# **State of Connecticut**



# Annual Report of Long-Term Care Facility Cost Year 2018

Name of Facility (as	licensed)							
Rose Haven								
Address (No. & Street	et, City, State, Z	Zip Code)						
31 North Street, Litcl	nfield, CT 0675	59						
Type of Facility								
Chronic and C		Rest Home wi	th Nursing					
☐ Nursing Home only ☐			Supervision or	ıly	$\checkmark$	Residenti	ial Ca	are Home
(CCNH)			(RHNS)					
Report for Year Begi	nning		Report for Yea	r Ending				
10/1/2017			9/30/2018					
License Numbers:		COMI	DIDIG	D11	4: 1.0	rr =1		1. 5
License Numbers:		CCNH	RHNS	Residential Care H				
		1036-C		1774-HFA			07-5346	
Medicaid Provider N	umbers:	CC	CNH RI		HNS		ICF-IID	
		8008102						
For Department Use	e Only							
Sequence Number	Signed and	Date	Sequence N	lumber	G: 1	137		
Assigned	Notarized	Received	Assign	ed	Signed a	nd Notari	zed	Date Received

# State of Connecticut Annual Report of Long-Term Care Facility

CSP-1 Rev.9/2002

### **General Information**

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Rose Haven	1036-C	9/30/2018	1	37

### Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Rose Haven [facility name], for the cost report period beginning October 1, 2017 and ending September 30, 2018, 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) David Bouchard			Printed Name (Owner) Brian J. Foley	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires
Address of Notary Public				

(Notary Seal)

# **Table of Contents**

Gen	eral Information - Administrator's/Owner's Certification	1
Gen	eral Information and Questionnaire - Data Required for Real Wage Adjustment	1A
Gen	eral Information and Questionnaire - Type of Facility - Organization Structure	2
Gen	eral Information and Questionnaire - Partners/Members	3
Gen	eral Information and Questionnaire - Corporate Owners	3A
Gen	eral Information and Questionnaire - Individual Proprietorship	3B
Gen	eral Information and Questionnaire - Related Parties	4
Gen	eral Information and Questionnaire - Basis for Allocation of Costs	5
Gen	eral Information and Questionnaire - Leases	6
Gen	eral Information and Questionnaire - Accounting Basis	7
	edule of Resident Statistics	8
Sch	edule of Resident Statistics (Cont'd)	9
A.	Report of Expenditures - Salaries & Wages	10
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant	
	Administrators and Other Relatives	11
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant	
	Administrators and Other Relatives (Cont'd)	12
B.	Report of Expenditures - Professional Fees	13
71	Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee	
	for Service Basis	14
C.	Expenditures Other than Salaries - Administrative and General	15
C.	Expenditures Other than Salaries (Cont'd) - Administrative and General	16
	Schedule C-1 - Management Services	17
C.	Expenditures Other than Salaries (Cont'd) - Dietary	18
C.	Expenditures Other than Salaries (Cont'd) - Laundry	19
C.	Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
	Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C.	Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
	Depreciation Schedule	23
	Amortization Schedule	24
C.	Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C.	Expenditures Other than Salaries (Cont'd) - Interest	26
C.	Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D.	Adjustments to Statement of Expenditures	28
D.	Adjustments to Statement of Expenditures (Cont'd)	29
F.	Statement of Revenue	30
G.	Balance Sheet	31
G.	Balance Sheet (Cont'd)	32
G.	Balance Sheet (Cont'd)	33
G.	Balance Sheet (Cont'd)	34
G.	Balance Sheet (Cont'd) - Reserves and Net Worth	35
H.	Changes in Total Net Worth	36
Ī.	Preparer's/Reviewer's Certification	37

# State of Connecticut **Department of Social Services**

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus		Page 1A	of 37	
Name of Facility	Period Cov	ered:	From	То
Rose Haven			10/1/2017	9/30/2018
Address of Facility 31 North Street, Litchfield, CT 06759				
Report Prepared By	Phone Nun		Date	
Apple Health Care. Inc.	(860) 678-9	755		
				Residentia 1 Care
Item	Total	CCNH	RHNS	Home
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.** 

# **General Information and Questionnaire Type of Facility - Organization Structure**

					Facility Report for Year		Page		of
		860	-567-9475		9/30/2018		2		37
Name of Facility (as shown on license)		Address (No. & Street, City, Ste							
Rose Haven			31 North St		Litchfield, CT				
	CCNH		RHNS		dential Care H	ome	Medicare P	rovi	ler No.
	1036-C			1774	4-HFA		07-5346		
Type of Facility (Check appropriate box(es	))								
☐ Chronic and Convalescent Nursing Home only (CCNH)			t Home with itervision only			Residenti	ial Care Hon	ne	
Type of Ownership (Check appropriate box									
O Proprietorship O LLC O	Partnership	•	Profit Corp.	0	Non-Profit Con	rp. O	Government	0	Trust
If this facility opened or closed during repo	e:		Date	Opened	Date Clos	sed			
Has there been any change in ownership									
or operation during this report year?		_0	Yes	<u> </u>	No	If "Yes,"	explain fully	у.	
Administrator									
Name of Administrator					Nursing Ho	me			
David Bouchard					Administrat	or's	002008		
					License N	√o.:			
Other Operators/Owners who are assistant a	ıdministrators	(full	or part time)	of th					
Name					License N	<b>Ло.:</b>			

# General Information and Questionnaire Partners/Members

Name of Facility		License No. 1036-C	Report for Year Ended 9/30/2018		Page 3	of 37
Rose Haven		1030-C	9/30/2018	State(a) and/a		
T 121 CD 4	1' /110	Dania ana /	State(s) and/o		or rown(	s) m
Legal Name of Parts	nership/LLC	Business A	which K	Which Registered		
			1			
			_	m1.1	0/ 0	,
Name of Partners/Members	Business Ac	ddress		Γitle	% Ow	ned
	I					

## General Information and Questionnaire Corporate Owners

Name of Facility	Report for Year	Page of				
Rose Haven	License No. 1036-C	9/30/2018		3A   37		
If this facility is owned or operated as a cor	poration, provide	the following inform	nation:	1 332   31		
Legal Name of Corporation		ness Address		ich Incorporated		
Rose Haven		, Litchfield, CT	Connecticut			
Name of Directors, Officers	Busin	ess Address	Title	No. Shares Held by Each		
Brian J. Foley	21 Waterville R 06001	21 Waterville Road Avon, CT President 06001				
Ryan Vess	21 Waterville R 06001	Road Avon, CT	Secretary			
Names of Stockholders Owning at Least 10% of Shares						
Brian J. Foley	21 Waterville R 06001	oad Avon, CT	President	100		

## General Information and Questionnaire Individual Proprietorship

- · · · · · · · · · · · · · · · · · · ·	License No.	Report for Year Ended	Page	of
Rose Haven	1036-C	9/30/2018	3B	37
If this facility is owned or operated as an individua	l proprietorship, pr	rovide the following informat	ion:	
Owi	ner(s) of Facility			

## General Information and Questionnaire Related Parties\*

Name of Facility		Licens	e No.		Report for Year Ended		Page	of
Rose Haven			1036-C	,	9/30/2018		4	37
A								
1	eiving compensation from the fa			_		If "Yes," provide the	ne Name/Ad	dress and
marriage, ability to cont	rol, ownership, family or busine	ess asso	ciation?	•	Yes O No	complete the inform	nation on Pa	ige 11 of the report.
					.98			
1	companies which provide goods		,					
including the rental of p	property or the loaning of funds	to this f	acility,					
related through family a	ssociation, common ownership,	contro	l, or bus	iness	O Yes O No.			
association to any of the	e owners, operators, or officials	of this 1	facility?			If "Yes," provide th	e following	information:
						, 1		
		Als	so Provi	des		Indicate Where		
		Good	ls/Servi	ces to		Costs are Included		
Name of Related	Business	Non-F	Related 1	Parties	Description of Goods/Services	in Annual Report	Cost	Actual Cost to the
Individual or Company		Yes	No	%**	Provided	Page # / Line #	Reported	Related Party
Brian J. Foley	21 Waterville Road Avon, CT 06001	0	0		Real Estate Rental	Pg. 22 Line 9	180,000	180,000
Apple Health Care	21 Waterville Road Avon, CT 06001	0	•		Management & Accounting Services	Pg. 16 Line m12	128,337	128,337
Corporate Employees	21 Waterville Road Avon, CT 06001	0	•		Employee Staffing	Pg. 10 Schedule	85,141	85,141
Employees @ Various Apple Facilities		0	•		Employee Staffing	Pg. 10 Schedule	(20,710)	(20,710)
Apple Health Care	21 Waterville Road Avon, CT 06001	0	•		Pension Plan (401K)	Pg. 15 Line 1a7	12,297	12,297
Aetna	PO Box 88860 Chicago, IL 60695	•	0		Group Medical	Pg. 15 Line 1a5	308,793	
Delta Dental	PO Box 222 Parsippany, NJ 07054	•	0		Group Dental	Pg. 15 Line 1a5	14,559	
Aetna Ancillary	PO Box 88860 Chicago, IL 60695	0	0		Group Life & Disability	Pg. 15 Line 1a6	14,133	
Marsh	PO Box 846015 Dallas, TX 75284	•	0		Property, Liability, & Umbrella Insurance	Pg. 27 Line 14a	43,477	

<sup>\*</sup> Use additional sheets if necessary.

<sup>\*\*</sup> Provide the percentage amount of revenue received from non-related parties.

## General Information and Questionnaire Related Parties\*

Name of Facility		License	e No.		Report for Year Ended		Page	of
Rose Haven			1036-C		9/30/2018		4	37
Are any individuals rece	iving compensation from the fa	cility re	lated th	rough		If "Yes," provide th	e Name/Ado	dress and
marriage, ability to conti	rol, ownership, family or busine	ss assoc	ciation?	•	Yes O No	complete the inform	nation on Pa	ge 11 of the report.
Are any individuals or co	ompanies which provide goods	or servi	ces,					
including the rental of pr	roperty or the loaning of funds t	to this fa	acility,					
related through family as	ssociation, common ownership,	control	, or bus	iness				
association to any of the	owners, operators, or officials	of this f	acility?			If "Yes," provide th	e following	information:
			so Provi			Indicate Where		
			Goods/Services to			Costs are Included		
Name of Related	Business		Related 1		Description of Goods/Services	in Annual Report	Cost	Actual Cost to the
Individual or Company	Address	Yes	No	%**	Provided	Page # / Line #	Reported	Related Party
AIG	PO Box 10472 Newark, NJ	¥			Worker's Compensation	Pg. 15 1a1	93,905	
Swallowing Diagnotics	21 Waterville Road Avon, CT	¥		83%	Diagnostic Services	Pg 20 5f	360	339
Ryan Vess	21 Waterville Road Avon, CT		¥			##		

<sup>\*</sup> Use additional sheets if necessary.

<sup>\*\*</sup> Provide the percentage amount of revenue received from non-related parties.

<sup>##</sup> Related expense has been disallowed on Pg. 28 Line 23

# **General Information and Questionnaire Basis for Allocation of Costs**

Name of Facility	License No		Report for Year Ended	Page	of		
Rose Haven	1036-C		9/30/2018	5	37		
If the facility is licensed as CDH and/or RCH o		IDS or TB	services with special Medicai	d rates, cos	ts		
must be allocated to CCNH and RHNS as follo	ws:						
Item		Method of Allocation					
Dietary		Number of	meals served to residents				
Laundry		Number of	pounds processed				
Housekeeping			square feet serviced				
			hours of routine care provided				
Nursing			classification, i.e., Director (or				
		Registered Nurses, Licensed Practical Nurses, Aides and					
		Attendants					
Direct Resident Care Consultants		Number of	hours of resident care provide	d by EACH	[		
		specialist (	(See listing page 13)				
Maintenance and operation of plant		Square feet	t				
Property costs (depreciation)		Square feet	t				
Employee health and welfare		Gross salar	ries				
Management services			e cost center involved				
All other General Administrative expenses		Total of Direct and Allocated Costs					
The preparer of this report must answer the fol	lowing quest	tions applic	able to the cost information pro	ovided.			
1. In the preparation of this Report, were all	O V	O No	If "No," explain fully why suc	h allocation	n was		
costs allocated as required?	Yes	O No	not made.				
2. Explain the allocation of related company e	xpenses and	attach copy	of appropriate supporting data	a.			
The costs incurred by Apple Health Care, inc.	(a related pa	rty), to prov	vide Accounting and Manageria	al services	to each		
facility owned by Brian J. Foley, are allocated			•				
	1						
3. Did the Facility appropriately allocate and s	self-disallow	direct and	indirect costs to non-nursing ho	ome cost ce	nters?		
(e.g., Assisted Living, Home Health, Outpar							
(0.5., 1 10010104 211115, 1101110 1101111, 0 31-711			If "No," explain fully why suc	ch allocatio	n was		
	Yes	O No	not made.	ni anocatio	ii 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.

Related * Owners, Operators Officers Yes N		9/30/2018			6	37
Owners, Operators Officers						
Operators Officers						
Officers	'	1		Annual		
	1	Date of	Term of	Amount	Ame	aunt
Yes N	Description of Items Leased	Lease**	Lease	of Lease	Clai	
0 0						
0 0						
0 0						
0 0						
0 0						
0 0						
0 0						
0 0						
0 0						
0 0						
	O					

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

<sup>\*\*</sup> Attach copies of newly acquired leases.

<sup>\*\*\*</sup> Amount should agree to Page 22, Line 6e.

## General Information and Questionnaire Accounting Basis

	License No.	Report for Year Ended		Page	OI
Rose Haven	1036-C	9/30/2018		7	37
The records of this facility for the p	period covered by this report	were maintained on the following basis:			
	Modified Cash				
Is the accounting basis for this					
1	Yes	If "No," explain.			
previous period?	No				
₹1					
Independent Accounting Firm					
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)			
1 Blum Shapiro & Co. PC		29 South Main St. West Hartford, CT 06	127		
2 Brazee & Huban		35 Wendell Ave. Pittsfield, MA 10202			
3					
4					
Services Provided by This Firm (de	escribe fully )				
1 Preparation of audited financials (dis-	allow Pg.28)		\$	9,497	
2 Preparation of tax returns			\$	2,206	
3			\$		
4			\$		
			Charge for	r Services Pr	ovided
			\$	11,704	
Are These Charges Reflected in the Expen	diture Portion of This Report? If Y	Yes, Specify Expense Classification and Line No.			
⊙ Yes O No	Pg. 15 1d				
Legal Services Information					
Name of Legal Firm or Independen	t Attorney		Telephone	Number	
1					
2					
			1		
3					
4					
4 5	7in Codo)				
4 5 Address (No. & Street, City, State,	Zip Code )				
4 5 Address (No. & Street, City, State, 1	Zip Code )				
4 5 Address (No. & Street, City, State, 1 2	Zip Code )				
4 5 Address (No. & Street, City, State, 1 2 3	Zip Code )				
4 5 Address (No. & Street, City, State, 1 2 3 4	Zip Code )				
4 5 Address (No. & Street, City, State, 1 2 3					
4 5 Address (No. & Street, City, State, 1 2 3 4 5			\$		
4 5 Address (No. & Street, City, State, 1 2 3 4 5 Services Provided by This Firm (de			\$ \$		
4 5 Address (No. & Street, City, State, 1 2 3 4 5 Services Provided by This Firm (de 1 2			\$		
4 5 Address (No. & Street, City, State, 1 2 3 4 5 Services Provided by This Firm (de 1 2 3			\$ \$		
4 5 Address (No. & Street, City, State, 1 2 3 4 5 Services Provided by This Firm (de 1 2 3 4			\$ \$ \$		
4 5 Address (No. & Street, City, State, 1 2 3 4 5 Services Provided by This Firm (de 1 2 3			\$ \$ \$ \$	r Sarvigas Dr	ovided
4 5 Address (No. & Street, City, State, 1 2 3 4 5 Services Provided by This Firm (de 1 2 3 4			\$ \$ \$ \$	r Services Pr	ovided
4 5 Address (No. & Street, City, State, 1 2 3 4 5 Services Provided by This Firm (de 1 2 3 4 5	escribe fully )  diture Portion of This Report? If Y	Yes, Specify Expense Classification and Line No.	\$ \$ \$ \$ Charge for	r Services Pr	ovided
4 5 Address (No. & Street, City, State, 1 2 3 4 5 Services Provided by This Firm (de 1 2 3 4 5	escribe fully )	Yes, Specify Expense Classification and Line No.	\$ \$ \$ \$ Charge for	r Services Pr	ovided

### **Schedule of Resident Statistics**

Name of Facility			License 1	No.			Report for Year Ended				Page	of	
Rose Haven			10	36-C			9/30/201	8			8	37	
						Period 10	/1 <b>Thru</b> 6	Thru 6/30 Period 7/1			1 Thru 9/:	l Thru 9/30	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total Residential Care Home	Total	CCNH	RHNS	Residential Care Home	Total	CCNH	RHNS	Residential Care Home	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	40	25		15	40	25		15	40	25		15	
B. On last day of THIS report period	40	25		15	40	25		15	40	25		15	
Number of Residents     A. As of midnight of PREVIOUS report period	36	22		14	36	22		14	34	22		12	
B. As of midnight of THIS report period	34	22		12	34	22		12	34	22		12	
3. Total Number of Days Care Provided During Period													
A. Medicare	2,567	2,567			1,963	1,963			604	604			
B. Medicaid (Conn.)	3,180	3,180			2,504	2,504			676	676			
C. Medicaid (other states)													
D. Private Pay	1,417	1,417			944	944			473	473			
E. State SSI for RCH													
F. Other (Specify) Home for the Aged	4,736			4,736	3,543			3,543	1,193			1,193	
G. Total Care Days During Period (3A thru F)	11,900	7,164		4,736	8,954	5,411		3,543	2,946	1,753		1,193	
Total Number of Days Not Included in Figures in 3G 4. for Which Revenue Was Received for Reserved Beds A. Medicaid Bed Reserve Days								,		,		.,	
B. Other Bed Reserve Days													
5. Total Resident Days (3G + 4A + 4B)	11,900	7,164		4,736	8,954	5,411		3,543	2,946	1,753		1,193	

## Annual Report of Long-Term Care Facility

CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Facil	ity			Licen	ise No.				Report	for Year	Ended		Page	of
Rose Haven				10	)36-C					9/30/201	8		9	37
	-	_	in the certified b		pacity du	ring th	ne repo	rt year	-?	0	Yes	•	No	
If "YES"			lowing informa	tion:	CI		: D. I			Car	pacity Afte	r Changa		
		Place of	Change Residential	_	Cr	ange	in Beds	8		Caj	bacity Arte	Change		
Date of	CCNH	RHNS	Care Home		Lost		(	Saine	1			Residential		
Change	(1)	(2)	(2)	(1)	(2)	(2)	(1)	(2)	(3)	CCNH	RHNS	Care Home	Reason fo	or Change
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNII	KIIIAS	Care Home	Reason R	n Change
		,			4 1	41		(		ad in itam	1 abova)	nroyide the nur	nhar of	
			in certified bed o 90 days followir			there	eport ye	ar (as	report	ed ili iteli	1 4 a00ve)	provide the har	inoci oi	
			C1 : D	.,	4 D					CC	NH	RHNS	Residential	Care Home
1st chan	mo.		Change in R	esidei	it Days						7/411	Kilivs	residential	Cure monie
2nd char														
3rd chan														
4th chan														
6. Number	of Resi	dents an	d Rates on Sept	ember	30 of Co	st Ye	ar							
			Medicare		Medi	caid		_		Se	elf-Pay		Other Stat	e Assisted
								1				Residential		
	Item		CCNH		CCNH	RI	HNS	C	CNH		INS	Care Home	R.C.H.	ICF-MR
No. of R		S	9		7				- 6				12	
Per Dier						110					441.00		126,40	
	oea rm.			-		-		$\vdash$			428.00		120.40	
a. One l			DITCCIII		221 70									
b. Two	bed rms		RUGS III	$\vdash$	231.79	$\vdash$								
b. Two	bed rms or mor		RUGS III		231.79									
b. Two	bed rms or mor		RUGS III		231.79									
b. Two	bed rms or mor		RUGS III		231.79									Residential
b. Two c. Three	bed rms e or mor rms.	re		tment						то	TAL	CCNH	RHNS	Residential Care Home
b. Two c. Three bed 7. Total No	e or mor rms.	e f Physic are - Par	al Therapy Trea							то	TAL 2,485	CCNH 2,485	RHNS	
b. Two c. Three bed 7. Total No	e or mor rms.	f Physic are - Par aid (Exc	al Therapy Trea t B lusive of Part B							то			RHNS	
b. Two c. Three bed 7. Total No	e or mor rms. umber o Medica 1. Ma	f Physic are - Par aid (Exc intenance	al Therapy Trea t B lusive of Part B te Treatments							ТО			RHNS	
b. Two c. Three bed 7. Total No	e or mor rms. umber o Medica 1. Ma 2. Res	f Physic are - Par aid (Exc intenance	al Therapy Trea t B lusive of Part B							ТО	2,485	2,485		
b. Two c. Three bed 7. Total No A. B.	umber o Medica 1. Ma 2. Res	f Physic are - Par aid (Exc intenanc storative	al Therapy Trea t B clusive of Part B the Treatments Treatments	)	s					ТО	7,950	2,485 7,950		
b. Two c. Three bed  7. Total Nu A. B.	mber o Medica 1. Ma 2. Res Other	f Physicare - Paraid (Excintenance torative	al Therapy Treat t B clusive of Part B ce Treatments Treatments	) ments	s					TO	2,485	2,485		
b. Two c. Three bed 7. Total No A. B. C. D. 8. Total No	bed rms e or mor rms.  umber o Medica 1. Ma 2. Res Other Total i	f Physica are - Par aid (Exc intenance storative Physical f Speecl	al Therapy Treat t B clusive of Part B the Treatments Treatments Treatments Therapy Treat the Therapy Treat	) ments	s					ТО	7,950	2,485 7,950		
b. Two c. Three bed 7. Total No A. B. C. D. 8. Total No A	bed rms e or mor rms.  umber o Medici Medici 1. Ma 2. Res Other Total i umber o Medic	f Physica are - Par aid (Exc intenance storative Physical f Speecl are - Par	al Therapy Treat t B clusive of Part B the Treatments Treatments Treatments Therapy Treat the Therapy Treat	ments	s					ТО	7,950 10,435	7,950 10,435		
b. Two c. Three bed 7. Total No A. B. C. D. 8. Total No A	bed rms e or mor rms.  umber o . Medic: . Medic: . Medic: . Other . Total i umber o . Medic.	f Physical f Speeclare - Paraid (Exc	al Therapy Treat t B clusive of Part B the Treatments Treatments Treatments Therapy Treat t B	ments	s					TO	7,950 10,435	7,950 10,435		
b. Two c. Three bed  7. Total No A. B.  C. D. 8. Total No A. B.	bed rms orms.  Imber o Medica Medica 1. Ma 2. Res Other Total Indumber o Medica 1. Medica 1. Medica 1. Medica 1. Medica 1. Medica 2. Res Medica 2. Res Medica 3. Res Medica 4. Res	f Physical f Speeclare - Paraid (Exception of Exception o	al Therapy Treat t B clusive of Part B the Treatments Treatments Therapy Treat t Therapy Treat t B clusive of Part B	ments	s					TO	7,950 10,435	7,950 10,435 128		
b. Two c. Three bed  7. Total No A. B.  C. D. 8. Total No A B	mber o Medica	f Physical f Speecl are - Par aid (Exciptorative Physical f Speecl are - Par aid (Exciptorative storative storative storative	al Therapy Treat t B clusive of Part B ce Treatments Treatments Therapy Treat t B clusive of Part B ce Treatments Treatments	ments	s					ТО	7,950 10,435 128	2,485 7,950 10,435 128		
b. Two c. Three bed  7. Total No A. B.  C. D. 8. Total No A B  C. D. C.	mber o Medica Me	f Physica are - Par aid (Exc intenance storative Physical f Speech are - Par aid (Exc intenance storative	al Therapy Treat t B clusive of Part B ce Treatments Treatments Therapy Treat t B clusive of Part B ce Treatments Treatments Treatments Treatments	ments ments )	S					ТО	7,950 10,435	7,950 10,435 128		
b. Two c. Three bed  7. Total No A. B.  C. D. 8. Total No A B  C. D. 9. Total No	bed rms orms.  umber o Medica Medica 1. Ma 2. Res Other Medica 1. Ma 2. Res Other Medica 1. Ma 2. Res Other Total i	f Physica are - Paraid (Exc intenance storative Physical f Speech aid (Exc intenance storative	al Therapy Treat t B clusive of Part B ce Treatments Treatments Therapy Treat t B clusive of Part B clusive of Part B ce Treatments Treatments Treatments Treatments	ments ments )	S					TO	7,950 10,435 128 429 557	2,485 7,950 10,435 128 429 557		
b. Two c. Three bed  7. Total No A. B.  C. D. 8. Total No A B  C. D. 9. Total No A	bed rms orms.  amber o Medica Medica 1. Ma 2. Res Other Medica 1. Ma 2. Res Other Total 2. Res Other Total 3. Medica 3. Res Other Total 4. Medica 4. Medica 5. Medica 6. Medica 7. Medica 7. Medica 8. Medica 8. Medica 9. Medica 9. Medica 1. Ma 9. Medica 1. Ma 9. Medica 1. Medica 1. Medica 1. Medica 2. Res 0. Medica 1. Medica 1. Medica 1. Medica 2. Res 0. Medica 1. Medica 1. Medica 1. Medica 2. Res 0. Medica 1. Medica 1. Medica 1. Medica 2. Res 0. Medica 1. Medica 1. Medica 2. Res 0. Medica 1. Medica 1. Medica 1. Medica 2. Res 0. Medica 1. Medica 1. Medica 1. Medica 2. Res 0. Medica 1. Medica 1. Medica 1. Medica 1. Medica 2. Res 0. Medica 1. Medica 1. Medica 1. Medica 1. Medica 1. Medica 2. Res 0. Medica 1. Medica 1. Medica 2. Res 0. Medica 1. Medica 1. Medica 1. Medica 1. Medica 1. Medica 2. Res 0. Medica 1. Medica 1. Medica 1. Medica 2. Res 0. Medica 1.	f Physica are - Par aid (Exc intenance storative Physical f Speech are - Par aid (Exc intenance storative	al Therapy Treat t B clusive of Part B ce Treatments Treatments Therapy Treat t B clusive of Part B ce Treatments Treatments Treatments Treatments Treatments Treatments Therapy Treatments Therapy Treatments Therapy Treatments	ments ) nents Treat	S					TO	7,950 10,435 128	2,485 7,950 10,435 128		
b. Two c. Three bed  7. Total No A. B.  C. D. 8. Total No A B  C. D. 9. Total No A	bed rms c or mor rms.  umber o Medici Medici 1. Ma 2. Res Other Medic 1. Ma 2. Res Other Total  umber o Medic 1. Ma 2. Res Other Medic Medic Medic Medic Medic Medic	f Physical are - Paraid (Excintenance of Physical are - Paraid (Excintenance of Cocupare - Paraid (Excintenance of Occupare of Occup	al Therapy Treat t B clusive of Part B the Treatments Treatments Therapy Treat t B clusive of Part B the Treatments Treatments Treatments Treatments Treatments Therapy Treatments	ments ) nents Treat	S					TO	7,950 10,435 128 429 557	2,485 7,950 10,435 128 429 557		
b. Two c. Three bed  7. Total No A. B.  C. D. 8. Total No A B  C. D. 9. Total No A	bed rms e or mor rms.  Imber o Medici Medici 1. Ma 2. Res Other Medici 1. Ma 2. Res Other Total 1. Ma 2. Res Medic 1. Ma 2. Res Medic 1. Ma 2. Res Medic 1. Ma	f Physical are - Paraid (Excintenance of Speech of Occupare - Paraid (Excintenance of Occupare of Occupance of Occu	al Therapy Treat t B clusive of Part B ce Treatments Treatments Therapy Treat t B clusive of Part B ce Treatments Treatments Treatments Treatments Treatments Treatments Therapy Treatments Therapy Treatments Therapy Treatments	ments ) nents Treat	S					TO	7,950 10,435 128 429 557	2,485 7,950 10,435 128 429 557		
b. Two c. Three bed  7. Total No A. B.  C. D. 8. Total No A B  C. D. 9. Total No A B	bed rms e or mor rms.  Imber o Medici Medici 1. Ma 2. Res Other Medici 1. Ma 2. Res Other Total 1. Ma 2. Res Medic 1. Ma 2. Res Medic 1. Ma 2. Res Medic 1. Ma	f Physical are - Paraid (Excintenance of Speech of Occupare - Paraid (Excintenance of Occupare of Occupance of Occu	al Therapy Treat t B clusive of Part B the Treatments Treatments Therapy Treat t B the Treatments Treatments Treatments Treatments Treatments Therapy Treatments Treatments Therapy Treatments	ments ) nents Treat	S					TO	7,950 10,435 128 429 557	2,485 7,950 10,435 128 429 557		

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

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility Rose Haven	License No. 1036-C		Report for Yea 9/30/2018	r Ended	Page	of
Are time records maintained by all individuals receiving co	-				10	37
The time records maintained by an individuals receiving co	impensation?	· ·	Y es Total Cost a		No	
			100010001	T TOUTS		
Ye					Residential	
A. Salaries and Wages*	CCNH	Hours	RHNS	Hours	Care Home	Hours
Salaries and wages*     Operators/Owners (Complete also Sec. I	A 100 A			To Carrie		
of Schedule A1)						-0.00
Administrator(s) (Complete also Sec. III						
of Schedule A1)	49,125	1,275			20.750	
3. Assistant Administrator (Complete also Sec. IV	49,123	1,273	55 N I I		32,750	85
of Schedule A1)						
4. Other Administrative Salaries (telephone						_
operator, clerks, receptionists, etc.)	10.266	(02)	1778	10 -	2211	
5. Dietary Service	12,366	693			8,244	46
a. Head Dietitian	4,080	140				
b. Food Service Supervisor	7,428	142 362			4.050	
c. Dietary Workers	101,475	6,869			4,952	24
6. Housekeeping Service	101,473	0,809	-		67,650	4,58
a. Head Housekeeper	20,817	1,280		-	13,878	85
b. Other Housekeeping Workers	28,923	2,315			19,282	
7. Repairs & Maintenance Services	20,723	2,515			19,202	1,54
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	27,120	1,303			18,080	86
8. Laundry Service	27,120	1,505	21		10,000	80
a. Supervisor						
b. Other Laundry Workers	26,100	1,876			17,400	1,25
9. Barber and Beautician Services		- 3,			17,400	1,23
10. Protective Services						
11. Accounting Services	21,18		77.3			F 13
a. Head Accountant						
b. Other Accountants	20,374	1,018			13,583	67
12. Professional Care of Residents						V
a. Directors and Assistant Director of Nurses	83,663	2,059				
b. RN						4 8 1 1 1 8
1. Direct Care	378,633	9,716				
2. Administrative**	83,855	2,680				
c. LPN						
1. Direct Care						
2. Administrative**						
d. Aides and Attendants	371,910	22,610			176,007	10,35
e. Physical Therapists	239,381	6,005				
f. Speech Therapists	19,634	536				
g. Occupational Therapists	84,066	2,665				
h. Recreation Workers	26,816	1,305			17,878	87
i. Physicians		A 10	2700			elle _
1. Medical Director						
Utilization Review     Resident Care***						
4. Other (Specify)						
4. Other (Specify)						100
j. Dentists		_				
k. Pharmacists						_
1. Podiatrists						
m. Social Workers/Case Management	19,230	807			10.000	
n. Marketing	19,230	807			12,820	538
o. Other (Specify)						
See Attached Schedule						
A-13. Total Salary Expenditures	1,604,995	65,516			402 522	22.000
Sand Paris Landonmini CD	1,007,223	05,510			402,523	23,089

<sup>\*</sup> 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.

<sup>\*\*</sup> 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.

<sup>\*\*\*</sup> 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)

	C	CNH	RI	INS	Residential	Care Home
Position	\$	Hours	\$	Hours	\$	Hours
55 to 15 to 15						
					THE STATE OF	
Harris - Harris - II-						
					-	
			Φ.		0	
Total	\$ -		\$ -	<u> </u>	\$ -	-

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

	CCN	H	R	HNS	Residentia	Care Home
Service	\$	Hours	\$	Hours	\$	Hours
Pointright	\$ 3,300	44		The state of		7.18
PatientPing	\$ 2,341	31		100		
MDS Consultant	\$ 4,762	63				
Total	\$ 10,404	139	\$ -		\$ -	W1 .

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

			Ibbibian		ators and Other	Kelau	ou i ai iics			
Name of Facility				License No.		Report for	Year Ended		Page	of
Rose Haven				1036-C		9/30/2018			11	37
N.	CCNIII	Salary Pai	Residential	Fringe Benefits and/or Other Payments	Full Description of	Total Hours	Line Where Claimed on	Name and Address of All	Total Hours	Compensation
Name	CCNH	RHNS	Care Home	(describe fully)	Services Rendered	Worked	Page 10	Other Employment**	Worked	Received
Section I - Operators/Owners										
Section II - Other related										
parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
,										
* No allowance for selection will be										

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

<sup>\*\*</sup> Include all employment worked during the cost year.

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

CSP-12 Rev. 10/2005

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

			License No.		Report for Y	ear Ended		Page	of
			1036-C		9/30/2018			12	37
CCNH	Salary Pai	d Residential Care Home	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
49,125		32,750				A2			
			Salary Paid  Residential CCNH RHNS Care Home	Salary Paid  Fringe Benefits and/or Other Residential Payments CCNH RHNS Care Home (describe fully)	Salary Paid  Fringe Benefits and/or Other Payments CCNH RHNS Care Home (describe fully)  Administrator 10/1/17	Salary Paid  Salary Paid  Fringe Benefits and/or Other Residential Payments (describe fully)  CCNH RHNS Care Home (describe fully)  Administrator 10/1/17-	Salary Paid  Salary Paid  Fringe Benefits and/or Other Residential Payments (describe fully)  CCNH RHNS Care Home (describe fully)  Administrator 10/1/17-  P3/30/2018  Total Line Where Claimed on Page 10	Salary Paid  Salary Paid  Residential CCNH RHNS Care Home Residential CARE Home Residential CARE Home Administrator 10/1/17-  Administrator 10/1/17-  Salary Paid  Total Line Where Claimed on Page 10  Other Employment**  Administrator 10/1/17-	Salary Paid  Salary Paid  Residential Payments CCNH RHNS Care Home Residential Control Residential Residential Payments (describe fully) Services Rendered Worked Page 10 Other Employment**  Administrator 10/1/17-  Administrator 10/1/17-

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

<sup>\*\*</sup> Include all other employment worked during the cost year.

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

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

CSP-13 Rev. 9/2002

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

Name of Facility Rose Haven	License No. 1036	i.C	Report for Y 9/30/2018	ear Ended	Page	of 37
	1050	,-C	Total Cost	and Hours	15	37
			10111 0031	and mours	T I	
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hour
B. Direct care consultants paid on a fee						
for service basis in lieu of salary	TO 100				Bull Harry	
(For all such services complete Schedule B1)	J. Line		10000		The Party	
1. Dietitian						
2. Dentist	3,088	41				
3. Pharmacist	842	11				
4. Podiatrist						
5. Physical Therapy		313	- PO - III			200
a. Resident Care						
b. Other						
6. Social Worker						
<ol><li>Recreation Worker</li></ol>						
8. Physicians				10		
a. Medical Director (entire facility)	32,400	189				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting	400	4				
c. Resident Care**						
d. Administrative Services facility			10 J 37 II		HI SHES	35,0
1. Infection Control Committee						
(Quarterly meetings) 2. Pharmaceutical Committee						
(Quarterly meetings)						
Staff Development Committee					<b></b>	
(Once annually)						
e. Other (Specify)				A Paris		
9. Speech Therapist						1,0
a. Resident Care	360	5				
b. Other						
10. Occupational Therapist					Calle to the last	
a. Resident Care						
b. Other						
11. Nurses and aides and attendants			F 02 1			
a. RN				E 2 2 2		
1. Direct Care	87,087	2,488				
2. Administrative***						
b. LPN		7 7 7 7 7 7				
1. Direct Care						
2. Administrative***						
c. Aides	9,325	622				
d. Other						
12. Other (Specify)						- 2.9
See Attached Schedule	10,404	139				
-13 Total Fees Paid in Lieu of Salaries	143,905	3,499				

<sup>\*</sup> 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.

<sup>\*\*</sup> 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.

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

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

Name of Facility					of		
Rose Haven		1036-C		9/30/2018		14	37
				to Owners,			
Name & Address of Individual	Full Expla	nation of Service		s, Officers	Expla	nation of F	Relationship
			Yes	No			
Healthdrive Dental		Dental	0	•			
West River of Connecticut LLC	P	harmacist	0	•			
Ethan Nguyen	Med	lical Director	0	•			
Ethan Nguyen	Utliz	ation Review	0	•			
Swallowing Diagnostics	S	T Consult	•	0	See disclosure	Pg. 4	
The Nurse Network	F	RN Direct	0	•			
Pointright		ntegrity Auditor	0	•			
PatientPing	Admissio	ons Discharge Fee	0	•			
MDS Consultant	MD	S Consultant	0	•			
			0	•			
			0	•			
			0	0			
			0	•			
			0	•			
			0	•			
			0	0			
			0	•			
			0	•			
			0	•			
			0	•			
			0	•			
			0	•			

<sup>\*</sup> Use additional sheets if necessary.

<sup>\*\*</sup> Refer to Page 4 for definition of related.

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

Name of Facility Rose Haven Licens 10	se No. )36-C	Report for Ye 9/30/2018	ear Ended	Page 15	of 37
Item		Total	CCNH	RHNS	Residential Care Home
Administrative and General		Total	CCNII	KIINS	Care Home
To 1 TT 14 0 XX 10 TO C.			273.7		13-13 14
<ul><li>a. Employee Health &amp; Welfare Benefits</li><li>1. Workmen's Compensation</li></ul>	\$	93,905	60,099		22 906
Disability Insurance	\$	93,903	00,099		33,806
3. Unemployment Insurance	\$	31,757	20,324		11 422
4. Social Security (F.I.C.A.)	\$	144,367	92,395		11,433 51,972
5. Health Insurance	\$	258,502	165,441		
6. Life Insurance (employees only)	Ψ	238,302	105,441	TOTAL THE T	93,061
(not-owners and not-operators)	\$	14,133	9,045		5,000
7. Pensions (Non-Discriminatory)	\$	12,297	7,870		5,088 4,427
(not-owners and not-operators)	Ψ	12,297	7,870		4,427
8. Uniform Allowance	\$				
9. Other (Specify)	\$				-
See Attached Schedule	Ψ			100	100000000000000000000000000000000000000
b. Personal Retirement Plans, Pensions, and	\$				
Profit Sharing Plans for Owners and	Ψ		The Part of the last	N	
Operators (Discriminatory)*			11 20 11		
CF(2-12-12-11-02-5))					Section 1
c. Bad Debts*	\$	89,624	89,624		
d. Accounting and Auditing	\$	11,704	7,022		4,681
e. Legal (Services should be fully described on Pag	ge 7) \$		·		
f. Insurance on Lives of Owners and	\$				
Operators (Specify)*		Charles and			
g. Office Supplies	\$	7,845	4,707		3,138
h. Telephone and Cellular Phones					N N N N N N N N N N N N N N N N N N N
1. Telephone & Pagers	\$	14,547	8,728		5,819
2. Cellular Phones	\$				
i. Appraisal (Specify purpose and	\$				
attach copy)*			15 1 1 S	THE REAL PROPERTY.	CONTRACTOR OF STREET
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	\$	95,810	95,810		
Subtotal	\$	774,490	561,066		213,424

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

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

Rose Haven 9/30/2018

Attachment Page 15

### **Schedule of Other Employee Benefits**

Description	CCNH	RHNS	Residential Care Home
Street Law March 1908			
	0.002	denin trad	MALLY &
interest to the latest the latest	The state of the s		
	CLASS CONTRACTOR OF THE PERSON	10	1007
		ale-al venilla	
	Tar Turk (second)	Trend Liberary (1)	deline de la
	ALC: N	Entratue vije	Sections 1
70.2			
	The state of the state of		
	[2] [2] [3] [4] [4] [4] [4] [4] [4] [4] [4] [4] [4		Total of the
Total	\$ -	\$ -	\$ -

### **Schedule of Other Taxes**

Description	CCNH	RHNS	Residential Care Home
	- V		21.
Total	\$ -	\$ -	\$ -

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

Name of Facility	License No.			Report for Year Ended		of
Rose Haven	1036-C		9/30/2018		16	37
Item			Total	CCNH	RHNS	Residentia
	tals Brought Forwa	ard•	774,490	561,066	KIIIVD	213,42
Travel and Entertainment	and Divagini I di iii		777,70	301,000		213,42
1. Resident Travel and Entertainment		\$	5,868	3,521		2,347
2. Holiday Parties for Staff		\$	2,613	2,613		2,547
3. Gifts to Staff and Residents		\$	5,028	3,017		2,011
4. Employee Travel		\$	4,961	2,977		1,985
5. Education Expenses Related to Seminars a	and Conventions	\$	2,207	1,324		883
6. Automobile Expense (not purchase or der		\$	2,201	1,521		005
7. Other (Specify)	W. Tarritarania Z	\$				
See Attached Schedule		*	110000		5 11 1 3 1	Time to
m. Other Administrative and General Expenses			1000			
1. Advertising Help Wanted (all such expens	ses )	\$				
2. Advertising Telephone Directory (all such	/	\$				
3. Advertising Other (Specify)***	1 /	\$	7,556	4,534		3,023
See Attached Schedule		,	RAULE I		OF PRI	3,023
4. Fund-Raising***		\$				
5. Medical Records		\$				
6. Barber and Beauty Supplies (if this service	e is supplied	\$				
directly and not by contract or fee for servi	* *					THE REAL PROPERTY.
7. Postage	,	\$	1,524	914		610
* 8. Dues and Membership Fees to Professiona	al	\$	2,491	1,495		996
Associations (Specify)				- K. O. W.	1 - 3-1	
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other Non-	Allowable Org.***	\$	969	581		388
9. Subscriptions		\$	1,499	900		600
10. Contributions***		\$				230
See Attached Schedule			11 11 11	- 12 2 77	A Section	7 5 7 11
11. Services Provided by Contract (Specify and	d Complete	\$				
Schedule C-2, Page 21 for each firm or in	-			FEIL	2 5 5 1	
12. Administrative Management Services**	,	\$	128,337	77,002		51,335
13. Other (Specify)		\$	62,618	37,571		25,047
See Attached Schedule				The Spinster		
C-14 Total Administrative & General Expenditures		\$	1,000,162	697,514		302,648

<sup>\*</sup> Do not include Subscriptions, which should go in item 9.

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

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

#### Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	Residential Care Home
e-off out of the second	Total I		
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

#### Schedule of Other Advertising

Description	с	CNH	R	HNS		idential e Home
Advertising - Public Relations	\$	4,534			\$	3,023
Total Other Advertising	\$	4,534	s	-	s	3,023

#### Schedule of Dues

Description	CCNH	RHNS	dential Home
ALTCFM	\$ 51		\$ 34
CAHCF	\$ 1,444		\$ 962
Total Dues	\$ 1,495	\$ -	\$ 996

#### Schedule of Contributions

Description	cc	NH	RHNS	Residential Care Home
	- 120	-		
Total Contributions	S	-	\$ -	\$ -

#### Schedule of Other Administrative and General

Description	CCNH	RHNS	 sidential re Home
Corporate Fees Non Reimbursable	\$ 14,921		\$ 9,948
Licenses & Fees	\$ 1,321		\$ 881
Pre Employment Screenings	\$ 3,694		\$ 2,463
Point Click Care Fees	\$ 4,791		\$ 3,194
Bank Charges, Penalties, Fees	\$ 3,376		\$ 2,251
Legal Fees - Collections, Probate, Conservator	\$ -		
Resident Expenses	\$ 7,199		\$ 4,800
Account W/O	\$ 467	4	\$ 312
State Penalty	\$ 1,800		\$ 1,200
Total Other Administrative and General	\$ 37,571	\$ -	\$ 25,047

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

Name of Facility	License No.	Report for Year Ended	Page of
Rose Haven	1036-C	9/30/2018	17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Apple Health Care, Inc.	128,337	Accounting & Management Services	Pg. 16 m12

<sup>\*</sup> 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)

Nam	e of Facility		ense	No.	Report for Y	ear Ended	Page of
Rose Haven			1036-C		9/30/2018		18   37
							Residential Care
	Item		_	Total	CCNH	RHNS	Home
2.	Dietary						CONTRACTOR OF THE PARTY OF THE
	a. In-House Preparation & Service			02 201	40.425	Elvenselle in on	22.056
	1. Raw Food		\$ \$	82,391	49,435		32,956 6,288
_	2. Non-Food Supplies		\$	15,719	9,431		0,288
	3. Other (Specify)		4		THE STATE OF		P. C. Steller Land
	b. Purchased Services (by contract other		\$	1,821	1,092		728
	than through Management Services)		1				
	(Complete Schedule C-2 att. Page 21)						VANETA ALL
	c. Other (Specify)		\$				
					N 7 76	35 11437	3 -1 2 3 3 3 3 3 3
2D	Total Dietary Expenditures (2a + b + c + d)		\$	99,931	59,958		39,972
2.0.	Total Dicially Emperium es (20 ° ° ° °)		Ψ	37,701			Residential Care
2F.	Dietary Questionnaire			Total	CCNH	RHNS	Home
G.	Resident Meals: Total no. of meals served per of	dav:*		98	59		39
H.		O Ye	es	•	No		-
						If yes, specify	
I.	Did you receive revenue from employees?	O Ye	es	•	No	amt.	
J.	Where is the revenue received reported in the C	Cost R	epor	? (Page/Line	Item)		
	Is cost of meals provided to persons other					If yes, specify	
K.	1	O Ye	es	•	No	cost.	
	Members, Guests) included in 2E?						
L.	Is any revenue collected from these people?	O Ye	es	•	No	If yes, specify	
	·			10 (D /T )	T. \	amt.	
M.	Where is the revenue received reported in the C	Cost R	Lepor	f? (Page/Line	Item)		
	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board					If yes, specify	
N.	meetings) provided to employees included	O Ye	es	•	No	cost.	
	in 2E?						
		^		^	NT.	If yes, specify	
O.	Is any revenue collected from employees?	O Ye	es	•	No	amt.	
P.	Where is the revenue received reported in the C	Cost R	lepor	t? (Page/Line	Item)		

<sup>\*</sup> 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		License			Year Ended	Page	of
Rose Have	Rose Haven		036-C	9/30/2018	3	19	37
	Item		Total	CCNH	RHNS	1	ential Care Iome
3. Laund a. In- 1.	Hry House Processing* Bed linens, cubicle curtains, draperies, gowns and other resident care items	Lbs.	2,755	2,314			441
	washed, ironed, and/or processed.***	Ant. p	2,733	2,314			441
2.	Employee items including uniforms, gowns, etc. washed, ironed and/or	Lbs.					
	processed.***	Amt. \$					
3.	Personal clothing of residents	Lbs.					
	washed, ironed, and/or processed.***	Amt. \$					
4.	Repair and/or purchase of linens.***	Lbs.					
tha (C	rchased Services (by contract other an through Management Services) complete Schedule C-2 att. Page 21)	Amt. \$	1,211	1,017			194
c. Ot	her (Specify)	\$	2-91	100			
	Laundry Expenditures (3a+b+c)	\$	3,966	3,331			635
	lry Questionnaire t of employee laundry included in 3E?	Yes	•	No	If yes, specify cost.		
H. Did yo	ou receive revenue from employees?	Yes	•	No	If yes, specify amt.		
I. Where	is the revenue received reported in the Cos	t Report?		(Page/Line			
	t of laundry provided to persons other mployees or residents included in 3E?	Yes	•	No	If yes, specify cost.		
	ou receive revenue from these people?	Yes	•	No	If yes, specify amt.		
L. Where	e is the revenue received reported in the Cos	t Report?		(Page/Line	Item)		

<sup>\*</sup> 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.

<sup>\*\*\*</sup> 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 Rose Haven		1	Repo	rt for Year E	nded	Page	of   37
Ros	e Haven	1036-C		9/30/2018		20	31
	Item			Total	CCNH	RHNS	Residential Care Home
4.	Housekeeping	Sq. Ft. Serviced					
	a. In-House Care	by Personnel			:=		
	1. Supplies - Cleaning (Mops, pails, brooms, etc.)	Amt.	\$	8,263	5,454		2,809
	b. Purchased Services (by contract other	Sq. Ft. Serviced					
	than through Management Services)	by Personnel					
	(Complete Schedule C-2 att. Page 21)	Amt.	\$	399	399		
	C. Other (Specify)		\$				- 107
4D.	Total Housekeeping Expenditures (4a +	b+c)	\$	8,662	5,853		2,809
5.	Resident Care (Supplies)**					P U Like	5.00
	a. Prescription Drugs***		- 1	1 5-11			1,1-10
	1. Own Pharmacy		\$				
	2. Purchased from		\$	81,386	81,386		
	West River/Neighborcare						
	b. Medicine Cabinet Drugs		\$				
	c. Medical and Therapeutic Supplies		\$	53,364	32,018		21,346
	d. Ambulance/Limousine***		\$				
	e. Oxygen			ALC: YES			
	1. For Emergency Use		\$				
	2. Other***		\$	11,413	11,413		
	f. X-rays and Related Radiological Procedures***		\$	24,918	24,918	The state of	
	g. Dental (Not dentists who should be inc salaries or fees)	cluded under	\$	Siste priza			
	h. Laboratory***		\$	5,851	5,851		
_	i. Recreation		\$	13,713	8,228		5,485
	j. Direct Management Services*		\$				
	k. Indirect Management Services*		\$				
_	1. Other (Specify)****		\$	5,329	5,130		199
	See Attached Schedule						
5M	. Total Resident Care Expenditures (5a -	5i)	\$	195,975	168,945		27,030

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

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

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

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

### **Schedule of Other Resident Care**

Description	C	CNH	RHNS	dential Home
Nursing Station Supplies	\$	387		\$ 199
Rehab Service Supplies	\$	3,527		
IV Therapy	\$	1,216		
				ise .
Total Other Resident Care	\$	5,130	\$ -	\$ 199

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

Name of Facility Rose Haven				License No. 1036-C	Report for Year Ende 9/30/2018	d			Page 21	of 37
		Related ** to Operators,	-				Total Cost	/Page Ref.**	*	
Name of Individual or Company	Address	Yes	No	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	Residential Care Home		Line
Litchfield Property Care	108 Torrington Rd, Litchfield, CT 06759	0	•		Landscaping Services	16,412		8,455	22	6f
		0	•							
		0	•							
		0	•							
		0	•							
		0	•							_
		0	•							_
		0	•							_
		0	•							
		0	•							
		0	•							
		0	•							
		0	•							_
		0	0							

<sup>\*</sup> List all contracted services over \$10,000. Use additional sheets if necessary.

<sup>\*\*</sup> Refer to Page 4 for definition of related.

<sup>\*\*\*</sup> 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 Y	ear Ended		Page of
Rose Haven	1036-C	9/30/2018			22   37
					Residential Care
Item		Total	CCNH	RHNS	Home
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$	55,013	36,309		18,705
b. Heat	\$	47,725	31,499		16,227
c. Light & Power	\$	38,135	25,169		12,966
d. Water	\$	28,377	18,729		9,648
e. Equipment Lease (Provide detail on p	age 6) \$				
f. Other (itemize)	\$	11,360	7,497		3,862
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a -	6f) \$	180,611	119,203		61,408
7. Depreciation (complete schedule page 23	*)				
a. Land Improvements	* \$				
b. Building & Building Improvements	\$				
c. Non-Movable Equipment	\$	3,515	2,320		1,195
d. Movable Equipment	\$	8,045	5,310		2,735
*7e. Total Depreciation Costs $(7a + b + c + d)$	\$	11,560	7,630		3,930
8. Amortization (Complete att. Schedule Pag	ge 24*)				
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$	32,546	21,480		11,066
d. Other (Specify)	\$				
*8e. Total Amortization Costs (8a + b + c + d	\$	32,546	21,480		11,066
9. Rental payments on leased real property le	ess				
real estate taxes included in item 10b	\$	180,000	118,800		61,200
10. Property Taxes					
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$	37,839	24,974		12,865
c. Personal property taxes	\$	2,600	1,716		884
11. Total Property Expenses $(7e + 8e + 9 + 1)$	.0) \$	264,545	174,600		89,945

<sup>\*</sup> 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		idential e Home
Refuse Removal	\$ 7,4	97	\$	3,862
				14.4
Water State				oll I
man de la lactación de la lactación de la lactación de la			The state of	
	Tel - (A) magnetical	اغسسال أناراه		
				10.1
NATA TATALON DE LA CONTRATA DE LA CO				
			4	
			100	
Total Other Repairs and Maintenance	\$ 7,4	97 \$ -	\$	3,862

### Annual Report of Long-Term Care Facility

CSP-23 Rev. 10/2006

**Depreciation Schedule** 

Is a mileage logbook maintained?   Date of Acquisition   Cost   Less   Less   Cost to Be Depreciation to Method of Year's Operations   Depreciation   Depr							lation Se	chedule					
Historical Cost   Less Exclusive of Exclusive of Exclusive of Exclusive of Exclusive of Land   Less   Depreciation to Beginning of Computing   Depreciation to   Life   Depreciation   D										Ended		Page	
Cost   Less   Exclusive of   Land   Value   Depreciation to   Depreciation to   Depreciation to   Depreciation to   Depreciation   Life   for This Year   Totals	Rose Haven					1036	5-C		9/30/2018			23	37
Exclusive of   Salvage   Cost to Be   Depreciation   Depreciatio						Historical							
A. Land Improvements 1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) 4. Subtotal  B. Building and Building Improvements 1. Acquired prior to this report period (attach schedule) 3. Acquired during this report period (attach schedule) 4. Subtotal  C. Nom-Movable Equipment 1. Acquired prior to this report period (attach schedule) 3. Acquired during this report period (attach schedule) 4. Subtotal  Es a mileage logbook maintained?  Yes No Moath Yesr Land  D. Movable Equipment 1. Motor Vehicles (Specify name, model and year of each vehicle) a. b. c  C. Movable Equipment 1. Motor Vehicles (Specify name, model and year of each vehicle) a. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) 4. Subtotal  Es a mileage logbook maintained?  Yes No Moath Yesr Land  D. Movable Equipment 1. Motor Vehicles (Specify name, model and year of each vehicle) a. b. c  C. Movable Equipment 2. Movable Equipment 3. Acquired prior to this report period 4. Subtotal  D. Movable Equipment 3. Acquired prior to this report period (attach schedule) 4. Subtotal  D. Movable Equipment 4. Subtotal  D. Movable Equipment 5. Movable Equipment 6. Acquired prior to this report period 6. Subtotal 6. Subt													
A. Land Improvements 1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) 4.4. Subtotal B. Building and Building Improvements 1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) 4. Subtotal C. Non-Movable Equipment 1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period 4. Subtotal C. Non-Movable Equipment 1. Acquired prior to this report period  Bis a mileage logbook plose of Acquisition Yes No Month Vear Exclusive of Land  D. Movable Equipment 1. Motor Vehicles (Specify name, model and year of each vehicle) a.  B. Movable Equipment 1. Motor Vehicles (Specify name, model and year of each vehicle) a.  B. Movable Equipment a. Acquired prior to this report period  221,759 221,759 221,759 221,759 201,059 S/L Various 7,458								1					
1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) 4.4. Subtotal B. Building and Building Improvements 1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period 4. Subtotal C. Non-Movable Equipment 1. Acquired prior to this report period    Sa mileage logbook maintained?   Acquisition   Year   Acquisition   Year   Acquired prior to this report period   Acquisition   Acquisitio						Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) 4. Subtotal  B. Building and Building Improvements 1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) 4. Subtotal  C. Non-Movable Equipment 1. Acquired during this report period (attach schedule) 3. Acquired during this report period (attach schedule) 4. Subtotal  Is a mileage logbook maintained?  Yes No Month Year  D. Movable Equipment 1. Motor Vehicles (Specify name, model and year of each vehicle) a.  b.  c.  d.  Movable Equipment 2. Disposals (attach schedule)  Date of Requisition  Year  Historical Cost Exclusive of Land  Value  Depreciation to Beginning of Computing Useful Depreciation for This Year  Totals  Totals  Totals  Totals	_												
3. Acquired during this report period (attach schedule)  B. Building and Building Improvements 1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule)  B-4. Subtotal  C. Non-Movable Equipment 1. Acquired furior to this report period (attach schedule) 3. Acquired during this report period 2. Disposals (attach schedule) 3. Acquired during this report period 4. Subtotal  Lis a mileage logbook maintained?  Acquired furior to this report period (attach schedule)  D. Movable Equipment 1. Motor Vehicles (Specify name, model and year of each vehicle) a. b. c. d. Movable Equipment a. Acquired prior to this report period  2. Disposals (attach schedule)  B-4. Subtotal  Acquired prior to this report period  65,321  65,321  65,321  Cost  Less  Cost to Be  Depreciation to  Reginning of Year's Operations Depreciation  Life for This Year Totals  Totals  Totals  Totals													
A-4. Subtotal  B. Building and Building Improvements 1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) B.4. Subtotal  C. Non-Movable Equipment 1. Acquired for to this report period 2. Disposals (attach schedule) 3. Acquired for to this report period 4. Subtotal  C. Non-Movable Equipment 1. Acquired for to this report period (attach schedule) 3. Acquired during this report period (attach schedule) C.4. Subtotal  Is a mileage logbook maintained? Acquisition Yes No Month Year Exclusive of Land  D. Movable Equipment 1. Motor Vehicles (Specify name, model and year of each vehicle) a. b. c. c. d. d.  2. Movable Equipment 4. Subtotal  D. Movable Equipment 5. Acquired for to this report period (attach schedule)  Cost Exes Less Less Cost to Be Depreciation to Beginning of Computing Useful Life for This Year Totals  Totals  Totals  Totals													
B. Building and Building Improvements  1. Acquired prior to this report period  2. Disposals (attach schedule)  3. Acquired during this report period (attach schedule)  B-4. Subtotal  C. Non-Movable Equipment  1. Acquired prior to this report period  2. Disposals (attach schedule)  3. Acquired during this report period  C. Subtotal  Is a mileage logbook maintained? Acquisition  Yes No Month Year  D. Movable Equipment  1. Motor Vehicles (Specify name, model and year of each vehicle)  a. b. c. c. d. Movable Equipment  a. Acquired prior to this report period  2. Disposals (attach schedule)  Cost  Land  Land  Land  Land  Land  Land  Land  Land  Accumulated Depreciation to Beginning of Year's Operations Depreciation Life for This Year  Totals  Totals		ch sch	edule)										
1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule)  B-4. Subtotal  C. Non-Movable Equipment 1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule)  C-4. Subtotal  Is a mileage logbook maintained?    Is a mileage logbook maintained?   Nonth   Year   Land   Value   Depreciation to   Depreciation	A-4. Subtotal										1 1 2 2		
2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule)  B-4. Subtotal  C. Non-Movable Equipment 1. Acquired prior to this report period 3. Acquired during this report period 3. Acquired during this report period (attach schedule) 3. Acquired during this report period (attach schedule) 4. Subtotal  Less Less Less Less Less Less Less Les	B. Building and Building Improvements												
3. Acquired during this report period (attach schedule)  B-4. Subtotal  C. Non-Movable Equipment  1. Acquired prior to this report period  3. Acquired during this report period  65,321  65,321  24,750  S/L  Various  3,515  2. Disposals (attach schedule)  3. Acquired during this report period (attach schedule)  C-4. Subtotal  Is a mileage logbook maintained?  Acquisition  Vess  No Month  Vess  Land  Depreciated  Accumulated Depreciation to Beginning of Year's Operations  Depreciation  Depreciation  Totals  Totals  Totals  Accumulated Depreciation  Depreciation  Depreciation  Totals  Totals  Accumulated Depreciation  Depreciation  Computing Useful Life  Totals  Totals  Totals  Accumulated Depreciation  Depreciation  Depreciation  Computing Useful Life  Totals  Totals  Totals													
B-4. Subtotal  C. Non-Movable Equipment  1. Acquired prior to this report period  2. Disposals (attach schedule)  3. Acquired during this report period (attach schedule)  C-4. Subtotal  Is a mileage logbook maintained?  Yes No Month Year Salvage Land Value  D. Movable Equipment  1. Motor Vehicles (Specify name, model and year of each vehicle)  a. b. c. d. Movable Equipment  2. Disposals (attach schedule)  Date of Acquisition Cost Less Exclusive of Land Value  Depreciation to Depreciation to Depreciation to Depreciation to Salvage Value  Depreciation to Depreciation to Depreciation to Depreciation to Salvage Value  Depreciation to Depreciation to Depreciation to Salvage Cost to Be Depreciation to Salvage Value  Depreciation to Depreciation to Depreciation Under the Salvage Value  Depreciation to Salvage Value  Depreciation to Depreciation to Depreciation to Salvage Value  Depreciation for This Year Totals  Totals  D. Movable Equipment  a. Acquired prior to this report period (attach schedule)  221,759  221,759  221,759  221,759  24,750  S/L Various  3,515  Acquired and year observed in the second of the se	Disposals (attach schedule)												
C. Non-Movable Equipment 1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule)  C.4. Subtotal    Is a mileage logbook maintained?   Date of Acquisition   Yes   No   Month   Year   Land   Value   Depreciated   Depreciation to   Depreciation   Deprec	3. Acquired during this report period (atta	ch sch	edule)										
1. Acquired prior to this report period 65,321 65,321 24,750 S/L Various 3,515 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule)  C-4. Subtotal  Is a mileage logbook maintained? Acquisition Pyes No Month Pyear Land  D. Movable Equipment 1. Motor Vehicles (Specify name, model and year of each vehicle) a. b. c. d. Movable Equipment a. Acquired prior to this report period  221,759  24,750  S/L Various 3,515  Various 3,515  Acquired prior to this report period (attach schedule)  3,515  Acquired prior to this report period (attach schedule)  Acquired p	B-4. Subtotal												
2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule)  C-4. Subtotal    Is a mileage logbook maintained?   Date of maintained?   Acquisition   Cost   Less   Exclusive of Land   Land   Cost   Co	C. Non-Movable Equipment												
2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule)  C-4. Subtotal    Sa mileage logbook maintained?   Date of Method of Year   No Month Year   Land   Value   Depreciation   Life   Depreciation   Depreciation   Life   Depreciation   Life   Depreciation   Depreciation	Acquired prior to this report period					65,321		65,321	24,750	S/L	Various	3,515	
C-4. Subtotal    Sa mileage   logbook   maintained?   Acquisition   Acquisition   Cost   Less   Exclusive of   Land   Value   Depreciation   Depreciation   Computing   Depreciation   Depreciation   Depreciation   Depreciation   Computing   Depreciation   Dep	Disposals (attach schedule)												
Is a mileage logbook maintained?   Date of maintained?   Acquisition   Cost   Less   Cost to Be Depreciation to   Depreciation to   Depreciation   Computing   Depreciation   Computing   Depreciation   Depreciation   Computing   Depreciation   Depreciation   Computing   Depreciation   Depreciation   Computing   Depreciation   Depreci	3. Acquired during this report period (atta	ch sch	edule)										
Is a mileage logbook maintained?   Date of Acquisition   Cost   Less   Less   Cost to Be Depreciation to Method of Year's Operations   Depreciation   Depr	C-4. Subtotal										Albert J.		3,515
logbook maintained?   Date of Acquisition   Cost   Less   Exclusive of Salvage   Value   Depreciation to Depreciation   Life   For This Year   Totals		Is a m	rileage							İ			-
Method of Year's Operations   Depreciation to Beginning of Year's Operations   Depreciation to Salvage   Depreciation to						Historical			Accumulated				
Exclusive of Land Value Depreciated Period Value Depreciated Period Depreciation Salvage Value Depreciated Period Salvage Value Depreciated Period Salvage Value Depreciated Period Salvage Value Depreciation Salvage Value Depreciation Salvage Value Depreciation Salvage Value Depreciation Vear's Operations Vear's Operations Vear's Operations Operations Operations Vear's Operations Operations Operations Vear's Operations Vear's Operations Operations Vear's Opera		_					Less			Method of			
Yes No Month Year Land Value Depreciated Year's Operations Depreciation Life for This Year Totals  D. Movable Equipment 1. Motor Vehicles (Specify name, model and year of each vehicle) a. b. c. d. 2. Movable Equipment a. Acquired prior to this report period  Year Land Value Depreciated Year's Operations Depreciation Life for This Year Totals  Zoperations Depreciation Life for This Year Totals				1		1 1		Cost to Be	-		I Isoful	Donragiotion	
D. Movable Equipment  1. Motor Vehicles (Specify name, model and year of each vehicle)  a. b. c. d. d. d. 2. Movable Equipment  a. Acquired prior to this report period 221,759 221,759 S/L Various 7,458		Yes	No	Month	Vear							1 1	Totals
1. Motor Vehicles (Specify name, model and year of each vehicle)  a.  b.  c.  d.  2. Movable Equipment a. Acquired prior to this report period  221,759  221,759  201,059 S/L Various  7,458	D Movable Equipment	100	110	Wolldi	Tour	Duite	70.00	Doprovatou	Total o Operations	Depresation	Eno	TOT THIS TOUR	Totals
and year of each vehicle) a. b. c. d. 2. Movable Equipment a. Acquired prior to this report period  221,759  221,759  201,059 S/L Various  7,458		124			100	1 1 mm 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		3 7 30			5-6-6		
a.  b.  c.  d.  2. Movable Equipment  a. Acquired prior to this report period  221,759  221,759  201,059 S/L Various  7,458			11.5			ST. 1150		-		The Figure		100	
b.     c.													
c.         d.           2. Movable Equipment         221,759           a. Acquired prior to this report period         221,759           221,759         201,059           S/L         Various           7,458													
2. Movable Equipment a. Acquired prior to this report period  221,759  221,759  201,059 S/L Various  7,458													
a. Acquired prior to this report period 221,759 221,759 201,059 S/L Various 7,458	d.												
	2. Movable Equipment										100		
	a. Acquired prior to this report period	HA				221,759		221,759	201,059	S/L	Various	7,458	
b. Disposals (attach schedule)	b. Disposals (attach schedule)	ELF										, -	
c. Acquired during this report period	c. Acquired during this report period				1 3			7			12 7		
(attach schedule) 6,269 6,269 S/L Various 587	(attach schedule)	131				6,269		6,269		S/L	Various	587	
	D-3. Subtotal	- 13	70		III - S				The same of	M STEEL			8,045
	E. Total Depreciation	-15-									-		11,560

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

•			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
				-
		0		Φ.
Total additions for Land Impro	vements	5 -		\$ -
Peletions:				
ADDOMESTIC ON THE PARTY OF THE				
			100	
		6		•
Total deletions for Land Impro	vements	\$ -		\$ -

<sup>\*</sup>Ties to Page 23, Line A3

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

	nones required during time report period		Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
otal additions for Building In	provements	\$ -		s -
Deletions:				
			1	
			181	
			1,010	
Total deletions for Building Im	provements	\$ -		\$ -

<sup>\*</sup>Ties to Page 23, Line B3

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

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
			100	
0.00				10.
			37 721	
Total additions for Non-Movab	ele Equipment	\$ -		\$ -
Deletions:				
			#1000	FILL DIL
No. 10 No				
12117 1117 1117				LE HI
Total deletions for Non-Movab	le Equipment	\$ -		\$ -

<sup>\*</sup>Ties to Page 23, Line C3

<sup>\*\*</sup>Ties to Page 23, Line A2

<sup>\*\*</sup>Ties to Page 23, Line B2

<sup>\*\*</sup>Ties to Page 23, Line C2

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

			Useful		
Description of Item		Cost	Life	Depr	eciation
4 Wireless Access points to cover buildings	\$	1,909		\$	477
50% deposit for Dryer	\$	2,180		\$	73
Final Payment Dryer	\$	2,180		\$	37
					- 7
Movable Equipment	5	6,269		\$	587
Movable Equipment	\$			5	
	Description of Item  4 Wireless Access points to cover buildings 50% deposit for Dryer Final Payment Dryer  Movable Equipment  Movable Equipment	4 Wireless Access points to cover buildings \$ 50% deposit for Dryer \$ Final Payment Dryer \$  Movable Equipment \$	4 Wireless Access points to cover buildings \$ 1,909 50% deposit for Dryer \$ 2,180 Final Payment Dryer \$ 2,180  Movable Equipment \$ 6,269	Description of Item  Cost Life  4 Wireless Access points to cover buildings 50% deposit for Dryer \$ 2,180  Final Payment Dryer \$ 2,180  Movable Equipment \$ 6,269	Description of Item  Cost Life Depr  4 Wireless Access points to cover buildings \$ 1,909 \$ 50% deposit for Dryer \$ 2,180 \$ Final Payment Dryer \$ 2,180 \$  Movable Equipment \$ 6,269 \$

<sup>\*</sup>Ties to Page 23, Line D2c

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

			Useful		
Acquisition Date	Description of Item	Cost	Life	Depre	ciation
Additions:					
					100
				-	
Total additions for Leasehold In	nprovement	s -		S	
Deletions:					
				1	
	THE RESERVE OF THE PARTY OF THE			+	
				-	
Total deletions for Leasehold In	a value of the company of the compan	S -		\$	

<sup>\*</sup>Ties to Page 24, Line C3
\*\*Ties to Page 24, Line C2

<sup>\*\*</sup>Ties to Page 23, Line D2b

CSP-24 Rev. 10/2006

## **Amortization Schedule\***

Name	ame of Facility			License No.		Report for Year Ended			Page	of
1	Haven			1036-C		9/30/2018			24	37
						Accumulated				
	Date of					Amort. to				
		Acqui	sition			Beginning of	Basis for			
				Length of	Cost to Be	Year's	Computing		Amortization	
	Item	Month	Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
A.	Organization Expense									
	1.									
	2.									
	3.									
A-4.	Subtotal							To the	STATE OF THE PARTY	
B.	Mortgage Expense									and the second
	1.									
	2.									
	3.									
B-4.								-733		
C.	<b>Leasehold Improvements and Other</b>								22.546	
	1. Acquired prior to this report period				992,715	763,467	Α		32,546	
	2. Disposals (attach schedule)									
	3. Acquired during this report period			The second						
	(attach schedule)									22.546
C-4.	Subtotal	L pair d			A STATE				MATERIAL PROPERTY.	32,546
D.	Total Amortization		7				Berner H	1155		32,546

<sup>\*</sup> Straight-line method must be 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.

<sup>\*\*</sup> Specify which of the following bases were used:

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

Name o Rose H	of Facility aven	License No. 1036-C	Report for Year Er	nded		Page 25	of 37
	operty Questionnaire	1000	7/30/2010			25	31
	art A						
	the property either owned by th	e Facility				If "Vos " complet	to Dout I
	leased from a Related Party?*	(e	9 Yes	0	No	If "Yes," complete If "No," complete	
-	*If any owner or operator of this fac	cility is related by family	marriage ownership abi	lity to control or		ii No, compiete	e ran C
	business association to any person	or organization from who	m buildings are leased, th	en it is considered			
	a related party transaction.						
	Description		Total				
1.				1 - 1 S E			
	Date Structure Completed	CD 1					
4.	If <b>NOT</b> Original Owner, Date Date of Initial Licensure	of Purchase					
	Total Licensed Bed Capacity		40				
6.			13,943	100 PSF 9			
	Acquisition Cost		15,943	EN ISTAN			
. •	a. Land						
	b. Building						
Pa	ort B - Owner and Related Pa	rties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortga	age
1.	Financing		ELECTRONIC DE LA CONTRACTION D				
	a. Type of Financing (e.g., fi	xed, variable)	Variable				
	b. Date Mortgage Obtained		12/07/16				
	c. Interest Rate for the Cost		4.48%				
	d. Term of Mortgage (number		5				
	e. Amount of Principal Borro		1,628,062				
	f. Principal balance outstand		1,554,799				
	Complete if Mortgage was I				A SEVERE		
	g. Type of Financing (e.g., fi				نديب عريش		9
	h. Date of Refinancing	xed, variable)					
	i. New Interest Rate						
	j. Term of Mortgage (number	er of years)			( = = = = = = = = = = = = = = = = = = =		
	k. Amount of Principal Borro						
	1. Principal Outstanding on 1						
	Part C - Arms-Length Lease		Improvements Only	7			
	Name and Address of Lesson		operty Leased		Term of Lease	Annual Amount	of Leas

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 Ye	ar Ended		Page of
Rose Haven 1036	-C	9/30/2018			26   37
Item		Total	CCNH	RHNS	Residential Care Home
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			1 11-5	
Address of Lender			AL STATE	1	
3. Third Mortgage		\$			
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage		\$			
Name of Lender	Rate	1000			
Address of Lender					
B. CHEFA Loan Information					LE CONTRACTOR
1. Original Loan Amount		\$			
2. Loan Origination Date					
3. Interest Rate %					
4. Term				History	d spiriting to
5. CHEFA Interest Expense					
12 B7. Total Building Interest Expense (A1 - A	A4 + B5)	\$	v Subtotals		<u> </u>

(Carry Subtotals forward to next page)

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

	Name of Facility  License No.  Rose Haven  1036-C			Report for Y 9/30/2018	ear Ended		Page of 27   37
Trobe Haven		1050 €		7/30/2010			Residential
	Ite	m		Total	CCNH	RHNS	Care Home
			ought Forward:	10001	001111	Idii	Curc Home
12. C. Mov	able Equipment						
1. A	automotive Equipme	nt	\$				
A	. Item	Rate	Amount				
Lender							
Address of Ler	nder						
2. O	ther (Specify)		\$			Carlle Ville	
A	. Item	Rate	Amount			IS IS IS	
Lender							
Address of Ler	nder						
В	. Item	Rate	Amount				
Lender							
Address of Ler	nder						
12. C. 3. T	otal Movable Equip	ment Interest			W W EXT		
E	xpense $(C1 + 2)$		\$				
12. D. Othe	r Interest Expense (A	Specify)	\$				
					6-11-16	10-42	
13. Total All	Interest Expense (1	2B7 + 12C3 + 12E	D) \$				
14. Insurance	•						
	rance on Property (b		\$	43,477	28,695		14,782
	ance on Automobile		\$				
	ance other than Proj		· · · · · · · · · · · · · · · · · · ·				
	mbrella (Blanket Co		\$ \$				
	re and Extended Co	verage					
3. O	ther (Specify)		\$				
	urance Expenditure		\$	43,477	28,695		14,782
15. Total All	Expenditures (A-13	3 thru C-14)	\$	3,948,751	3,006,999		941,752

## D. Adjustments to Statement of Expenditures

	of Fa Have			Lic	ense No. 1036-C	Report for Year Ended 9/30/2018		Page of 28   37
No.	Page No.	No.	Item Description		Total Amount of Decrease	CCNH	RHNS	Residential Care
	10 - S	alarie	es and Wages					A Law Editors
1.			Outpatient Service Costs	\$				
2.			Salaries not related to Resident Care	\$	24.066	04.066		-
3.	10	A12g	Occupational Therapy	\$	84,066	84,066		1.676
4.			Other - See attached Schedule	\$	4,190	2,514		1,676
	13 - I		sional Fees	•				1 2
5.			Resident Care Physicians **	\$				+
6.	13	B10a	Occupational Therapy	\$				
7.			Other - See attached Schedule	\$				
	s 15 &	16 -	Administrative and General		100		No.	
8.			Discriminatory Benefits	\$	00.70	00.524		
9.		1c	Bad Debts	\$	89,624	89,624		2.700
_	15/16	1d/m	Accounting	\$	9,497	5,698		3,799
10a.			Legal	\$				
11.			Telephone	\$				
12.			Cellular Telephone	\$				
13.			Life insurance premiums on the life				-3-1	
			of Owners, Partners, Operators	\$				-
14.			Gifts, flowers and coffee shops	\$				
15.			Education expenditures to colleges or universities for tuition and related costs			34.3		
			for owners and employees	\$				
16.	-	-	Travel for purposes of attending	Ψ				
10.			conferences or seminars outside the continental U.S. Other out-of-state	Φ.				
		_	travel in excess of one representative	\$				
17.			Automobile Expense (e.g. personal use)	\$		1.50.1		2.020
18.		m2/3	Unallowable Advertising *	\$		4,534		3,023
19.			Income Tax / Corporate Business Tax	\$				
20.	16	m10	Fund Raising / Contributions	\$				
21.			Unallowable Management Fees	\$		-		
22.			Barber and Beauty	\$				10.00
_ 23.			Other - See attached Schedule	\$	45,923	27,554		18,369
	2 18 - 1	Dietar	y Expenditures					A CONTRACTOR OF THE PARTY OF TH
24.	30	IV1	Meals to employees, guests and others who are not residents	\$	135	135	2 - 12 - 2	
Page	19 -	Launa	lry Expenditures		SATE FAR			
25.			Laundry services to employees, guests	_	8-11-			
		1	and others who are not residents	\$				
		House	ekeeping Expenditures					
26			Housekeeping services to employees, guests				U. U. C. C. C.	
		1	and others who are not residents	\$				-
			Subtotal (Items 1 - 2	6) \$		214,124		26,86

<sup>\*</sup> All except "Help Wanted".

<sup>(</sup>Carry Subtotal forward to next page)

<sup>\*\*</sup> 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		esidential are Home
VAR	VAR	Social Service/Marketing	\$	2,514		\$	1,676
	Ton E						THE ST
Total Oth	on Salarias	Adjustment		2.514			
1 otal Oth	er Salaries	Adjustment	S	2,514	\$	S	1,670

## Schedule of Fees Adjustments

Page Ref	Line Ref Description	CCNH	RHNS	Residential Care Home
Total Oth	To a A Minister and			
1 otal Otne	r Fees Adjustments	\$ -	- \$	S -

### Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS		sidential re Home
16	m13	Corp Fee- Non-reimbursable	\$ 14,921		\$	9,948
16	1.3	Employee Recognition/Gifts/Parties	\$ 3,017		\$	2,011
16	8a	Chamber of Commerce	\$ 581		\$	388
16	m13	Bank Charges, penalties, fines	\$ 2,026		\$	1,350
16	m13	Resident Expenses	\$ 4,320		\$	2,880
16	m13	Account W/O	\$ 280		\$	187
16	m13	State Penalty	\$ 1,800		\$	1,200
30	IV8	Settlement	\$ 360		S	240
30	IV8	Account W/O	\$ 248		\$	166
Total Othe	er A&G Ad	justments	\$ 27,554	\$ -	S	18,369

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

Name	e of Fa	cility	D. Adjustments to Stateme		ense No.	Report for Y		Daga of
	Have			LIC	1036-C	9/30/2018	ear Ended	Page of
Rosc	Tiave			_	Total	9/30/2018		29   37
Itam	Page	Lina						B .1 1 G
	No.				Amount of	COM	DIDIG	Residential Care
No.	NO.	NO.	Item Description	Φ.	Decrease	CCNH	RHNS	Home
Daga	20 1	Danida	Subtotals Brought Forward	\$	240,990	214,124		26,866
27.			ent Care Supplies***	•	01.004	01.004		
28.		5a2 L1	Prescription Drugs	\$	81,304	81,304		
29.		_	Ambulance/Limousine	\$	5,868	5,868		
		h	X-rays, etc	\$	24,918	24,918		
30.	20	f	Laboratory	\$	5,851	5,851		
31.			Medical Supplies	\$				
32.	20	5e2	Oxygen (non emergency)	\$	10,010	10,010		
33.			Occupational Therapy	\$				
34.			Other - See Attached Schedule	\$	4,743	4,743		
_	22 - N	Iainte	enance and Property	_				
35.			Excess Movable Equipment Depreciation		AND THE PERSON			
			See Attached Schedule	\$				
36.			Depreciation on Unallowable	- 1	1000			
			Motor Vehicles	\$				
37.			Unallowable Property and Real					
			Estate Taxes	\$				
38.			Rental of Building Space or Rooms	\$				
39.			Other - See Attached Schedule	\$				
Page	27 <b>-</b> I	nsura	nce				17 277	
40.			Mortgage Insurance	\$				
41.			Property Insurance	\$				
Other	r - Mis	scellai	neous					ALL IN PRESENT
42.			Other - Indirect	\$				
43.	30	IV5	Interest Income on Account Rec.	\$	6	6		
44.			Other - Miscellaneous Administrative	\$				
45.			Management Fees Direct	\$				
46.			Management Fees Indirect	\$				
47.			Other - Direct	\$				
Not I	or Pr	ofit P	roviders Only					
48.			Building/Non Movable Eq. Depreciation	7	TO STORE OF			
			Unallowable Building Interest -				Section 1	
			See Attached Schedule	\$				
49.	Total		unt of Decrease (Items 1 - 48)	\$	373,692	346,825		26,866

<sup>\*\*\*</sup> 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**

Page Ref		Description	CCNH	RHNS	Residential Care Home
20	5j	IV Therapy Supplies	\$ 1,21	6	
20	5j	Rehab Service Supplies	\$ 3,52		
Total Othe	r Ancillary	Costs	\$ 4.74	3 \$ -	•

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
				STORY	
				1	
Fotal Exce	ss Movable	Equipment Depreciation	\$ -	S -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref Description	CCNH	RHNS	Residential Care Home
				-
Total Othe	r Property Adjustments	\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	 CCNH	RHNS	Residential Care Home
		Interest	\$ -		
Total Other	r Adiustm	ents	\$ -	s -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
	144				
					HE STEWN
Total Una	lowable B	ilding Interest	\$ -	S -	\$ -

## F. Statement of Revenue

Name of Facility Rose Haven	License No. 1036-C	Report for Yo 9/30/2018	ear Ended		Page of 30   37
	Item	Total	CCNH	RHNS	Residential Car Home
I. Resident Room, Board	& Routine Care Revenue			10.4	
1. a. Medicaid Reside	ents (CT only)	\$ 645,393	645,393		
b. Medicaid Room	and Board Contractual Allowance **	\$			
2. a. Medicaid (All ot	her states )	\$			
b. Other States Roo	om and Board Contractual Allowance **	\$			
3. a. Medicare Reside	ents (all inclusive)	\$ 1,045,780	1,045,780		
b. Medicare Room	and Board Contractual Allowance **	\$ 464,155	464,155		
4. a. Private-Pay Resi	dents and Other	\$ 1,333,938	733,941		599,99
b. Private-Pay Room	m and Board Contractual Allowance **	\$			
II. Other Resident Rever	iue		1073		
1. a. Prescription Dru	gs - Medicare	\$ 62,174	62,174		
b. Prescription Dru	gs - Medicare Contractual Allowance **	\$ (62,174)	(62,174)		
c. Prescription Dru	gs - Non-Medicare	\$ 20,657	20,657		
d. Prescription Dru	gs - Non-Medicare Contractual Allowance **	\$ (20,657)	(20,657)		
2. a. Medical Supplie	s - Medicare	\$			
b. Medical Supplies	s - Medicare Contractual Allowance **	\$			
c. Medical Supplies	s - Non-Medicare	\$			
d. Medical Supplies	s - Non-Medicare Contractual Allowance **	\$			
3. a. Physical Therapy	y - Medicare	\$ 312,842	312,842		
b. Physical Therapy	y - Medicare Contractual Allowance **	\$ (248,798)	(248,798)		
c. Physical Therapy	y - Non-Medicare	\$ 52,395	52,395		
d. Physical Therapy	- Non-Medicare Contractual Allowance **	\$ (50,050)	(50,050)		
4. a. Speech Therapy	- Medicare	\$ 21,961	21,961		
b. Speech Therapy	- Medicare Contractual Allowance **	\$ (17,719)	(17,719)		
c. Speech Therapy	- Non-Medicare	\$ 3,105	3,105		
d. Speech Therapy	- Non-Medicare Contractual Allowance **	\$ (3,105)	(3,105)		
5. a. Occupational Th	nerapy - Medicare	\$ 442,893	442,893		
b. Occupational Th	nerapy - Medicare Contractual Allowance **	\$ (334,983)	(334,983)		
c. Occupational Th	nerapy - Non-Medicare	\$ 66,780	66,780		
d. Occupational Th	nerapy - Non-Medicare Contractual Allowance **	\$ (63,675)	(63,675)		
6. a. Other (Specify) -	Medicare	\$			
b. Other (Specify) -	Non-Medicare	\$			
II. Total Resident Reven	ue (Section I. thru Section II.)	\$ 3,670,912	3,070,914		599,99
V. Other Revenue*					
1. Meals sold to guests	s, employees & others	\$ 135	135		
2. Rental of rooms to r	non-residents	\$			
3. Telephone		\$			
4. Rental of Television	and Cable Services	\$			
5. Interest Income (Spe	ecify)	\$ 6	6		
6. Private Duty Nurses	' Fees	\$			
7. Barber, Coffee, Bear	uty and Gift shops	\$			
8. Other (Specify)		\$ 16,261	16,261		
V. Total Other Revenue (	1 thru 8)	\$ 16,403	16,403		
VI. Total All Revenue (III		\$ 3,687,314	3,087,317		599,997
		 -,,	-,-01,011		377,33

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

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

#### Schedule of Other Resident Revenue - Medicare

### Related Exp

			Residential
Page Ref Description	CCNH	RHNS	Care Home
Total Other Resident Revenue - Medicare	\$ -	\$ -	\$

### Schedule of Other Non-Medicare Resident Revenue

#### Related Exp

e Ref Description	CCNH	RHNS	Residentia Care Home
30 Optum Capitation	\$ -		3.44
al Other Resident Revenue	\$ -	\$ -	\$ -

### **Interest Income**

#### Account

Page Ref	Account	Balance	C	CNH	RHN	NS	Reside Care H	
30IV5	Interest on Accounts Receivable	646,138	\$	6	Jambi	-16		
-								
								-
Total Inte	erest Income		\$	6	\$	•	\$	-

### Schedule of Other Revenue

Page Ref	Description	CCNH RHN	Residential Care Home
30IV8	Rebates/ refunds	\$ 15,247	
30IV8	Settlement	\$ 600	
30IV8	Account W/O	\$ 414	
Total Oth	er Revenue	\$ 16,261 \$	- \$ -

## G. Balance Sheet

Name of	f Facility	License No.	Report for Year Ended	I	Page o
Rose Ha	aven	1036-C	9/30/2018		31   37
		Account			Amount
Assets					
	arrent Assets				
	Cash (on hand and in banks			\$	
	Resident Accounts Receivab			\$	646,13
3.	Other Accounts Receivable	(Excluding Owners of	or Related Parties)	\$	
4	Inventories			\$	20,23
5.	Prepaid Expenses			\$	11,61:
	a.			35	
	b			1.5	
	c			35	
	d. See Schedule		11,615	0.00	
6.	Interest Receivable			\$	
7.	Medicare Final Settlement R	.eceivable		\$	
8.	Other Current Assets (itemiz	e)		\$	611,10:
				523	
				185	
	See Schedule		611,105		
A-9. To	tal Current Assets (Lines A1	thru 8)	·	\$	1,289,089
	xed Assets			Ť	1,=05,005
1.	Land			\$	
2.	Land Improvements	*Historical Cost		\$	
	•	Accum. Depreciati	ion Net	١	
3.	Buildings	*Historical Cost	1100	\$	
		Accum. Depreciati	ion Net	۱	
4.	Leasehold Improvements	*Historical Cost	992,715	\$	196,702
	1	Accum. Depreciati		١٣	170,702
5.	Non-Movable Equipment	*Historical Cost	65,321	\$	37,056
	1 1	Accum. Depreciati		I <sup>*</sup>	37,030
6.	Movable Equipment	*Historical Cost	228,028	\$	18,924
	1 1	Accum. Depreciati		۱۳	10,727
7.	Motor Vehicles	*Historical Cost	203,101 1100	\$	
		Accum. Depreciati	on Net	lΨ	
8.	Minor Equipment-Not Depre		1101	\$	
9.	Other Fixed Assets (itemize)				
7.	Omei Pixeu Asseis (nemize)			\$	
	See Schedule			_	
-10.	Total Fixed Assets (Lines B	1 thru 9)		\$	252,682

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

# G. Balance Sheet (cont'd)

Name	e of	Facility	License No.	Report for Year Ended		Page		of
Rose			1036-C	9/30/2018		32		37
	Account					Am	ount	
				Total Brought Forward:	\$		1,541,	771
C.	Lea	asehold or like property record	ded for Equity Purpose	es.				
	1.	Land			\$			
	2.	Land Improvements	*Historical Cost					
			Accum. Depreciatio	n Net	\$			
	3.	Buildings	*Historical Cost		ŀ			
			Accum. Depreciation	n Net	\$			
	4.	Non-Movable Equipment	*Historical Cost					
			Accum. Depreciation	n Net	\$			
	5.	Movable Equipment	*Historical Cost					
			Accum. Depreciation	n Net	\$			
	6.	Motor Vehicles	*Historical Cost					
			Accum. Depreciation	n Net	\$			
	7. Minor Equipment-Not Depreciable							
C-8	To	tal Leasehold or Like Proper	ties (C1 thru 7)		\$			
D.								
	1.	Deferred Deposits			\$			
	2.	Escrow Deposits			\$			
	3.	Organization Expense	*Historical Cost	·	1			
			Accum. Depreciation	on Net	\$			
	4.	Goodwill (Purchased Only)			\$			
	5.	Investments Related to Resident	dent Care (itemize)		\$			
					. 0			
				_				
	6.	Loans to Owners or Related			\$			
		Name and Address	Amount	Loan Date	H			
_		0.1 4 ('			\$			628
	7.	Other Assets (itemize)			D.	7 - O - O - O - O - O - O - O - O - O -		020
		1			ш			
		See Schedule		628				
D 0	T	otal Investments and Other A	ssets (Lines D1 thru 7		\$			628
		otal All Assets (Lines A9 + B		/	\$		1,542	

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

## G. Balance Sheet (cont'd)

Name of Fac	Tame of Facility License No. Report for Year Ended			Page	of			
Rose Haven	Rose Haven 1036-C 9/30/2018			33	37			
			Account				Am	ount
Liabilities								
A.	Cu	rrent Liabilities						
	1.	Trade Accounts Payable				\$		230,622
	2.	Notes Payable (itemize)				\$		
						B		
		See Schedule						
	3.	Loans Payable for Equipm	ent (Current nortion	(itomiza)		\$		
	<i>J</i> .	Name of Lender	Purpose	Amount	Date Due	3		
		Name of Lender	1 urpose	Amount	Date Due			
						3		
						En		
						130		
						130		
						13		
						100		
						-2		
	4.	Accrued Payroll (Exclusiv	e of Owners and/or S	Stockholders only)		\$		46,087
	5.	Accrued Payroll (Owners				\$		10,007
	6.	Accrued Payroll Taxes Pa		• •		\$		5,569
	7.	Medicare Final Settlement				\$		
	8.	Medicare Current Financia	ng Payable			\$		
	9.	Mortgage Payable (Curren	nt Portion)			\$		
	10.	Interest Payable (Exclusive	e of Owner and/or Re	elated Parties)		\$		
	11.	Accrued Income Taxes*				\$		
	12.	Other Current Liabilities (	itemize)			\$		198,521
						100	100	111111111
						+		
						1		
				See Schedule	198,521	117		
A-13.	To	tal Current Liabilities (Lin	es A1 thru 12)			\$		480,799

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

# G. Balance Sheet (cont'd)

Account   Account   Amount   Amount   480,799	Name of Facility	License No.	Report for Year	Ended	Page		of
Liabilities (cont'd) B. Long-Term Liabilities 1. Loans Payable-Equipment (itemize)  Name of Lender  Purpose  Amount  Date Due  2. Mortgages Payable 3. Loans from Owners or Related Parties (itemize)  Name and Address of Lender  Amount  Loan Date  4. Other Long-Term Liabilities (itemize)  See Schedule  B-5. Total Long-Term Liabilities (Lines B1 thru 4)  4 480,799   4 480,799  \$ 1,465,140	Rose Haven	1036-C	9/30/2018		34		37
Liabilities (cont'd)  B. Long-Term Liabilities 1. Loans Payable-Equipment (itemize)  Name of Lender  Purpose  Amount  Date Due  2. Mortgages Payable 3. Loans from Owners or Related Parties (itemize)  Name and Address of Lender  Amount  Loan Date  4. Other Long-Term Liabilities (itemize)  See Schedule  B-5. Total Long-Term Liabilities (Lines B1 thru 4)  \$ 1,465,140	Account						
B. Long-Term Liabilities 1. Loans Payable-Equipment (itemize)  Name of Lender  Purpose  Amount  Date Due  2. Mortgages Payable 3. Loans from Owners or Related Parties (itemize)  Name and Address of Lender  Amount  Loan Date  4. Other Long-Term Liabilities (itemize)  See Schedule  B-5. Total Long-Term Liabilities (Lines B1 thru 4)  \$ 1,465,140			Total Broug	ht Forward:		48	0,799
1. Loans Payable-Equipment (itemize)   S							
Name of Lender  Purpose Amount Date Due  2. Mortgages Payable 3. Loans from Owners or Related Parties (itemize) Name and Address of Lender  Amount Loan Date  4. Other Long-Term Liabilities (itemize) See Schedule B-5. Total Long-Term Liabilities (Lines B1 thru 4)  See Schedule 1,465,140					_		
2. Mortgages Payable 3. Loans from Owners or Related Parties (itemize)  Name and Address of Lender  Amount  Loan Date  4. Other Long-Term Liabilities (itemize)  See Schedule  B-5. Total Long-Term Liabilities (Lines B1 thru 4)  \$ 1,465,140					\$		
3. Loans from Owners or Related Parties (itemize)  Name and Address of Lender  Amount  Loan Date  4. Other Long-Term Liabilities (itemize)  See Schedule  B-5. Total Long-Term Liabilities (Lines B1 thru 4)  \$ 1,465,140	Name of Lender	Purpose	Amount	Date Due			
3. Loans from Owners or Related Parties (itemize)  Name and Address of Lender  Amount  Loan Date  4. Other Long-Term Liabilities (itemize)  See Schedule  B-5. Total Long-Term Liabilities (Lines B1 thru 4)  \$ 1,465,140							
3. Loans from Owners or Related Parties (itemize)  Name and Address of Lender  Amount  Loan Date  4. Other Long-Term Liabilities (itemize)  See Schedule  B-5. Total Long-Term Liabilities (Lines B1 thru 4)  \$ 1,465,140							
3. Loans from Owners or Related Parties (itemize)  Name and Address of Lender  Amount  Loan Date  4. Other Long-Term Liabilities (itemize)  See Schedule  B-5. Total Long-Term Liabilities (Lines B1 thru 4)  \$ 1,465,140							
3. Loans from Owners or Related Parties (itemize)  Name and Address of Lender  Amount  Loan Date  4. Other Long-Term Liabilities (itemize)  See Schedule  B-5. Total Long-Term Liabilities (Lines B1 thru 4)  \$ 1,465,140							
3. Loans from Owners or Related Parties (itemize)  Name and Address of Lender  Amount  Loan Date  4. Other Long-Term Liabilities (itemize)  See Schedule  B-5. Total Long-Term Liabilities (Lines B1 thru 4)  \$ 1,465,140							
3. Loans from Owners or Related Parties (itemize)  Name and Address of Lender  Amount  Loan Date  4. Other Long-Term Liabilities (itemize)  See Schedule  B-5. Total Long-Term Liabilities (Lines B1 thru 4)  \$ 1,465,140							
3. Loans from Owners or Related Parties (itemize)  Name and Address of Lender  Amount  Loan Date  4. Other Long-Term Liabilities (itemize)  See Schedule  B-5. Total Long-Term Liabilities (Lines B1 thru 4)  \$ 1,465,140							
3. Loans from Owners or Related Parties (itemize)  Name and Address of Lender  Amount  Loan Date  4. Other Long-Term Liabilities (itemize)  See Schedule  B-5. Total Long-Term Liabilities (Lines B1 thru 4)  \$ 1,465,140							
3. Loans from Owners or Related Parties (itemize)  Name and Address of Lender  Amount  Loan Date  4. Other Long-Term Liabilities (itemize)  See Schedule  B-5. Total Long-Term Liabilities (Lines B1 thru 4)  \$ 1,465,140				1 1			
3. Loans from Owners or Related Parties (itemize)  Name and Address of Lender  Amount  Loan Date  4. Other Long-Term Liabilities (itemize)  See Schedule  B-5. Total Long-Term Liabilities (Lines B1 thru 4)  \$ 1,465,140	2 Mortgages Pavable	<u> </u>	.l		<u>s</u>		
Name and Address of Lender		ated Parties (itemize)	1				
4. Other Long-Term Liabilities (itemize) \$ 1,465,140  See Schedule 1,465,140  B-5. Total Long-Term Liabilities (Lines B1 thru 4) \$ 1,465,140				Secretary.	Control of	-010	
See Schedule	Traine and Address of Lender	Timount	- Boun 2				
See Schedule							
See Schedule				- 1			
See Schedule				- 1			
See Schedule				- 1			
See Schedule				- 1			
See Schedule							
See Schedule				- 1			
See Schedule				- 1			
See Schedule				- 1			
See Schedule	4 Od 7 T T 1:4114	('' ' '			<u>Ф</u>	1 46	5 140
B-5. Total Long-Term Liabilities (Lines B1 thru 4) \$ 1,465,140	4. Other Long-Term Liabilities ( <i>itemize</i> )				D.	1,40	5,140
B-5. Total Long-Term Liabilities (Lines B1 thru 4) \$ 1,465,140							
B-5. Total Long-Term Liabilities (Lines B1 thru 4) \$ 1,465,140							
B-5. Total Long-Term Liabilities (Lines B1 thru 4) \$ 1,465,140	Sag Schadula		1 465 140				
20. 21		Lines B1 thm 4)	1,705,170		\$	1.46	5,140
	C. Total All Liabilities (Lines A-	13 + B-5)					

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

Dogo Dof	Line Def	Description
Page Kei	Line Kei	Describtion

31	A5	Prepaid Insurance	\$	0
31	A5	Prepaid Property Tax	\$	11,615
31	A5	Prepaid Other	\$	-
Total Prepaid Expenses				

\_\_\_\_\_

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

Page Ref	I ine Ref	Description

31	A8	Payroll Deducted Life Insurance	\$	7,815
31	A8	Due Affiliate -Corporate	\$	602,898
31	A8	A/P Patient Exchange	\$	393
Total Other Current Assets (Itemize)				611,105

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

Page Ref	Line Ref	Description

31	B9	Fixed Asset Clearing Account	\$	-
31	B9	Construction in Progress	\$	-
Total Other Other Fixed Assets (Itemize)				-

Schedule of Other Assets Page 32 Line D7

Page Ref Line Ref Description

rage Kei	Line Kei	Description		
		Loans Rec Officers/Owners	\$	-
		Capitalized Refinance	\$	-
		Leasehold Deposits	\$	628
Total Other Assets				628

\_\_\_\_\_

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

Page Ref Line Ref Description

Total Notes Payable			\$	-
Total Notes Payable				

\_\_\_\_\_

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

Page Ref Line Ref Description

	Page Ket	Line Ket	Description		
	33	A12	Accrued PTO	\$	67,246
	33	A12	Accrued Pension	\$	479
	33	A12	Accrued Worker's Comp	\$	56,365
	33	A12	Accrued Expense Other		58,093.38
	33	A12	Accrued Professional Fees		6,031.18
	33	A12	Payroll W/H		4,695.95
	33	A12	Due Affiliate (Credit Balance)		
	33	A12	Gemino Revolving Loan		0.00
	33	A12	Exchange		5,610.07
Total Other Current Liabilities (Itemize) \$					

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

Page Ref Line Ref Description

34	B4	A/P Other	\$ 1,465,140
Total Other Current Liabilities (Itemize)			\$ 1,465,140

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

Nar	ne of Facility	License No.	Report for	Year Ended		Page	of
Ros	se Haven	1036-C	1036-C 9/30/2018			35	37
		Account				Am	ount
A.	Reserves						
	1. Reserve for value of leased	land			\$		
	<ol> <li>Reserve for depreciation value of leased buildings and appurtenances to be amortized</li> <li>Reserve for depreciation value of leased personal property (Equity)</li> </ol>						
	4. Reserve for leasehold real p	roperties on which	fair rental valu	e is based	\$		
	5. Reserve for funds set aside a	as donor restricted			\$		
	6. Total Reserves				\$		
B.	Net Worth						
	1. Owner's Capital				\$		3,812,245
	2. Capital Stock				\$		1,000
	3. Paid-in Surplus				\$		
	4. Treasury Stock				\$		
	5. Cumulated Earnings				\$		(3,955,348)
	6. Gain or Loss for Period	10/1/201	7 thru	9/30/2018	\$		(261,437)
	7. Total Net Worth				\$		(403,539)
C.	Total Reserves and Net Worth				\$		(403,539)
D.	Total Liabilities, Reserves, and	Net Worth			\$		1,542,400

# H. Changes in Total Net Worth

Nam	e of Facility	License No.	Report for Year	Ended	Page	of
	Haven	1036-C	9/30/2018		36	37
		Account			A	Mount
A.	Balance at End of Prior Period as	shown on Report of	09/30/2017		\$	(139,582)
B.	Total Revenue (From Statement of				\$	3,687,314
C.	Total Expenditures (From Statem		Page 27)		\$	3,948,751
D.	Net Income or Deficit				\$	(261,437)
E.	Balance	\$	(401,019)			
F.	Additions					
	1. Additional Capital Contribute	ed (itemize)			100	
	-				10.64110	
					00000	The state of the s
		100				
					10 miles	est the second
	2. Other (itemize)					
	<b>2.</b> Case (************************************					Section 1
					117 31	
F-3.	Total Additions				\$	
G.	Deductions					
	1. Drawings of Owners/Operato	ors/Partners (Specify)		(4)	\$	2,520
	Name and Address (No., Cit		Title	Amount	FERE	
Bria	n Foley		President	2,520		
					HALL ST	
					Harley .	
	2. Other Withdrawings (Specify	·)			\$	
_	Purpose	LA YOU	A) - II II			
	Turpose					
					4 64	
					1 30	
	2 Total Doductions				\$	2,520
TY	3. Total Deductions  Balance at End of Period	09/30/	/12		\$	(403,539)
H.	Datance at Ena of Fertou	09/30/	/10		ΙΨ	(403,339)

# I. Preparer's/Reviewer's Certification

Name o	f Facility	License No. Report for Year Ended			Page	of				
Rose Ha	aven	1036-C	9/30/2018 37			37				
		Check appropriate category								
	Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)	☑ Residential Care Home							
Preparer/Reviewer Certification										
a a p e	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.									
Signatur	re of Preparer	Title	Date S							
Printed 1	Name of Preparer		·							
Robert (	Gwizdak									
Addres A	Address			Phone Number						
21 Wate	erville Road Avon, CT 06001			(860) 678-9755						
Annual l	Report Contact			Phone Number						
Susan So	outhey		(860) 470-7542							
Annual 1	Report Contact Email Address			,						
ssouthey	@apple-rehab.com									