

# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2022

Name of Facility (as licensed) Branford Hills Health Care Center		
Address (No. & Street, City, State, Zip Code) 189 Alps Road, Branford, CT 06405		
Type of Facility		
<input checked="" type="checkbox"/> Chronic and Convalescent 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 6/30/2022	Report for Year Ending 9/30/2022	

License Numbers:	CCNH 997C	RHNS	(Specify)	Medicare Provider
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Medicaid Provider Numbers:	CCNH 9977	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) Branford Hills Health Care Center	License No. 997C	Report for Year Ended 9/30/2022	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 Branford Hills Health Care Center [facility name], for the cost report period beginning June 30, 2022 and ending September 30, 2022, 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 Woxland		Printed Name (Owner) Aaron Sodden		
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 Branford Hills Health Care Center	Period Covered:		From 6/30/2022	To 9/30/2022
Address of Facility 189 Alps Road, Branford, CT 06405				
Report Prepared By CJLC LLC	Phone Number 860-610-9009	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	\$			
<b>6. Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
<b>8. Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

## **General Information and Questionnaire**

### **Type of Facility - Organization Structure**

Phone No. of Facility 203-481-6221	Report for Year Ended 9/30/2022	Page 2	of 37		
Name of Facility (as shown on license) Branford Hills Health Care Center		Address (No. & Street, City, State, Zip) 189 Alps Road, Branford, CT 06405			
License Numbers: 997C	CCNH	RHNS	(Specify)		
Medicare Provider No.					
Type of Facility (Check appropriate box(es))					
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> 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 checked="" type="radio"/> LLC <input type="radio"/> Partnership <input 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 6/30/2022	Date Closed		
Has there been any change in ownership or operation during this report year?		<input checked="" type="radio"/> Yes <input type="radio"/> No	If "Yes," explain fully. <div style="border: 1px solid black; height: 150px; margin-top: 5px;"></div>		
<b>Administrator</b> Name of Administrator Janet Woxland <table border="1" style="float: right; margin-top: -20px;"> <tr> <td>Nursing Home Administrator's License No.:</td> <td>1516</td> </tr> </table>				Nursing Home Administrator's License No.:	1516
Nursing Home Administrator's License No.:	1516				
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name		License No.:			

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

# **General Information and Questionnaire**

## **Corporate Owners**

Name of Facility Branford Hills Health Care Center	License No. 997C	Report for Year Ended 9/30/2022	Page 3A	of 37
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If this facility is owned or operated as a corporation, provide the following information:

# **General Information and Questionnaire**

## **Individual Proprietorship**

Name of Facility Branford Hills Health Care Center	License No. 997C	Report for Year Ended 9/30/2022	Page 3B	of 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

## General Information and Questionnaire

### Related Parties\*

Name of Facility Branford Hills Health Care Center	License No. 997C	Report for Year Ended 9/30/2022			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input checked="" type="radio"/> Yes <input type="radio"/> No <small>If "Yes," provide the Name/Address and complete the information on Page 11 of the report.</small>				
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 <small>If "Yes," provide the following information:</small>				
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	%**				
Ark Healthcare Management LLC	494 Elm Street, Stamford, CT 06902	<input type="radio"/>	<input checked="" type="radio"/>		Management fees	16/m12	239,639	239,639
ABH Propco LLC	189 Alps Road, Branford, CT 06405	<input type="radio"/>	<input checked="" type="radio"/>		Property rental	22/9	300,000	300,000
ABH Pharmacy	189 Alps Road, Branford, CT 06405	<input type="radio"/>	<input checked="" type="radio"/>		Prescription Drugs	20/5a1	80,744	80,744
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

\* Use additional sheets if necessary.

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

## **General Information and Questionnaire**

### **Basis for Allocation of Costs**

Name of Facility Branford Hills Health Care Center	License No. 997C	Report for Year Ended 9/30/2022	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	License No.	Report for Year Ended	Page	of
Branford Hills Health Care Center	997C	9/30/2022	7	37

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 1 AR Solutions 2 3 4	Address (No. & Street, City, State, Zip Code)
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**Services Provided by This Firm (*describe fully*)**

1	Billing Assistance	\$	24,010
2		\$	
3		\$	
4		\$	
Charge for Services Provided			\$ 24,010

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 Ford & Harrison LLP	
2	
3	
4	
5	

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

**Services Provided by This Firm (*describe fully*)**

1	Employee matters	\$	1,365
2		\$	
3		\$	
4		\$	
5		\$	
		Charge for Services Provided	
		\$	1,365

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

Are These Changes Reflected in the Expenditure Portion Pg 15/1e

## Schedule of Resident Statistics

Name of Facility Branford Hills Health Care Center			License No. 997C			Report for Year Ended 9/30/2022				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					190	190							
A. On last day of PREVIOUS report period	190	190											
B. On last day of THIS report period	190	190							190	190			
2. Number of Residents													
A. As of midnight of PREVIOUS report period													
B. As of midnight of THIS report period	146	146							146	146			
3. Total Number of Days Care Provided During Period					9	9			1,218	1,218			
A. Medicare	1,227	1,227											
B. Medicaid (Conn.)	10,587	10,587			108	108			10,479	10,479			
C. Medicaid (other states)													
D. Private Pay	1,044	1,044			13	13			1,031	1,031			
E. State SSI for RCH													
F. Other (Specify) Managed Care	1,006	1,006			19	19			987	987			
G. Total Care Days During Period (3A thru F)	13,864	13,864			149	149			13,715	13,715			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days	64	64							64	64			
B. Other Bed Reserve Days													
<b>5. Total Resident Days (3G + 4A + 4B)</b>	<b>13,928</b>	<b>13,928</b>			<b>149</b>	<b>149</b>			<b>13,779</b>	<b>13,779</b>			

## Schedule of Resident Statistics (Cont'd)

Name of Facility Branford Hills Health Care Center			License No. 997C			Report for Year Ended 9/30/2022			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 (1)	RHNS (2)		(Specify) (3)
				(1)	(2)	(3)	(1)				
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	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR		
No. of Residents	13	115		18							
Per Diem Rate											
a. One bed rm.		287.38		610.00							
b. Two bed rms.				560.00							
c. Three or more bed rms.											
7. Total Number of Physical Therapy Treatments							TOTAL	CCNH	RHNS	(Specify)	
							340	340			
A. Medicare - Part B											
B. Medicaid (Exclusive of Part B)											
1. Maintenance Treatments											
2. Restorative Treatments							33	33			
C. Other							1,900	1,900			
D. <b>Total Physical Therapy Treatments</b>							2,273	2,273			
8. Total Number of Speech Therapy Treatments											
A. Medicare - Part B							152	152			
B. Medicaid (Exclusive of Part B)											
1. Maintenance Treatments											
2. Restorative Treatments							1	1			
C. Other							306	306			
D. <b>Total Speech Therapy Treatments</b>							459	459			
9. Total Number of Occupational Therapy Treatments											
A. Medicare - Part B							536	536			
B. Medicaid (Exclusive of Part B)											
1. Maintenance Treatments											
2. Restorative Treatments							47	47			
C. Other							2,050	2,050			
D. <b>Total Occupational Therapy Treatments</b>							2,633	2,633			

## Report of Expenditures - Salaries &amp; Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2022		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
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	45,930	340			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	273,141	6,756			
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor					
c. Dietary Workers	214,824	8,994			
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers	104,463	4,159			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance					
b. Other Maintenance Workers	34,794	1,039			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers					
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					
b. RN					
1. Direct Care	268,752	5,188			
2. Administrative**	25,979	551			
c. LPN					
1. Direct Care	297,507	7,728			
2. Administrative**					
d. Aides and Attendants	524,227	21,846			
e. Physical Therapists					
f. Speech Therapists					
g. Occupational Therapists					
h. Recreation Workers	44,649	1,742			
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	29,128	858			
n. Marketing					
o. Other (Specify)					
See Attached Schedule					
A-13. Total Salary Expenditures	1,863,394	59,201			

\* 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 Branford Hills Health Care Center			License No. 997C		Report for Year Ended 9/30/2022			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
Branford Hills Health Care Center				997C		9/30/2022			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>										
Janet Woxland	45,930				Administrator	340	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 Branford Hills Health Care Center	License No. 997C	Report for Year Ended 9/30/2022		Page 13	of 37
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary</b> (For all such services complete Schedule B1)					
1. Dietitian	540	15			
2. Dentist	5,168	10			
3. Pharmacist					
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	88,367	1,383			
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	16,500	78			
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	28,951	304			
b. Other					
10. Occupational Therapist					
a. Resident Care	112,299	1,724			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	88,776	1,131			
2. Administrative***					
b. LPN					
1. Direct Care	223,727	3,357			
2. Administrative***					
c. Aides	294,252	7,608			
d. Other					
12. Other (Specify)					
See Attached Schedule					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	858,579	15,610			

\* 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

\* Use additional sheets if necessary.

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

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

Name of Facility Branford Hills Health Care Center	License No. 997C	Report for Year Ended 9/30/2022		Page 15	of 37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	55,724	55,724		
2. Disability Insurance	\$				
3. Unemployment Insurance	\$	52,238	52,238		
4. Social Security (F.I.C.A.)	\$	137,527	137,527		
5. Health Insurance	\$	101,140	101,140		
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$				
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*	\$	47,657	47,657		
d. Accounting and Auditing	\$	24,010	24,010		
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$	1,365	1,365		
f. Insurance on Lives of Owners and Operators (Specify)*	\$				
g. Office Supplies	\$	5,335	5,335		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	2,922	2,922		
2. Cellular Phones	\$	175	175		
i. Appraisal ( <i>Specify purpose and attach copy</i> )*	\$				
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$				
k. Other Taxes ( <i>Not related to property - See Page 22</i> )					
1. Income*	\$	23,000	23,000		
2. Other (Specify) See Attached Schedule	\$				
3. Resident Day User Fee	\$	241,267	241,267		
<b>Subtotal</b>	\$	<b>692,359</b>	<b>692,359</b>		

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

(Carry Subtotals forward to next page)

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

Attachment Page 15

**Schedule of Other Employee Benefits**

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

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**Schedule of Other Taxes**

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

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

Name of Facility Branford Hills Health Care Center	License No. 997C	Report for Year Ended 9/30/2022	Page 16	of 37
Item	Total	CCNH	RHNS	(Specify)
<b><i>Subtotals Brought Forward:</i></b>	<b>692,359</b>	<b>692,359</b>		
I. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$			
3. Gifts to Staff and Residents	\$	4,564	4,564	
4. Employee Travel	\$	2,267	2,267	
5. Education Expenses Related to Seminars and Conventions	\$	2,103	2,103	
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	\$	100	100	
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	\$	691	691	
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	1,418	1,418	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	135	135	
9. Subscriptions	\$			
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**	\$	239,639	239,639	
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	41,080	41,080	
<b>C-14 Total Administrative &amp; General Expenditures</b>	<b>\$ 984,356</b>	<b>984,356</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>	\$ -	\$ -	\$ -

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
Marketing	\$ 100		
<b>Total Other Advertising</b>	\$ 100	\$ -	\$ -

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 1,418		
<b>Total Dues</b>	\$ 1,418	\$ -	\$ -

**Schedule of Contributions**

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

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
FEES & REGISTRATION	\$ 400		
LICENSES & PERMITS	\$ 110		
PURCHASED SERVICES	\$ 1,566		
COMPUTER SERVICES	\$ 17,453		
SMALL COMPUTER EQUIPMENT	\$ 8,715		
PAYROLL SERVICE	\$ 8,522		
BANK CHARGES	\$ 1,468		
MISCELLANEOUS ADMIN EXPENSE	\$ 2,846		
<b>Total Other Administrative and General</b>	\$ 41,080	\$ -	\$ -

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

Name of Facility Branford Hills Health Care Center	License No. 997C	Report for Year Ended 9/30/2022	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 #
ARK HealthCare Management	239,639	Management Services	16/m12

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

**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
	997C	9/30/2022		18   37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 127,983	127,983		
2. Non-Food Supplies	\$ 25,254	25,254		
3. Other (Specify) _____	\$			
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 2,792	2,792		
c. Other (Specify) _____	\$			
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 156,029</b>	<b>156,029</b>		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	3	3		
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 provided to employees included in 2D?) at monthly staff meetings, board meetings	<input checked="" type="radio"/> Yes <input type="radio"/> No		If yes, specify cost.	
				\$735
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 Branford Hills Health Care Center	License No. 997C	Report for Year Ended 9/30/2022	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. \$			
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.			
	Amt. \$			
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.			
	Amt. \$			
4. Repair and/or purchase of linens.***	Lbs.			
	Amt. \$			
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$			
c. Other ( <i>Specify</i> )	\$	36,840	36,840	
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	<b>\$</b>	<b>36,840</b>	<b>36,840</b>	
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 Branford Hills Health Care Center	License No. 997C	Report for Year Ended 9/30/2022		Page 20	of 37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 11,028	11,028		
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )					
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.	\$ 973	973		
C. Other ( <i>Specify</i> )	\$				
<b>4D. Total Housekeeping Expenditures (4a + b + c )</b>	\$	<b>12,001</b>	<b>12,001</b>		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	120,109	120,109		
b. Medicine Cabinet Drugs	\$				
c. Medical and Therapeutic Supplies	\$	67,956	67,956		
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$				
f. X-rays and Related Radiological Procedures***	\$	39	39		
g. Dental ( <i>Not dentists who should be included under         salaries or fees</i> )	\$				
h. Laboratory***	\$				
i. Recreation	\$	4,953	4,953		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other ( <i>Specify</i> )**** See Attached Schedule	\$	24,787	24,787		
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	<b>217,844</b>	<b>217,844</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**

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

\* 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 Branford Hills Health Care Center	License No. 997C	Report for Year Ended 9/30/2022			Page 22 of 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 38,269	38,269			
b. Heat	\$ 7,104	7,104			
c. Light & Power	\$ 19,957	19,957			
d. Water	\$ 9,967	9,967			
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$				
f. Other ( <i>itemize</i> )	\$ 24,550	24,550			
See Attached Schedule					
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$ 99,848	99,848			
7. Depreciation ( <i>complete schedule page 23*</i> )					
a. Land Improvements	\$				
b. Building & Building Improvements	\$				
c. Non-Movable Equipment	\$				
d. Movable Equipment	\$ 19,148	19,148			
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$ 19,148	19,148			
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )					
a. Organization Expense	\$ 5,223	5,223			
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$ 246	246			
d. Other ( <i>Specify</i> )	\$				
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$ 5,469	5,469			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 300,000	300,000			
10. Property Taxes					
a. Real estate taxes paid by owner	\$ 42,589	42,589			
b. Real estate taxes paid by lessor	\$				
c. Personal property taxes	\$ 4,989	4,989			
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$ 372,196	372,196			

\* 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**

## Depreciation Schedule

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

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

\*\*Ties to Page 23, Line A2

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

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

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

**\*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	Pick One	Useful Life		
		Movable Category	Cost	5	Depreciation
Additions:					
6/1/2022	Computer Equipment'	Administrative	\$ 20,101	5	\$ 1,005
6/1/2022	Software	Administrative	\$ 12,000	3	\$ 999
8/17/2022	ID Badge Maker	Administrative	\$ 1,200	5	\$ 20
6/1/2022	Acquired Prior Owner Equipment	Administrative	\$ 342,484	5	\$ 17,124
		PICK A CATEGORY			
		PICK A CATEGORY			
<b>Total additions for Movable Equipment</b>			<b>\$ 375,785</b>		<b>\$ 19,148</b>
Deletions:					
<b>Total deletions for Movable Equipment</b>			<b>\$ -</b>		<b>\$ -</b>

\*Ties to Page 23, Line D2c

\*\*Ties to Page 23, Line D2b

## Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Useful Life		
		Cost	15	Depreciation
Additions:				
8/2/2022	Controlled Air	\$ 6,482	15	\$ 72
8/5/2022	Electrical Improvements	\$ 7,845	15	\$ 88
8/25/2022	Controlled Air	\$ 11,497	15	\$ 64
8/31/2022	Sidewalk	\$ 4,041	15	\$ 22
9/15/2022	Glass Replacement	\$ 417	15	
9/26/2022	Outside Railing	\$ 3,775	15	
<b>Total additions for Leasehold Improvement</b>		<b>\$ 34,057</b>		<b>\$ 246</b>
Deletions:				
<b>Total deletions for Leasehold Improvement</b>		<b>\$ -</b>		<b>\$ -</b>

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Amortization Schedule\***

Name of Facility Branford Hills Health Care Center			License No. 997C		Report for Year Ended 9/30/2022			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. Start Up Costs	6	2022	15	313,294				5,223	
2.									
3.									
<b>A-4. Subtotal</b>								<b>5,223</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)				34,057				246	
<b>C-4. Subtotal</b>								<b>246</b>	
<b>D. Total Amortization</b>									<b>5,469</b>

\* 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 Branford Hills Health Care Center	License No. 997C	Report for Year Ended 9/30/2022	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	190			
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

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 9/30/2022			Page of 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					
<b>12 B7. Total Building Interest Expense (A1 - A4 + B5)</b>	<b>\$</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 9/30/2022			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						
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)			\$			
12. D. Other Interest Expense (Specify)			\$	345	345	
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)			\$	345	345	
14. Insurance						
a. Insurance on Property (buildings only)			\$	71,715	71,715	
b. Insurance on Automobiles			\$			
c. Insurance other than Property (as specified above)			\$			
1. Umbrella ( <i>Blanket Coverage</i> )			\$			
2. Fire and Extended Coverage			\$			
3. Other (Specify)			\$			
14d. <b>Total Insurance Expenditures</b> (14a + b + c)			\$	71,715	71,715	
15. <b>Total All Expenditures</b> (A-13 thru C-14)			\$	4,673,147	4,673,147	

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

Name of Facility Branford Hills Health Care Center			License No. 997C	Report for Year Ended 9/30/2022		Page 28	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			<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.			Resident Care Physicians **	\$			
6.	13	10a	Occupational Therapy	\$	112,299	112,299	
7.			Other - See attached Schedule	\$			
			<b>Pages 15 &amp; 16 - Administrative and General</b>				
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$	47,657	47,657	
10.			Accounting	\$			
10a.			Legal	\$			
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 *	\$	100	100	
19.	15	1k1	Income Tax / Corporate Business Tax	\$	23,000	23,000	
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$	135	135	
			<b>Page 18 - Dietary Expenditures</b>				
24.			Meals to employees, guests and others who are not residents	\$			
			<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)			\$	183,191	183,191		

\* 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

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

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

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m81	Chamber of Commerce	\$ 135		
<b>Total Other A&amp;G Adjustments</b>			\$ 135	\$ -	\$ -

State of Connecticut

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

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

Name of Facility Branford Hills Health Care Center				License No. 997C	Report for Year Ended 9/30/2022		Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)	
Subtotals Brought Forward				\$ 183,191	183,191			
<b>Page 20 - Resident Care Supplies***</b>								
27.	20	5a	Prescription Drugs	\$ 120,109	120,109			
28.			Ambulance/Limousine	\$				
29.	20	5f	X-rays, etc	\$ 39	39			
30.			Laboratory	\$				
31.			Medical Supplies	\$				
32.			Oxygen (non emergency)	\$				
33.			Occupational Therapy	\$				
34.			Other - See Attached Schedule	\$ 196	196			
<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>				\$ 303,536	303,536			

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

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

### Schedule of Excess Movable Equipment Depreciation

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

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

Attachment Page 29

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

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

## **Schedule of Unallowable Building Interest**

**F. Statement of Revenue**

Name of Facility Branford Hills Health Care Center	License No. 997C	Report for Year Ended 9/30/2022			Page 30   37
		Total	CCNH	RHNS	(Specify)
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 4,527,220	4,527,220			
b. Medicaid Room and Board Contractual Allowance **	\$ (1,693,541)	(1,693,541)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 494,003	494,003			
b. Medicare Room and Board Contractual Allowance **	\$ 105,780	105,780			
4. a. Private-Pay Residents and Other	\$ 1,533,668	1,533,668			
b. Private-Pay Room and Board Contractual Allowance **	\$ (315,125)	(315,125)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 20,033	20,033			
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$ 20,384	20,384			
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	\$ 58,109	58,109			
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$ 92,437	92,437			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$ 26,095	26,095			
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$ 22,208	22,208			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 109,916	109,916			
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$ 110,684	110,684			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other ( <i>Specify</i> ) - Medicare	\$ (133,177)	(133,177)			
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ (185,966)	(185,966)			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 4,792,728	4,792,728			
<b>IV. Other Revenue*</b>					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income ( <i>Specify</i> )	\$ 81	81			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 3,566	3,566			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 3,647	3,647			
<b>VI. Total All Revenue</b> (III +V)	\$ 4,796,375	4,796,375			

\* 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)
	LAB - MED A	\$ 5,333		
	C/A MEDICARE A - THERAPY	\$ (120,738)		
	C/A MEDICARE B THERAPY	\$ (17,772)		
<b>Total Other Resident Revenue - Medicare</b>		<b>\$ (133,177)</b>	<b>\$ -</b>	<b>\$ -</b>

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

Page Ref	Description	CCNH	RHNS	(Specify)
	LAB - MANAGED CARE	\$ 7,939		
	C/A MANAGED CARE - THERAPY	\$ (165,583)		
	C/A MANAGED CARE - ANCILLARIES	\$ (28,322)		
<b>Total Other Resident Revenue</b>		<b>\$ (185,966)</b>	<b>\$ -</b>	<b>\$ -</b>

**Interest Income****Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Income	\$ 81			
<b>Total Interest Income</b>		<b>\$ 81</b>	<b>\$ -</b>	<b>\$ -</b>	

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
	MISCELLANEOUS INCOME	\$ 2,728		
	OTHER INCOME	\$ 3		
	DONATIONS	\$ 835		
<b>Total Other Revenue</b>		<b>\$ 3,566</b>	<b>\$ -</b>	<b>\$ -</b>

**G. Balance Sheet**

Name of Facility Branford Hills Health Care Center	License No. 997C	Report for Year Ended 9/30/2022	Page 31	of 37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$ 1,461,861	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 1,904,802	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$ 35,407	
a. _____				
b. _____				
c. _____				
d. See Schedule		35,407		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$ 1,275,940	
_____				
_____				
See Schedule		1,275,940		
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$ 4,678,010	
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	34,058	\$	33,812
	Accum. Depreciation	246	Net	
5. Non-Movable Equipment	*Historical Cost	_____	\$	
	Accum. Depreciation	_____	Net	
6. Movable Equipment	*Historical Cost	375,785	\$	356,637
	Accum. Depreciation	19,148	Net	
7. Motor Vehicles	*Historical Cost	_____	\$	
	Accum. Depreciation	_____	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	(325,360)
See Schedule		(325,360)		
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	65,089

\* 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 Branford Hills Health Care Center	License No. 997C	Report for Year Ended 9/30/2022	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	4,743,099
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	313,294 5,223 Net	\$	308,071
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>			\$	308,071
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$	5,051,170

\* 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**

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

Page Ref	Line Ref	Description	
		ESCROW	\$ 2,753
		ESCROW - COMPLETION/REPAIR	\$ 40,306
		ESCROW - TAX	\$ 118,193
		ESCROW - INSURANCE	\$ 102,021
		ESCROW - OWNER-ELECTIVE REPAIR	\$ 1,000,000
		ESCROW - REPLACEMENT RESERVE	\$ 12,667
<b>Total Other Current Assets (Itemize)</b>			<b>\$ 1,275,940</b>

**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	
		DUE FROM ABH PHARMACY	\$ 141
		DUE FROM ABH PROPCO	\$ 49,566
		DUE FROM PREVIOUS OWNER	\$ 1,059,342
		SUSPENSE	\$ 2,036
		EMPLOYEE 401-K LOAN	\$ 104
		PATIENT REFUND	\$ (5,220)
		ACCRUED EXPENSES AND OTHER	\$ 52,330
		DUE TO STAMFORD	\$ 5,007
<b>Total Other Current Liabilities (Itemize)</b>			<b>\$ 1,163,306</b>

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2022	33	37
Account		Amount		
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable			\$	1,280,610
2. Notes Payable ( <i>itemize</i> )			\$	
See Schedule				
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )			\$	
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )			\$	132,217
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )			\$	
6. Accrued Payroll Taxes Payable			\$	56,334
7. Medicare Final Settlement Payable			\$	
8. Medicare Current Financing Payable			\$	
9. Mortgage Payable ( <i>Current Portion</i> )			\$	2,278,350
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )			\$	
11. Accrued Income Taxes*			\$	
12. Other Current Liabilities ( <i>itemize</i> )			\$	1,163,306
See Schedule		1,163,306		
<b>A-13. Total Current Liabilities</b> (Lines A1 thru 12)			\$	4,910,817

\* 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 Branford Hills Health Care Center	License No. 997C	Report for Year Ended 9/30/2022	Page 34	of 37
Account			Amount	
Total Brought Forward:			\$ 4,910,817	
<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> )			\$ 1	
Rounding			1	
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)			\$ 1	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)			\$ 4,910,818	

## G. Balance Sheet (cont'd)

### Reserves and Net Worth

Name of Facility Branford Hills Health Care Center	License No. 997C	Report for Year Ended 9/30/2022	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				\$
6. Gain or Loss for Period	6/30/2022	thru	9/30/2022	\$ 140,353
7. Total Net Worth				\$ 140,353
<b>C. Total Reserves and Net Worth</b>				\$ 140,353
<b>D. Total Liabilities, Reserves, and Net Worth</b>				\$ 5,051,170

## H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Branford Hills Health Care Center	997C	9/30/2022	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2021				\$		
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )				\$ 4,796,375		
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )				\$ 4,656,023		
D. Net Income or Deficit				\$ 140,353		
E. Balance				\$ 140,353		
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>				\$ 140,353		

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

Name of Facility Branford Hills Health Care Center	License No. 997C	Report for Year Ended 9/30/2022	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		

### Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
Printed Name of Preparer		
CJLC LLC		
Address Address 225 Pitkin St., East Hartford, CT 06108		Phone Number 860-610-9009
Contacted Person Regarding Additional Information Needed Regarding This Report CJLC		Phone Number 860-610-9009
Contact Email Address annualreports@cjlc.com		