State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2017

Name of Facility (as licensed) The Rosegarden Health & Rehabilitation Center LLC	
Address (No. & Street, City, State, Zip Code) 3584 E Main Street Waterbury CT 06705	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2300			075399A

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	21270		

For Department Use Only

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

Table of Contents

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1A Rev. 6/95

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility The Rosegarden Health & Rehabilitation Center LLC	Period Covered:		From 10/1/2016	To 9/30/2017
Address of Facility 3584 E Main Street Waterbury CT 06705				
Report Prepared By Burg & Weingarten CPA PC	Phone Number 718-845-6141		Date 2/13/2018	

Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid $				
2. Laundry wages paid $				
3. Housekeeping wages paid $				
4. Nursing wages paid $				
5. All other wages paid $				
6. ***Total Wages Paid*** $				
7. Total salaries paid $				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report) $				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2017	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for The Rosegarden Health & Rehabilitation Center LLC [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)	Date
Veronica Cretella		2/14/18	Miriam Stern	2-14-18
Printed Name (Administrator) VERONICA CRETELLA			Printed Name (Owner) Miriam Stern	
Subscribed and Sworn to before me:	State of CT	Date 2/14/18	Signed (Notary Public) June Sturtevant	Comm. Expires Y 1 30 22
Address of Notary Public 600 Bond Street Bpt CT 06610				

(Notary Seal)

JUNE STURTEVANT
NOTARY PUBLIC
State of Connecticut
My Commission Expires
April 30, 2022

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-2 Rev. 10/2005

General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-384-6400	9/30/2017	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
The Rosegarden Health & Rehabilitation Center LLC	3584 E Main Street Waterbury CT 06705

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2300			075399A

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
VERONICA CRETELLA	000796

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

Name	License No.:

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3 Rev. 10/2005

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2017	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
The Rosegarden Health & Rehabilitation Center LLC	3584 E Main Street Waterbury CT 06705	Waterbury CT

Name of Partners/Members	Business Address	Title	% Owned
Rachel Blass	600 Bond St Bridgeport CT 06610	Member	17.5
Norma Loren	600 Bond St Bridgeport CT 06610	Member	17.5
Gladys Neuman	600 Bond St Bridgeport CT 06610	Member	
Miriam Stern	600 Bond St Bridgeport CT 06610	Member	65

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3A Rev. 10/2005

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Cent	2300	9/30/2017	3A	37

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

Legal Name of Corporation	Business Address	State(s) in Which Incorporated

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
N/A			
Names of Stockholders Owning at Least 10% of Shares			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center L	2300	9/30/2017	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility
N/A

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-4 Rev. 10/2005

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2017	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⊙ No

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Paradise Realty of Waterbury LLC	3845 E Main St Waterbury CT	○	⊙		Rental of land and building	P22 L 9	300,000	98,353
Bridgeport Healthcare Center Inc	600 Bond Street Bridgeport CT 06610	○	⊙		Allocation of costs, Various funding			
Comprehensive Rehabilitation Services LLC	26 Firemans Memorial Dr Suite 205 pomona NY 10970	○	⊙		Physical, Occupational & Speech Therapy Se	P13 L.5,9,10	176,376	
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					

* Use additional sheets if necessary.
** Provide the percentage amount of revenue received from non-related parties.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-5 Rev. 9/2002

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center	2300	9/30/2017	5	37

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

⊙ Yes ○ No If "No," explain fully why such allocation was not made.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-6 Rev. 9/2002

General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2017	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Everbank Commercial Finance	O	⊙	Copier	12/10/14	60 months	1,331	1,331
Marlin Leasing 300 Fellowship Road Mount Laurel	O	⊙	Copier	08/24/17	63 Months	2,184	182
DE Lage Landen Financial PO Box 41601 Philadelphia PA 19101-1601	O	⊙	Copier	10/06/16	60 months	2,861	2,789
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					

Is a Mileage Log Book Maintained for All Leased Vehicles ? O Yes O No **Total** *** 4,302

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
** Attach copies of newly acquired leases.
*** Amount should agree to Page 22, Line 6e.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 6/95

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabili	2300	9/30/2017	7	37

The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Burg & Weingarten CPA PC	149-12 83rd Street Howard Beach NY 11414
2 Zimmet Healthcare Services Group	4006 Rt 9 South Morganville NJ 07751
3 Craig Lubitski Consulting LLC	225 Pitkin St East Hartford CT 06108
4	

Services Provided by This Firm (*describe fully*)

1	General accounting, Balance sheet, Trial balance, Audit, Budgeting, Cost Report & etc	$ 38,400
2	Medicare cost report	$ 4,838
3	General accounting, Audits	$ 4,250
4		$

Charge for Services Provided $ 47,488

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

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Murtha Cullina LLP	860-240-6000
2 Berchem Moses & Devlin	203-783-1200
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)
1 185 Asylum St Hartford CT 06103
2 75 Broad St Milford CT 06460
3
4
5

Services Provided by This Firm (*describe fully*)

1	Title 19 Regulations	$ 3,496
2	All labor matters	$ 17,388
3		$
4		$
5		$

Charge for Services Provided $ 20,884

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 9/2002

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2017	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	82	82			82	82			82	82		
B. On last day of THIS report period	82	82			82	82			82	82		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	50	50			50	50			52	52		
B. As of midnight of THIS report period	45	45			52	52			45	45		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,090	1,090			757	757			333	333		
B. Medicaid (Conn.)	15,985	15,985			11,989	11,989			3,996	3,996		
C. Medicaid (other states)												
D. Private Pay	12	12			12	12						
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	17,087	17,087			12,758	12,758			4,329	4,329		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	5	5			3	3			2	2		
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	17,092	17,092			12,761	12,761			4,331	4,331		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Cen	2300	9/30/2017	9	37

4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	3	42						
Per Diem Rate								
a. One bed rm.	Various	247.02		305.00				
b. Two bed rms.	Various	247.02		295.00				
c. Three or more bed rms.	Various	247.02		275.00				

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	355	355		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	841	841		
C. Other				
D. ***Total Physical Therapy Treatments***	1,196	1,196		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	5	5		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	15	15		
C. Other				
D. ***Total Speech Therapy Treatments***	20	20		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,029	1,029		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	1,434	1,434		
C. Other				
D. ***Total Occupational Therapy Treatments***	2,463	2,463		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2017	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

Item	Total Cost and Hours					
	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	75,866	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	181,838	10,778				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	238,574	14,785				
6. Housekeeping Service						
a. Head Housekeeper	50,784	2,843				
b. Other Housekeeping Workers	113,710	8,449				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	52,068	2,349				
b. Other Maintenance Workers	3,838	206				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	79,060	5,424				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	150,044	3,915				
b. RN						
1. Direct Care	354,878	10,476				
2. Administrative**						
c. LPN						
1. Direct Care	693,672	24,660				
2. Administrative**						
d. Aides and Attendants	614,921	40,986				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	72,908	3,965				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	62,274	2,140				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	2,744,435	133,056				

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-11 Rev. 10/2005

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2017	11	37

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

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2017	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Veronica Cretella 62 Klein Drive Prospect Ct 06712	75,866				Administrator	2,080	A2			
Section IV - Assistant Administrators										

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

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center LL	2300	9/30/2017	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian	32,966	531				
2. Dentist	4,120	88				
3. Pharmacist	8,790	220				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	59,790	1,008				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	21,600	144				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	324	6				
b. Other						
10. Occupational Therapist						
a. Resident Care	116,262	2,434				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	3,894	16				
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	247,746	4,447				

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

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2017	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Comprehensive Rehabilitation Services LLC 26 Firemens Dr Suite 205 Pomona NY 10970	Speech Therapy	⊙	○	Children of Member
Comprehensive Rehabilitation Services LLC 26 Firemens Dr Suite 205 Pomona NY 10970	Physical Therapy	⊙	○	Children of Member
Comprehensive Rehabilitation Services LLC 26 Firemens Dr Suite 205 Pomona NY 10970	Occupational Therapy	⊙	○	Children of Member
Debbie Rescsanski 293 Burr Hall Rd Middlebury CT 06762	Dietary Consultant	○	⊙	
Healthdrive Dental 85 Barnes Rd Suite 207 Wallingford CT 06492	Dental Consultant	○	⊙	
LTC Management 174 Scott Road Prospect, CT 06712	Dental Consultant	○	⊙	
Mark Raad MD 464 Wolcott CT 06716	Medical Director	○	⊙	
Medwiz Pharmacy 240 N Main St Spring Valley NY 10977	Nursing Registry	○	⊙	
Medwiz Pharmacy 240 N Main St Spring Valley NY 10977	Pharmacy Consultant	○	⊙	
		○	⊙	
		○	○	
		○	○	
		○	○	
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		○	○	

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center L	2300	9/30/2017	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	152,196	152,196		
2. Disability Insurance	$	4,733	4,733		
3. Unemployment Insurance	$	65,912	65,912		
4. Social Security (F.I.C.A.)	$	209,035	209,035		
5. Health Insurance	$	167,867	167,867		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	559	559		
7. Pensions (Non-Discriminatory)	$	273,150	273,150		
(not-owners and not-operators)					
8. Uniform Allowance	$	12,273	12,273		
9. Other (*Specify*)	$	294,347	294,347		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	162,530	162,530		
d. Accounting and Auditing	$	47,488	47,488		
e. Legal (*Services should be fully described on Page 7)*	$	20,884	20,884		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	6,566	6,566		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	28,200	28,200		
2. Cellular Phones	$	506	506		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$	290	290		
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	336,321	336,321		
Subtotal	$	1,782,857	1,782,857		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Union Welfare Fund	$ 285,865		
Union Training Fund	$ 8,482		
Total	$ 294,347	$ -	$ -

Schedule of Other Taxes

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2017	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,782,857	1,782,857		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	5,308	5,308		
5. Education Expenses Related to Seminars and Conventions	$	3,859	3,859		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*) See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	1,621	1,621		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$				
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	1,616	1,616		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	445	445		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	32,880	32,880		
12. Administrative Management Services**	$				
13. Other (*Specify*) See Attached Schedule	$	143,804	143,804		
C-14 Total Administrative & General Expenditures	$	1,972,390	1,972,390		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

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

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CT ASSOC HEALT CARE FACILITIES	$ 350		
AMERICAN EXPRESS	$ 95		
Total Dues	$ 445	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Licences	$ 605		
Bank Charges	$ 27,384		
Patient Expense	$ 10		
Non Reimbursable	$ 115,805		
Total Other Administrative and General	$ 143,804	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation C	2300	9/30/2017	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 #

*** 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.**

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-18 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2017	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	162,357	162,357		
2. Non-Food Supplies	$	49,214	49,214		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	211,571	211,571		

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

H.	Is cost of employee meals included in 2E?	O Yes	⊙ No	
I.	Did you receive revenue from employees?	O Yes	⊙ No	If yes, specify amt.
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	O Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	O Yes	⊙ No	If yes, specify amt.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	O Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	O Yes	⊙ No	If yes, specify amt.
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.
** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-19 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2017	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*					
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	Amt. $	29,148	29,148		
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $	847	847		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	29,995	29,995		

3F.	Laundry Questionnaire			
G.	Is cost of employee laundry included in 3E?	○ Yes	⊙ No	If yes, specify cost.
H.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	○ Yes	⊙ No	If yes, specify cost.
K.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
L.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3E.

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-20 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center	2300	9/30/2017	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	78,279	78,279		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	78,279	78,279		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	56,243	56,243		
b. Medicine Cabinet Drugs		$	7,626	7,626		
c. Medical and Therapeutic Supplies		$	120,856	120,856		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	15,910	15,910		
f. X-rays and Related Radiological Procedures***		$	1,405	1,405		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	6,315	6,315		
i. Recreation		$	7,472	7,472		
j. Other (Specify)**** See Attached Schedule		$	10,844	10,844		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	226,671	226,671		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
IV Supplies	$ 3,223		
Wound Vac	$ 5,685		
Physical Therapy Supplies	$ 1,936		
Total Other Resident Care	$ 10,844	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 10/2001

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2017	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
ADL Data Systems	9 Skyline Drive Hawthorne NY 10532	○	⊙		Computer Software	20,834			16	m.11
Winter Bros	307 White St Danbury Ct 06816	○	⊙		Waste Removal	25,570			22	6.f
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
The Rosegarden Health & Rehabilitation Cente	2300	9/30/2017	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	38,864	38,864		
b. Heat	$	33,745	33,745		
c. Light & Power	$	50,179	50,179		
d. Water	$	66,924	66,924		
e. Equipment Lease (*Provide detail on page 6*)	$	4,301	4,301		
f. Other (*itemize*)	$	52,178	52,178		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	246,191	246,191		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$				
d. Movable Equipment	$	34,536	34,536		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	34,536	34,536		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	20,416	20,416		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	20,416	20,416		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	300,000	300,000		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	77,024	77,024		
c. Personal property taxes	$	12,398	12,398		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	444,374	444,374		

* Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 24.

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Contracted Services	$ 52,178		
Total Other Repairs and Maintenance	$ 52,178	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-23 Rev. 10/2006

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2017	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	50,000							
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	3,150,000							
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 (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					459,110		459,110	271,497	S/L	5 yrs	34,536	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)												
D-3. Subtotal												34,536
E. ***Total Depreciation***												34,536

The Rosegarden Health & Rehabilitation Center LLC
9/30/2017

Schedule of Land Improvements Acquired during this report period

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

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

Schedule of Building Improvements Acquired during this report period

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

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

Schedule of Non-Movable Equipment Acquired during this report period

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

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

Schedule of Movable Equipment Acquired during this report period

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

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

Schedule of Leasehold Improvements Acquired during this report period

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2017	24	37

Item	Date of Acquisition Month	Date of Acquisition Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period				592,863	143,315			20,416	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									20,416
D. ***Total Amortization***									20,416

* Straight-line method must be used.

** Specify which of the following bases were used:

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-25 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitatic	2300	9/30/2017	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ⊙ Yes ○ No

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

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

Description	Total
1. Date Land Purchased	11/13/04
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	11/13/04
4. Date of Initial Licensure	11/13/04
5. Total Licensed Bed Capacity	82
6. Square Footage	
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Variable			
b. Date Mortgage Obtained	11/13/04			
c. Interest Rate for the Cost Year	8.05%			
d. Term of Mortgage (number of years)	15			
e. Amount of Principal Borrowed	3,968,027			
f. Principal balance outstanding as of 9/30/17	688,471			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-26 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
The Rosegarden Health & Rehabilitati	2300	9/30/2017	26 | 37

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

(Carry Subtotals forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-27 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
The Rosegarden Health & Rehabilit	2300	9/30/2017	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				
12. C. Movable Equipment				
1. Automotive Equipment $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*) $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
B. Item / Rate / Amount				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $				
12. D. Other Interest Expense (*Specify*) $ Insurance, Notes, Working Capital	154,803	154,803		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	154,803	154,803		
14. Insurance				
a. Insurance on Property (buildings only) $	14,893	14,893		
b. Insurance on Automobiles $	2,222	2,222		
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	10,400	10,400		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $ General Liability, Crime, PF Bond,	48,450	48,450		
14d. ***Total Insurance Expenditures (14a + b + c)*** $	75,965	75,965		
15. ***Total All Expenditures (A-13 thru C-14)*** $	6,432,420	6,432,420		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-28 Rev. 9/2002

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2017	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1.c	Bad Debts $	162,530	162,530		
10.			Accounting & Legal $				
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.			Unallowable Advertising * $				
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	115,805	115,805		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $				
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	278,335	278,335		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m 13	Non Reimbursable	$ 115,805		
Total Other A&G Adjustments			$ 115,805	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-29 Rev. 10/2006

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2017	29	37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	278,335	278,335		
Page 20 - Resident Care Supplies***								
27.	20	5.a.2	Prescription Drugs	$	56,243	56,243		
28.			Ambulance/Limousine	$				
29.	20	5.f	X-rays, etc	$	1,405	1,405		
30.	20	5.h	Laboratory	$	6,315	6,315		
31.			Medical Supplies	$				
32.	20	5.e.2	Oxygen (non emergency)	$	15,910	15,910		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	18,470	18,470		
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$				
36.			Depreciation on Unallowable Motor Vehicles	$				
37.			Unallowable Property and Real Estate Taxes	$				
38.			Rental of Building Space or Rooms	$				
39.			Other - See Attached Schedule	$				
Page 27 - Insurance								
40.			Mortgage Insurance	$				
41.			Property Insurance	$				
Other - Miscellaneous								
42.			Research or Experimental Activities	$				
43.			Radio and Television Revenue	$				
44.			Vending Machine Revenue	$				
45.			Purchase Discounts and Allowances	$				
46.			Duplications of functions or services	$				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	$				
48.			Interest Income on Accounts Rec	$				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	$				
Not For Profit Providers Only								
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	$				
51.	***Total Amount of Decrease (Items 1 - 50)***			$	376,678	376,678		

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

Attachment Page 29

The Rosegarden Health & Rehabilitation Center LLC
9/30/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5.j	IV Supplies	$ 3,223		
20	5.j	Wound Vac	$ 5,685		
20	5.b	Emergency Box	$ 7,626		
20	5.j	Physical Therapy Supplies	$ 1,936		
Total Other Ancillary Costs			$ 18,470	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

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

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation	2300	9/30/2017	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	4,582,740	4,582,740		
b. Medicaid Room and Board Contractual Allowance **	$	(622,314)	(622,314)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	356,259	356,259		
b. Medicare Room and Board Contractual Allowance **	$				
4. a. Private-Pay Residents and Other	$	3,540	3,540		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$				
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$				
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	75,268	75,268		
b. Physical Therapy - Medicare Contractual Allowance **	$				
c. Physical Therapy - Non-Medicare	$	12,022	12,022		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$				
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	171	171		
5. a. Occupational Therapy - Medicare	$	150,576	150,576		
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$	38,000	38,000		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	4,596,262	4,596,262		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	(32,533)	(32,533)		
V. Total Other Revenue (1 thru 8)	$	(32,533)	(32,533)		
VI. Total All Revenue (III +V)	$	4,563,729	4,563,729		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

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

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Part B	$ (11,150)		
	Prior Adjustment	$ (21,383)		
Total Other Revenue		$ (32,533)	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-31 Rev. 6/95

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitatio	2300	9/30/2017	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 14,669
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 624,748
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 21,177
a. Copier Contract		111		
b. Taxes		21,066		
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 660,594
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	592,863		$ 429,132
	Accum. Depreciation	163,731	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	459,110		$ 153,077
	Accum. Depreciation	306,033	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 582,209

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

(Carry Total forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-32 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation	2300	9/30/2017	32	37

Account				Amount
			Total Brought Forward:	$ 1,242,803
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost	50,000		
	Accum. Depreciation		Net	$ 50,000
3. Buildings	*Historical Cost	3,150,000		
	Accum. Depreciation		Net	$ 3,150,000
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$ 3,200,000
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 4,442,803

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-33 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Cente	2300	9/30/2017	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 1,884,604
2. Notes Payable (*itemize*)				$ 59,086
Value Health Care Services			59,086	
3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 126,644
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 712,177
7. Medicare Final Settlement Payable				$
8. Medicare Current Financing Payable				$
9. Mortgage Payable (*Current Portion*)				$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
11. Accrued Income Taxes*				$
12. Other Current Liabilities (*itemize*)				$ 24,729
Overdraft			18,282	
Loans & Exchanges			6,447	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 2,807,240

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

(Carry Total forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Ce	2300	9/30/2017	34	37

Account	Amount
Total Brought Forward:	2,807,240
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*)	$ 1,877,332

Name and Address of Lender	Amount	Loan Date
Paradise Realty of Waterbury	819,581	
Bridgeport Health Care	1,057,751	

4. Other Long-Term Liabilities (*itemize*)	$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 1,877,332
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 4,684,572

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-35 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitatic	2300	9/30/2017	35	37

Account		Amount
A. **Reserves**		
1. Reserve for value of leased land		$ 50,000
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized		$ 3,150,000
3. Reserve for depreciation value of leased personal property *(Equity)*		$
4. Reserve for leasehold real properties on which fair rental value is based		$
5. Reserve for funds set aside as donor restricted		$
6. Total Reserves		$ 3,200,000
B. **Net Worth**		
1. Owner's Capital		$ (1,573,078)
2. Capital Stock		$
3. Paid-in Surplus		$
4. Treasury Stock		$
5. Cumulated Earnings		$
6. Gain or Loss for Period	10/1/2016 thru 9/30/2017	$ (1,868,691)
7. Total Net Worth		$ (3,441,769)
C. ***Total Reserves and Net Worth***		$ (241,769)
D. ***Total Liabilities, Reserves, and Net Worth***		$ 4,442,803

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-36 Rev. 6/95

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation (	2300	9/30/2017	36	37

Account	Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2016	$ (1,573,078)
B. Total Revenue (*From Statement of Revenue Page 30*)	$ 4,563,729
C. Total Expenditures (*From Statement of Expenditures Page 27*)	$ 6,432,420
D. Net Income or Deficit	$ (1,868,691)
E. Balance	$ (3,441,769)
F. Additions	
1. Additional Capital Contributed (*itemize*)	
2. Other (*itemize*)	
F-3. Total Additions	$
G. Deductions	
1. Drawings of Owners/Operators/Partners (*Specify*)	$

Name and Address (*No., City, State, Zip*)	Title	Amount

2. Other Withdrawings *(Specify)*	$

Purpose	Amount

3. Total Deductions	$
H. ***Balance at End of Period*** 09/30/17	$ (3,441,769)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-37 Rev. 9/2002

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation	2300	9/30/2017	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
	Partner	2/13/18

Printed Name of Preparer
Burg & Weingarten CPA PC

Address	Phone Number
149-12 83rd St Howard Beach NY 11414	718-845-6141