	14,711,245		

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

Name of Facility			License No.	Report for Year Ended		Page of
Item No.	Page No.	Line No.		CCNH	RHNS	28   37
			Item Description	Total Amount of Decrease		
<b>Page 10 - Salaries and Wages</b>						
1.			Outpatient Service Costs	\$		
2.			Salaries not related to Resident Care	\$		
3.			Occupational Therapy	\$		
4.			Other - See attached Schedule	\$		
<b>Page 13 - Professional Fees</b>						
5.	13	B8c	Resident Care Physicians **	\$ (8,039)	(8,039)	
6.	13	10a	Occupational Therapy	\$ 481,678	481,678	
7.			Other - See attached Schedule	\$		
<b>Pages 15 &amp; 16 - Administrative and General</b>						
8.			Discriminatory Benefits	\$		
9.	15	1c	Bad Debts	\$ 41,381	41,381	
10.			Accounting	\$		
10a.			Legal	\$ 235	235	
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	m3	Unallowable Advertising *	\$ 796	796	
19.			Income Tax / Corporate Business Tax	\$		
20.			Fund Raising / Contributions	\$		
21.	16	m12	Unallowable Management Fees	\$ 8,300	8,300	
22.			Barber and Beauty	\$		
23.			Other - See attached Schedule	\$ 11,073	11,073	
<b>Page 18 - Dietary Expenditures</b>						
24.	30	IV1	Meals to employees, guests and others who are not residents	\$ 1,350	1,350	
<b>Page 19 - Laundry Expenditures</b>						
25.			Laundry services to employees, guests and others who are not residents	\$		
<b>Page 20 - Housekeeping Expenditures</b>						
26.			Housekeeping services to employees, guests and others who are not residents	\$		
Subtotal (Items 1 - 26)			\$ 536,774	\$ 536,774		

\* All except "Help Wanted".

(Carry Subtotal forward to next page )

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

### **Schedule of Other Salaries Adjustment**

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

## Schedule of Fees Adjustments

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

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Resident Reimburse on Lost/Stolen Items	\$ 137		
16	m13	Collection Fees/Credit Card Fees	\$ 3,861		
16	m13	Late fees/Fines/Finance Charges-Adm	\$ 7,075		
<b>Total Other A&amp;G Adjustments</b>			\$ 11,073	\$ -	\$ -

State of Connecticut

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

CSP-29 Rev. 10/2006

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

Name of Facility			License No.	Report for Year Ended		Page	of
Item No.	Page No.	Line No.		2408	9/30/2020	29	37
						Total Amount of Decrease	
						CCNH	RHNS
						(Specify)	
			Subtotals Brought Forward			\$ 536,774	536,774
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5a2	Prescription Drugs	\$ 166,827	166,827		
28.	20	5d	Ambulance/Limousine	\$ 1,507	1,507		
29.	20	5f	X-rays, etc	\$ 9,470	9,470		
30.	20	5h	Laboratory	\$ 17,682	17,682		
31.			Medical Supplies	\$			
32.	20	5f	Oxygen (non emergency)	\$ 17,031	17,031		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 4,357	4,357		
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation				
			See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation				
			Unallowable Building Interest -				
			See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>			\$	753,648	753,648		

\*\*\* 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.

Senior Philanthropy of Stamford d/b/a Long Ridge Post-Acute Care  
9/30/2020

### **Schedule of Other Ancillary Costs**

### Schedule of Excess Movable Equipment Depreciation

### Schedule of Other Property Adjustments

### **Schedule of Other Adjustments**

Attachment Page 29

### **Schedule of Unallowable Building Interest**

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended 9/30/2020			Page 30	of 37
Item		Total	CCNH	RHNS	(Specify)	
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 14,843,362	14,843,362				
b. Medicaid Room and Board Contractual Allowance **	\$ (6,198,836)	(6,198,836)				
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 2,371,228	2,371,228				
b. Medicare Room and Board Contractual Allowance **	\$ 990,543	990,543				
4. a. Private-Pay Residents and Other	\$ 1,196,920	1,196,920				
b. Private-Pay Room and Board Contractual Allowance **	\$ 328,184	328,184				
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 191,028	191,028				
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$ 74,408	74,408				
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	\$ 1,488,600	1,488,600				
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$ 402,191	402,191				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 430,060	430,060				
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$ 157,285	157,285				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 1,685,000	1,685,000				
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$ 394,657	394,657				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other ( <i>Specify</i> ) - Medicare	\$ (3,001,106)	(3,001,106)				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ (1,039,195)	(1,039,195)				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 14,314,329	14,314,329				
<b>IV. Other Revenue*</b>						
1. Meals sold to guests, employees & others	\$ 1,350	1,350				
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income ( <i>Specify</i> )	\$ (4)	(4)				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$ (18,229)	(18,229)				
<b>V. Total Other Revenue</b> (1 thru 8)	\$ (16,883)	(16,883)				
<b>VI. Total All Revenue</b> (III +V)	\$ 14,297,446	14,297,446				

\* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

\*\* Facility should report all contractual allowances and/or payer discounts.

**Schedule of Other Resident Revenue - Medicare**

**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
30/II6a	Laboratory- MCR A-SNF	\$ 38,649		
30/II6a	IV Therapy-MCR A-SNF	\$ 14,674		
30/II6a	XRay MRA	\$ 22,265		
30/II6a	Contractual Adj-Ancill-MCR A-SNF	\$ (1,857,527)		
30/II6a	Flu Shots - MCR B - SNF	\$ 2,100		
30/II6a	Sequestration - MCR B	\$ (8,172)		
30/II6a	Contractual Adj- Ancill- MCR B-SNF	\$ (1,213,095)		
<b>Total Other Resident Revenue - Medicare</b>		<b>\$ (3,001,106)</b>	<b>\$ -</b>	<b>\$ -</b>

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

**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
30/II6b	Laboratory	\$ 289		
30/II6b	Laboratory- MCD- SNF	\$ 5,118		
30/II6b	IV Therapy-MCD-SNF	\$ 8,546		
30/II6b	X-Ray - MCD	\$ 1,997		
30/II6b	Contractual Adj- Ancillaries- MCD-SNF	\$ (610,338)		
30/II6b	Contractual Adj- Ancill- Hospice-SNF	\$ (275)		
30/II6b	Lab Rev-Ins	\$ (208)		
30/II6b	Contractual Allowance-Ins. R/S	\$ 181		
30/II6b	Contractual Allowance Ancillary INS	\$ (7,280)		
30/II6b	Lab HMO	\$ 5,692		
30/II6b	IV THERAPY	\$ 1,350		
30/II6b	Radiology HMO	\$ 5,683		
30/II6b	Sequestration - HMO	\$ (2,791)		
30/II6b	Contractual Adj Ancillary HMO	\$ (447,159)		
<b>Total Other Resident Revenue</b>		<b>\$ (1,039,195)</b>	<b>\$ -</b>	<b>\$ -</b>

**Interest Income**

**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30/IV5	Interest Income	\$ (4)			
<b>Total Interest Income</b>		<b>\$ (4)</b>	<b>\$ -</b>	<b>\$ -</b>	

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
30/IV8	Donations	\$ 140		
30/IV8	Miscellaneous Operating Income-Admin	\$ (6,236)		
30/IV8	Gain/Loss-Sale/Disposal of Assets	\$ (12,133)		
<b>Total Other Revenue</b>		<b>\$ (18,229)</b>	<b>\$ -</b>	<b>\$ -</b>

**G. Balance Sheet**

Name of Facility Senior Philanthropy of Stamford d/b/a I	License No. 2408	Report for Year Ended 9/30/2020	Page 31	of 37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$ 1,467,622	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 859,110	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$ 73,696	
a. _____				
b. _____				
c. _____				
d. See Schedule		73,696		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$ 4,182,219	
See Schedule		4,182,219		
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$ 6,582,647	
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	Accum. Depreciation	Net	\$
3. Buildings	*Historical Cost	504,720		\$ 406,606
	Accum. Depreciation	98,113	Net	
4. Leasehold Improvements	*Historical Cost	Accum. Depreciation	Net	\$
5. Non-Movable Equipment	*Historical Cost	Accum. Depreciation	Net	\$
6. Movable Equipment	*Historical Cost	1,429,216		\$ 137,740
	Accum. Depreciation	1,291,476	Net	
7. Motor Vehicles	*Historical Cost	Accum. Depreciation	16,887 Net	\$ (16,887)
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	(48,700)
See Schedule		(48,700)		
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	478,759

\* 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	License No.	Report for Year Ended	Page of
Senior Philanthropy of Stamford d/b/a L	2408	9/30/2020	32   37
Account			Amount
Total Brought Forward:			\$ 7,061,406
C. Leasehold or like property recorded for Equity Purposes.			
1. Land			\$
2. Land Improvements	*Historical Cost _____	Accum. Depreciation	Net \$
3. Buildings	*Historical Cost _____	Accum. Depreciation	Net \$
4. Non-Movable Equipment	*Historical Cost _____	Accum. Depreciation	Net \$
5. Movable Equipment	*Historical Cost _____	Accum. Depreciation	Net \$
6. Motor Vehicles	*Historical Cost _____	Accum. Depreciation	Net \$
7. Minor Equipment-Not Depreciable			\$
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$
D. Investment and Other Assets			
1. Deferred Deposits			\$
2. Escrow Deposits			\$
3. Organization Expense	*Historical Cost _____	Accum. Depreciation	Net \$
4. Goodwill (Purchased Only)			\$
5. Investments Related to Resident Care ( <i>itemize</i> )			\$
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$
Name and Address	Amount	Loan Date	
7. Other Assets ( <i>itemize</i> )			\$
See Schedule			
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$ 7,061,406

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

**Schedule of Prepaid Expenses Page 31 Line A5**

Page Ref	Line Ref	Description	
	31	AS	Prepaid Insurance
	31	AS	Prepaid Taxes and Licenses
	31	AS	Prepaid Uniforms
	31	AS	Prepaid Other
<b>Total Prepaid Expenses</b>			<b>\$ 73,696</b>

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

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

**Schedule of Other Assets Page 32 Line D7**

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

Schedule of Notes Payable (Itemize) Page 33 Line A2

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

Page Ref	Line Ref	Description	
33	A12	Medicaid Remittance Adjustment	\$ (10,766)
33	A12	Employee Deductions- Garnishments	\$ 199
33	A12	Employee Deductions- HSA	\$ 385
33	A12	Employee Deductions- FSA	\$ 911
33	A12	Employee Deductions- ST/LIFE	\$ 9,088
33	A12	Employee Deductions- Child Support	\$ 471
33	A12	Employee Deductions - AFLAC	\$ 9
33	A12	Employee Deductions - Union Dues	\$ 1,538
33	A12	Resident Trust	\$ 49,337
33	A12	Deferred Rent - Current	\$ 382,802
33	A12	Uncleared Checks	\$ 77,431
33	A12	Accrued Workers Comp	\$ 361,746
33	A12	Accrued Insurance	\$ 187,664
33	A12	Unclaimed Property	\$ 3,388
33	A12	Accrued Legal Fees	\$ 50,055
33	A12	Accrued Accounting/Audit Fees	\$ 4,735
33	A12	Accrued Personal Property Taxes	\$ 2,351
33	A12	Accrued Other	\$ 13,143
33	A12	Due to Medicaid - Bed Fees	\$ 126,582
33	A12	Due to Medicaid - Copays	\$ 10,574
33	A12	Due to PO	\$ 160,310
33	A12	Medicare Advance Payable	\$ 647,381
33	A12	Due to Members	\$ 28,656
33	A12	HHS Stimulus	\$ 908,642
33	A12	SBA PPP Loan	\$ 1,527,300
33	A12	Due to Medicaid - Long-Term	\$ 456,106
33	A12	Deferred Rent	1687149.03
<b>Total Other Current Liabilities (Itemize)</b>			\$ 6,736,568

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

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

Name of Facility Senior Philanthropy of Stamford d/b/a Long R	License No. 2408	Report for Year Ended 9/30/2020	Page 33	of 37										
Account				Amount										
<b>Liabilities</b>														
A. Current Liabilities														
1. Trade Accounts Payable				\$ 2,348,631										
2. Notes Payable ( <i>itemize</i> )				\$ 138,478										
See Schedule				138,478										
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$										
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; padding: 2px;">Name of Lender</th> <th style="text-align: left; padding: 2px;">Purpose</th> <th style="text-align: left; padding: 2px;">Amount</th> <th style="text-align: left; padding: 2px;">Date Due</th> <th style="text-align: left; padding: 2px;"></th> </tr> </thead> <tbody> <tr><td style="height: 100px;"></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>					Name of Lender	Purpose	Amount	Date Due						
Name of Lender	Purpose	Amount	Date Due											
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$ 163,561										
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$										
6. Accrued Payroll Taxes Payable				\$ 45,715										
7. Medicare Final Settlement Payable				\$										
8. Medicare Current Financing Payable				\$										
9. Mortgage Payable ( <i>Current Portion</i> )				\$										
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$										
11. Accrued Income Taxes*				\$										
12. Other Current Liabilities ( <i>itemize</i> )				\$ 6,736,568										
See Schedule				6,736,568										
<b>A-13. Total Current Liabilities</b> (Lines A1 thru 12)				<b>\$ 9,432,954</b>										

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

(Carry Total forward to next page)

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

Name of Facility Senior Philanthropy of Stamford d/b/a Long	License No. 2408	Report for Year Ended 9/30/2020	Page 34	of 37
Account			Amount	
Total Brought Forward:			9,432,954	
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )			\$	
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable			\$	
3. Loans from Owners or Related Parties ( <i>itemize</i> )			\$	
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities ( <i>itemize</i> )			\$ 47,923	
See Schedule			47,923	
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)			\$ 47,923	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)			\$ 9,480,877	

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

Name of Facility Senior Philanthropy of Stamford d/b/a	License No. 2408	Report for Year Ended 9/30/2020	Page 35	of 37
Account				Amount
<b>A. Reserves</b>				
1. Reserve for value of leased land				\$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized				\$
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )				\$
4. Reserve for leasehold real properties on which fair rental value is based				\$
5. Reserve for funds set aside as donor restricted				\$
6. Total Reserves				\$
<b>B. Net Worth</b>				
1. Owner's Capital				\$
2. Capital Stock				\$
3. Paid-in Surplus				\$
4. Treasury Stock				\$
5. Cumulated Earnings				\$ (2,005,671)
6. Gain or Loss for Period 10/1/2019 thru 9/30/2020				\$ (413,799)
7. Total Net Worth				\$ (2,419,470)
<b>C. Total Reserves and Net Worth</b>				\$ (2,419,470)
<b>D. Total Liabilities, Reserves, and Net Worth</b>				\$ 7,061,406

## H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Senior Philanthropy of Stamford d/b/a L	2408	9/30/2020	36	37
Account				Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2019				\$ (2,005,682)
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )				\$ 14,297,446
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )				\$ 14,711,245
D. Net Income or Deficit				\$ (413,799)
E. Balance				\$ (2,419,481)
F. Additions				
1. Additional Capital Contributed ( <i>itemize</i> )				
2. Other ( <i>itemize</i> )				
F-3. Total Additions				\$
G. Deductions				
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )				\$
Name and Address (No., City, State, Zip )	Title	Amount		
2. Other Withdrawings ( <i>Specify</i> )				\$
Purpose	Amount			
3. Total Deductions				\$
H. <b>Balance at End of Period</b>				\$ (2,419,481)

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

Name of Facility Senior Philanthropy of Stamford d/b/a	License No. 2408	Report for Year Ended 9/30/2020	Page 37	of 37
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*Check appropriate category*

<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)
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### Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
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Printed Name of Preparer

CJLC LLC

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