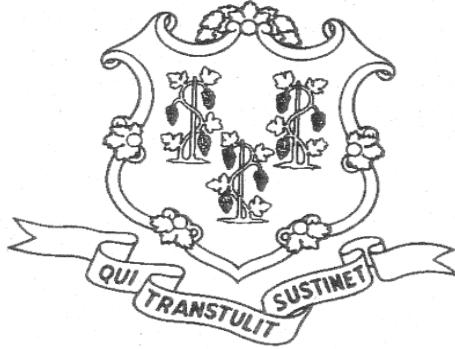


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2019

Name of Facility (as licensed) CSC Enterprises, Inc d/b/a Branford Hills Health Care Ctr	
Address (No. & Street, City, State, Zip Code) 189 Alps Road, Branford, CT 06405	
Type of Facility	
<input type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019

License Numbers:	CCNH 997C	RHNS	(Specify)	Medicare Provider 9977
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Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) CSC Enterprises, Inc d/b/a Branford Hills Health Care	License No. 997C	Report for Year Ended 9/30/2019	Page 1	of 37
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Administrator's/Owner's Certification

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

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

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

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

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Janet A Woxland			Printed Name (Owner) Charles F Shelton, Jr.	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility CSC Enterprises, Inc d/b/a Branford Hills Health Care Ctr	Period Covered:		From 10/1/2018	To 9/30/2019
Address of Facility 189 Alps Road, Branford, CT 06405				
Report Prepared By Renee P Grailich, CPA, Director of Finance	Phone Number 203-483-4402	Date 2/10/2020		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire

Type of Facility - Organization Structure

	Phone No. of Facility 203-481-6221	Report for Year Ended 9/30/2019	Page 2
Name of Facility (as shown on license) CSC Enterprises, Inc d/b/a Branford Hills Health Care Ctr		Address (No. & Street, City, State, Zip) 189 Alps Road, Branford, CT 06405	
License Numbers:	CCNH 997C	RHNS	(Specify)
Medicare Provider No. 9977			
Type of Facility (Check appropriate box(es))			
<input type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)			
Type of Ownership (Check appropriate box)			
<input checked="" type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust			
If this facility opened or closed during report year provide:		Date Opened	Date Closed
Has there been any change in ownership or operation during this report year?		<input type="radio"/> Yes	<input checked="" type="radio"/> No
		If "Yes," explain fully.	
Administrator Name of Administrator Janet A Woxland			
		Nursing Home Administrator's License No.:	001516
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name Charles F Shelton Jr			License No.: 211

General Information and Questionnaire Partners/Members

General Information and Questionnaire
Corporate Owners

Name of Facility CSC Enterprises, Inc d/b/a Branford Hills Hea	License No. 997C	Report for Year Ended 9/30/2019	Page of 3A 37
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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	
CSC Enterprises Inc dba Branford Hills Health Care Ctr	189 Alps Rd Branford, CT 06405	CT	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Charles F Shelton Jr	29 Blackstone Ave, Branford, CT 06405	resident/Treasur	99
Doris J Shelton	29 Blackstone Ave, Branford, CT 06405	Secretary	1
Names of Stockholders Owning at Least 10% of Shares			
Charles F Shelton Jr	29 Blackstone Ave, Branford, CT 06405	resident/Treasur	99

General Information and Questionnaire

Individual Proprietorship

General Information and Questionnaire

Related Parties*

Name of Facility CSC Enterprises, Inc d/b/a Branford Hills Health Care	License No. 997C	Report for Year Ended 9/30/2019			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?			<input checked="" type="radio"/> Yes <input type="radio"/> No		If "Yes," provide the Name/Address and complete the information on Page 11 of the report.			
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?			<input checked="" type="radio"/> Yes <input type="radio"/> No		If "Yes," provide the following information:			
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Charles F Shelton Jr	Branford Hills Realty Associates New Haven, CT	<input type="radio"/>	<input checked="" type="radio"/>		Arms-length lease of land & building	22/9	345,334	345,334
Charles F Shelton Jr	Blackstone Assoc, Branford, CT 06405	<input type="radio"/>	<input checked="" type="radio"/>		Management Services - financial & banking	30a/IV8	49,900	49,900
Charles F Shelton Jr	Minetta LLC, Branford, CT 06405	<input type="radio"/>	<input checked="" type="radio"/>		Management Services - financial & banking	30a/IV8	49,900	49,900
Charles F Shelton Jr	Trison LLC, Branford, CT 06405	<input type="radio"/>	<input checked="" type="radio"/>		Management Services - financial & banking	30a/IV8	49,900	49,900
DJS Enterprises LLC dba BHHC Pharmacy	189 Alps Rd, Branford, CT 06405	<input type="radio"/>	<input checked="" type="radio"/>		See Page 4a	See Page 4a	597,491	597,491
ACD Enterprises LLC	161 Denison Drive, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		Rent Land/building - Administrative Offices	22/9	49,900	49,900
BHHCC Memorial Trust	189 Alps Rd, Branford, CT 06405	<input type="radio"/>	<input checked="" type="radio"/>		Provides benefits to residents	N/A (no costs)	N/A	N/A
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

* Use additional sheets if necessary.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility CSC Enterprises, Inc d/b/a Branford Hills Health	License No. 997C	Report for Year Ended 9/30/2019	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

Outpatient Therapy, Respiratory Therapy and BHHCC Pharmacy

General Information and Questionnaire Leases (Excluding Real Property)

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

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

⊕ No

Total ***

16,898

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

** Attach copies of newly acquired leases.

*** Amount should agree to Page 22, Line 6e.

General Information and Questionnaire

Accounting Basis

Name of Facility CSC Enterprises, Inc d/b/a Branford	License No. 997C	Report for Year Ended 9/30/2019	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm 1 O'Connor Davies 2 Laydon & Company LLC 3 4	Address (No. & Street, City, State, Zip Code) 100 Great Meadow Rd, Wethersfield, CT 06109 PO Box 945 Orange, CT 06477
--	---

Services Provided by This Firm (*describe fully*)

1 OCD - Accounting and Financial Reporting	\$ 9,300
2 OCD - Medicare Cost Report	\$ 3,000
3 Laydon - Review of patient fund account	\$ 3,275
4	\$
	Charge for Services Provided \$ 15,575

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

Yes No Expenditures Other Than Salaries - A&G Line 1e

Legal Services Information

Name of Legal Firm or Independent Attorney 1 Czepiga, Daly, Pope & Perri 2 Murtha Cullina LLP 3 4 5	Telephone Number 860-236-7673 203-772-7700
--	--

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

1 15 Massirio Drive, Berlin, CT 06037	
2 265 Church St, New Haven, CT 06510	
3	
4	
5	

Services Provided by This Firm (*describe fully*)

1 Operating Lease Agreements	\$ 4,176
2 Employee Issues	\$ 8,239
3	\$
4	\$
5	\$
	Charge for Services Provided \$ 12,415

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

Yes No Expenditures Other Than Salaries - A & G Line 1e

Schedule of Resident Statistics

Name of Facility CSC Enterprises, Inc d/b/a Branford Hills Health Care Ctr			License No. 997C				Report for Year Ended 9/30/2019				Page 8 of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	380	190		190	380	190		190	380	190		190
B. On last day of THIS report period	190			190	380	190		190	190			190
2. Number of Residents												
A. As of midnight of PREVIOUS report period	374	187		187	374	187		187	334	167		167
B. As of midnight of THIS report period	368	184		184	334	167		167	368	184		184
3. Total Number of Days Care Provided During Period												
A. Medicare	6,727	3,386		3,341	4,903	2,474		2,429	1,824	912		912
B. Medicaid (Conn.)	102,604	51,302		51,302	78,188	39,094		39,094	24,416	12,208		12,208
C. Medicaid (other states)												
D. Private Pay	20,269	10,112		10,157	13,683	6,819		6,864	6,586	3,293		3,293
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	129,600	64,800		64,800	96,774	48,387		48,387	32,826	16,413		16,413
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	726	363		363	476	238		238	250	125		125
B. Other Bed Reserve Days	100	50		50	90	45		45	10	5		5
5. Total Resident Days (3G + 4A + 4B)	130,426	65,213		65,213	97,340	48,670		48,670	33,086	16,543		16,543

Schedule of Resident Statistics (Cont'd)

Name of Facility CSC Enterprises, Inc d/b/a Branford Hills Hea	License No. 997C	Report for Year Ended 9/30/2019	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?

 Yes No

If "YES", provide the following information:

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

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

1st change	Change in Resident Days			CCNH	RHNS	(Specify)
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	13	140		31				
Per Diem Rate								
a. One bed rm.				515.00				
b. Two bed rms.	575.00	250.40		472.50				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B		TOTAL	CCNH	RHNS	(Specify)
		8,364	8,364		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments		287	287		
C. Other		813	813		
D. Total Physical Therapy Treatments		9,464	9,464		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		497	497		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments		23	23		
C. Other		41	41		
D. Total Speech Therapy Treatments		561	561		

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		11,555	11,555		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments		218	218		
C. Other		808	808		
D. Total Occupational Therapy Treatments		12,581	12,581		

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of	
		997C	9/30/2019		10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes <input type="radio"/> No				
Item	CCNH	Hours	RHNS	Hours	(Specify)	
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	183,893	2,216				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	191,240	2,088				
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	683,253	17,546				
5. Dietary Service						
a. Head Dietitian	77,358	2,064				
b. Food Service Supervisor	78,166	2,192				
c. Dietary Workers	860,059	51,543				
6. Housekeeping Service						
a. Head Housekeeper	65,228	1,474				
b. Other Housekeeping Workers	447,667	28,885				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	84,162	2,128				
b. Other Maintenance Workers	114,019	4,344				
8. Laundry Service						
a. Supervisor	32,621	768				
b. Other Laundry Workers	205,110	11,905				
9. Barber and Beautician Services						
10. Protective Services	214,565	13,644				
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	274,370	5,589				
b. RN						
1. Direct Care	1,168,319	36,762				
2. Administrative**	191,336	5,047				
c. LPN						
1. Direct Care	1,547,020	56,478				
2. Administrative**	124,459	3,956				
d. Aides and Attendants	3,044,435	220,675				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	182,163	8,784				
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	192,931	6,484				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	211,007	8,757				
A-13. Total Salary Expenditures	10,173,381	493,329				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

Schedule of Other Fees (Page 13)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

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

Name of Facility CSC Enterprises, Inc d/b/a Branford Hills Health Care Ctr				License No. 997C		Report for Year Ended 9/30/2019			Page 11	of 37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
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
CSC Enterprises, Inc d/b/a Branford Hills Health Care Ctr				997C		9/30/2019			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Janet A. Woxland	183,893				Administrator	2,216	A2			
Section IV - Assistant Administrators										
Charles F Shelton, Jr	191,240			Auto Exp See Pg 28	Assistant Administrator	2,088	A3			

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility CSC Enterprises, Inc d/b/a Branford Hills Health Ca	License No. 997C	Report for Year Ended 9/30/2019		Page 13	of 37
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)					
1. Dietitian					
2. Dentist	20,363	156			
3. Pharmacist	(3,168)	268			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	572,867	4,869			
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	66,000	208			
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	100,275	649			
b. Other					
10. Occupational Therapist					
a. Resident Care	667,614	4,157			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care					
2. Administrative***					
b. LPN					
1. Direct Care					
2. Administrative***					
c. Aides					
d. Other					
12. Other (Specify)					
See Attached Schedule	105,519	2,086			
B-13 Total Fees Paid in Lieu of Salaries	1,529,470	12,393			

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

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

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

Report of Expenditures

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

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
CSC Enterprises, Inc d/b/a Branford Hills Health	997C	9/30/2019	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 227,039	227,039		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 153,659	153,659		
4. Social Security (F.I.C.A.)	\$ 728,054	728,054		
5. Health Insurance	\$ 1,009,981	1,009,981		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 29,410	29,410		
8. Uniform Allowance	\$			
9. Other (Specify) See Attached Schedule	\$ 25,823	25,823		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 300,000	300,000		
d. Accounting and Auditing	\$ 15,575	15,575		
e. Legal (Services should be fully described on Page 7)	\$ 12,415	12,415		
f. Insurance on Lives of Owners and Operators (Specify)*	\$ 11,470	11,470		
g. Office Supplies	\$ 264,860	264,860		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 20,435	20,435		
2. Cellular Phones	\$ 3,509	3,509		
i. Appraisal (Specify purpose and attach copy)*	\$			
j. Corporation Business Taxes (franchise tax)	\$			
k. Other Taxes (Not related to property - See Page 22)				
1. Income*	\$			
2. Other (Specify) See Attached Schedule	\$ 5,076	5,076		
3. Resident Day User Fee	\$ 1,217,457	1,217,457		
Subtotal	\$ 4,024,763	4,024,763		

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

(Carry Subtotals forward to next page)

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

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Employee Background Checks	\$ 1,053		
Employee Drug Screening	\$ 7,280		
Workshoes and Tools	\$ 9,311		
Employee Finger Printing	\$ 6,362		
Pneumonia Shots	\$ 1,288		
Medical Reimbursements	\$ 529		
Total	\$ 25,823	\$ -	\$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Sales and use tax	\$ 5,076		
Total	\$ 5,076	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2019		16	37
Item		Total	CCNH	RHNS	(Specify)
	<i>Subtotals Brought Forward:</i>	4,024,763	4,024,763		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	11,661	11,661		
3. Gifts to Staff and Residents	\$	19,224	19,224		
4. Employee Travel	\$	330	330		
5. Education Expenses Related to Seminars and Conventions	\$	6,874	6,874		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	9,669	9,669		
7. Other (<i>Specify</i>) See Attached Schedule	\$	15,618	15,618		
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	33,800	33,800		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	15,860	15,860		
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	\$	11,409	11,409		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	14,900	14,900		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	260	260		
9. Subscriptions	\$	4,402	4,402		
10. Contributions*** See Attached Schedule	\$	3,000	3,000		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$				
12. Administrative Management Services**	\$	46,656	46,656		
13. Other (<i>Specify</i>) See Attached Schedule	\$	39,839	39,839		
C-14 Total Administrative & General Expenditures	\$	4,258,265	4,258,265		

* 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)
Travel & Entertainment	\$ 618		
Board of Director Expense	\$ 15,000		
Total Other Travel and Entertainment	\$ 15,618	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotions	\$ 15,860		
Total Other Advertising	\$ 15,860	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 13,426		
ALTCFM	\$ 340		
ACHCA	\$ 150		
AMEX	\$ 455		
INC - HARTFORD CHAPTER	\$ 40		
CT BAR ASSOC	\$ 280		
SOCIETY FOR HUMAN RESOURCE MGMT	\$ 209		
Total Dues	\$ 14,900	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
BHHCC Memorial Trust	\$ 1,900		
Branford Rotary Club	\$ 1,100		
Total Contributions	\$ 3,000	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
License - Admin - CFSJR	\$ 205		
License - RN Renewal - Janet Woxland	\$ 110		
License - East Shore District Health Dept	\$ 495		
Annual CSC Enterprises	\$ 150		
State of CT - Elevator License	\$ 480		
State of CT - Boiler/Heater License	\$ 400		
Department of Consumer Protection - ER Box	\$ 50		
Secretary of the State - Notary Renewal - Ann Caprio	\$ 60		
Penalty	\$ 3,000		
Cable Internet Charges	\$ 3,281		
Ethernet Internet Charges	\$ 13,110		
Cable TV LW3	\$ 18,498		
Total Other Administrative and General	\$ 39,839	\$ -	\$ -

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
CSC Enterprises, Inc d/b/a Branford Hills	997C	9/30/2019	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 #
A/R Solutions PO Box 592 Wallingford, CT 06492	31,050	Billing	P16LM11
Hollis D Segur PO Box 400 Cheshire, CT 06410	1,808	Consultation Fee	P16LM11
NRC Health PO Box 809030 Chicago, IL 60680	7,698	Patient Surveys	P16LM11
National Datacare PO 222430 Chantilly VA 20153	1,780	Resident Fund Processing	P16LM11
Unemployment Tax Mgmt PO 4074 Wakefield, MA 01880	4,320	Consultation Fee	P16LM11

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

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

Name of Facility	License No.	Report for Year Ended		Page of
	997C	9/30/2019		18 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 516,742	516,742		
2. Non-Food Supplies	\$ 120,575	120,575		
3. Other (Specify) _____	\$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 746	746		
c. Other (Specify) _____	\$			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 638,063	638,063		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				
H. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify cost.
K. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify cost.
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

C. Expenditures Other Than Salaries (cont'd) - Laundry Basis for Allocation of Costs

(See Note on Page 5)

Name of Facility CSC Enterprises, Inc d/b/a Branford Hills Health Care C	License No. 997C	Report for Year Ended 9/30/2019	Page 19	of 37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$			
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. \$	31,264	31,264	
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$			
c. Other (Specify) Supplies	\$	17,793	17,793	
3D. Total Laundry Expenditures (3a + b + c)	\$	49,057	49,057	
3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify cost.
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify amt.
H. Where is the revenue received reported in the Cost Report?				(Page/Line Item)
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify cost.
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify amt.
K. Where is the revenue received reported in the Cost Report?				(Page/Line Item)

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3D.

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2019		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced				
a. In-House Care	by Personnel				
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	56,824	56,824		
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel				
	Amt. \$				
C. Other (Specify)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	56,824	56,824		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$	543,080	543,080		
2. Purchased from OMNICARE INC	\$	29,605	29,605		
b. Medicine Cabinet Drugs	\$				
c. Medical and Therapeutic Supplies	\$	427,343	427,343		
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	34,759	34,759		
f. X-rays and Related Radiological Procedures***	\$	21,851	21,851		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	93,703	93,703		
i. Recreation	\$	11,556	11,556		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (Specify)**** See Attached Schedule	\$	54,030	54,030		
5M. Total Resident Care Expenditures (5a - 5j)	\$	1,215,927	1,215,927		

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

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

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

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

Schedule of Other Resident Care

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

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

** Refer to Page 4 for definition of related.

*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended		Page of
		9/30/2019		22 37
Item	Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant				
a. Repairs & Maintenance	\$ 103,767	103,767		
b. Heat	\$ 88,236	88,236		
c. Light & Power	\$ 150,737	150,737		
d. Water	\$ 47,593	47,593		
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 16,898	16,898		
f. Other (<i>itemize</i>)	\$ 188,814	188,814		
See Attached Schedule				
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 596,045	596,045		
7. Depreciation (<i>complete schedule page 23*</i>)				
a. Land Improvements	\$ 24,022	24,022		
b. Building & Building Improvements	\$			
c. Non-Movable Equipment	\$			
d. Movable Equipment	\$ 64,062	64,062		
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 88,084	88,084		
8. Amortization (<i>Complete att. Schedule Page 24*</i>)				
a. Organization Expense	\$			
b. Mortgage Expense	\$ 13,517	13,517		
c. Leasehold Improvements	\$ 201,726	201,726		
d. Other (<i>Specify</i>)	\$			
*8e. Total Amortization Costs (8a + b + c + d)	\$ 215,243	215,243		
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 433,159	433,159		
10. Property Taxes				
a. Real estate taxes paid by owner	\$			
b. Real estate taxes paid by lessor	\$ 175,765	175,765		
c. Personal property taxes	\$ 25,716	25,716		
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 937,967	937,967		

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

Schedule of Other Repairs and Maintenance

Depreciation Schedule

Schedule of Land Improvements Acquired during this report period

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

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

Schedule of Non-Movable Equipment Acquired during this report period

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

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/24/2018	40 Qt Floor Model Mixer & Adapter Kit	\$ 9,708	10	\$ 890
11/8/2018	Wascomat Washer Kit	\$ 2,800	5	\$ 513
11/16/2018	Sara Flex HEB0000-01 Ser #300273859	\$ 3,481	10	\$ 290
11/21/2018	Maxi Move Scale L-Height	\$ 6,198	10	\$ 517
12/4/2018	Conveyor Toaster	\$ 1,164	10	\$ 97
12/4/2018	2 Tables Plus Adjustable Base	\$ 882	15	\$ 49
12/10/2018	2 Akin Tables	\$ 773	15	\$ 47
12/23/2018	32 Mattresses Geo Plus	\$ 7,841	15	\$ 1,176
1/9/2019	5 Beds plus rail sets	\$ 7,845	10	\$ 588
1/27/2019	31 Mattresses Geo Plus	\$ 7,598	5	\$ 1,013
2/7/2019	14 Arm Chairs	\$ 6,307	15	\$ 280
2/11/2019	3 Tables/3 Akin Tables	\$ 2,398	15	\$ 107
2/20/2019	32 Mattresses Geo Plus	\$ 8,128	5	\$ 1,084
3/26/2019	Table plus base	\$ 520	15	\$ 17
4/1/2019	Akin Table	\$ 691	15	\$ 23
4/24/2019	2 Tables Plus Adjustable Base	\$ 927	15	\$ 26
5/1/2019	31 Geo Plus Mattresses	\$ 6,934	5	\$ 578
5/6/2019	Table plus base	\$ 518	15	\$ 14
5/6/2019	Table plus base	\$ 518	15	\$ 14
5/10/2019	Akin Table	\$ 482	15	\$ 13
5/10/2019	Akin Table	\$ 482	15	\$ 13
5/12/2019	Stand/Monitor BP Connex Spot	\$ 3,177	5	\$ 265
5/31/2019	8 Burner Stainless Commercial Grill	\$ 2,120	7	\$ 101
6/7/2019	ECG/Cart/Arm Cable Shelf	\$ 3,722	7	\$ 177
6/17/2019	Slings	\$ 6,142	5	\$ 307
6/25/2019	Scanner/Cart	\$ 7,314	7	\$ 261
8/1/2019	Akin Table	\$ 554	10	\$ 9
8/13/2019	Respirronics Dream Station Ser #J248735123	\$ 995	5	\$ 33
9/12/2019	Maxi Move Scale L-Height Ser #300014142	\$ 1,088	10	\$ 9
9/18/2019	Burnisher Advolution 20" 01520A	\$ 2,086	5	\$ 35
Total additions for Movable Equipment		\$ 103,393		\$ 8,546 *
Deletions:				
7/31/2007	3 Queen Anne Tables	\$ (1,332)		
2/28/2009	PT OT LW3 Furniture	\$ (5,780)		
3/31/2009	PT OT LW3 Furniture	\$ (2,037)		
3/31/2009	PT OT LW3 Furniture	\$ (851)		
3/31/2009	PT OT LW3 Furniture	\$ (2,250)		
3/31/2009	Rug Cleaner	\$ (2,862)		
4/30/2009	8 Reclining Chairs	\$ (13,593)		
8/7/2012	8 Mattresses	\$ (2,251)		
9/27/2013	Floor Burnisher	\$ (6,168)		
4/30/2009	22 LW3 Chairs	\$ (13,440)		
1/31/2010	EZ-Way Sling	\$ (4,453)		
3/12/2007	4 Chairs - LW3 DR	\$ (1,278)		
3/3/2005	Washing Machine	\$ (15,691)		
8/7/2006	Washer-Extractor	\$ (13,495)		
3/31/2011	PCC Implementation	\$ (4,250)		
1/1/2012	PCC Implementation	\$ (7,500)		
5/16/2007	Furniture	\$ (7,486)		
11/30/2007	Floor Mixer	\$ (7,204)		
Total deletions for Movable Equipment		\$ (111,921)		\$ - **

*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:				
10/11/2018	Room 228 FRP & Base	\$ 1,081	5	\$ 216
10/23/2018	3rd FL RTU	\$ 14,979	10	\$ 1,373
10/30/2018	2 PTAC units LW2 DR	\$ 4,202	5	\$ 770
10/30/2018	PTAC unit HR office	\$ 2,187	5	\$ 401
11/27/2018	Fire Doors	\$ 2,129	10	\$ 178
1/4/2019	Room #230 prep & paint	\$ 1,569	5	\$ 235
1/11/2019	Linen Rm/Loading Dock/Dish Wash/Stairs	\$ 10,440	10	\$ 783

1/24/2019	Room #230 FRP & Base	\$ 1,081	5	\$ 144	ttachment Pages 23 24
2/6/2019	Room #312 prep & paint	\$ 1,569	5	\$ 209	
2/8/2019	Room #312 FRP & base	\$ 1,081	5	\$ 144	
2/24/2019	Recessed Lights - Entry Ceiling	\$ 5,805	10	\$ 339	
3/6/2019	Room #330 prep & paint	\$ 1,569	5	\$ 183	
3/12/2019	Room #330 FRP & base	\$ 1,081	5	\$ 126	
4/2/2019	Room #200 prep & paint	\$ 1,569	5	\$ 157	
4/8/2019	Room #200 FRP & base	\$ 1,081	5	\$ 108	
4/26/2019	Room #326 prep & paint	\$ 1,569	5	\$ 131	
6/20/2019	Upgrade to FX80 system - Controlled Air	\$ 9,947	10	\$ 249	
6/23/2019	Room #326 FRP & base	\$ 1,181	5	\$ 59	
7/4/2019	2nd FL Shower room remodel	\$ 1,190	5	\$ 60	
7/11/2019	Room #328 prep & paint	\$ 1,569	10	\$ 39	
7/22/2019	Shower Rooms - replace shower valves & grab bars	\$ 2,321	10	\$ 39	
8/14/2019	Room #328 FRP & base	\$ 1,181	5	\$ 39	
8/14/2019	2nd FL Shower room remodel	\$ 1,190	10	\$ 20	
8/19/2019	Room #362 prep & paint	\$ 1,153	5	\$ 19	
9/12/2019	Kitchen/Elevator Lobby/LW3	\$ 14,545	10	\$ 121	
Total additions for Leasehold Improvemen		\$ 87,269		\$ 6,142	*
Deletions:					
12/28/2004	DW Circuit	\$ (1,229)			
6/29/2005	Alarm Pressure Switch	\$ (4,217)			
1/18/2006	A/C Upgraded Controls	\$ (3,247)			
7/15/2007	LW Conference Room	\$ (2,727)			
12/31/2007	6 Wanderguards	\$ (14,938)			
1/14/2008	4 Toilets	\$ (1,483)			
10/5/2005	Kitchen Exhaust Fan	\$ (4,328)			
7/31/2007	Fire Doors	\$ (4,399)			
10/15/2006	Nurse Call System	\$ (77,700)			
8/31/2007	3 PTAC Units	\$ (8,309)			
Total deletions for Leasehold Improvemen		\$ (122,577)		\$ -	**

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility CSC Enterprises, Inc d/b/a Branford Hills Health Care Ctr			License No. 997C		Report for Year Ended 9/30/2019			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1. Closing Costs	9	18	5 YR	67,942		67,942		13,517	
2.									
3.									
B-4. Subtotal									13,517
C. Leasehold Improvements and Other									
1. Acquired prior to this report period				4,608,248	2,976,240			195,584	
2. Disposals (attach schedule)				(122,577)	(121,929)				
3. Acquired during this report period (attach schedule)				87,269				6,142	
C-4. Subtotal									201,726
D. Total Amortization									215,243

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility CSC Enterprises, Inc d/b/a Branford H	License No. 997C	Report for Year Ended 9/30/2019	Page 25	of 37
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11. Property Questionnaire

Part A

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

Yes

No

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

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

Description	Total			
1. Date Land Purchased	01/01/80			
2. Date Structure Completed	01/01/80			
3. If NOT Original Owner, Date of Purchase	N/A			
4. Date of Initial Licensure	Est 1980			
5. Total Licensed Bed Capacity	190			
6. Square Footage	Est 80,109			
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	09/25/18			
c. Interest Rate for the Cost Year	3.04%			
d. Term of Mortgage (number of years)	25			
e. Amount of Principal Borrowed	3,769,805			
f. Principal balance outstanding as of 09/30/19	3,700,571			

Complete if Mortgage was Refinanced

During Current Cost Year

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

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

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

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

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

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended 9/30/2019			Page 27	of 37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		\$				
12. D. Other Interest Expense (Specify)		\$	3,288	3,288		
Equipment Lease Financing						
13. Total All Interest Expense (12B7 + 12C3 + 12D)		\$	3,288	3,288		
14. Insurance						
a. Insurance on Property (buildings only)		\$	19,735	19,735		
b. Insurance on Automobiles		\$	5,311	5,311		
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$	132,234	132,234		
2. Fire and Extended Coverage		\$	114	114		
3. Other (Specify)		\$	300	300		
Bond						
14d. Total Insurance Expenditures (14a + b + c)		\$	157,694	157,694		
15. Total All Expenditures (A-13 thru C-14)		\$	19,615,981	19,615,981		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of	
Item No.	Page No.	Line No.		997C	9/30/2019	28 37	
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	\$	60,093	60,093	
			Page 13 - Professional Fees				
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$	667,615	667,615	
7.			Other - See attached Schedule	\$	100,077	100,077	
			Pages 15 & 16 - Administrative and General				
8.			Discriminatory Benefits	\$	5,238	5,238	
9.			Bad Debts	\$	300,000	300,000	
10.			Accounting	\$	3,000	3,000	
10a.			Legal	\$			
11.			Telephone	\$	(2,344)	(2,344)	
12.			Cellular Telephone	\$	2,789	2,789	
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$	11,470	11,470	
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)	\$	10,288	10,288	
18.			Unallowable Advertising *	\$			
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$	3,000	3,000	
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$	77,527	77,527	
			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	\$	2,493	2,493	
Subtotal (Items 1 - 26)			\$	1,241,246	1,241,246		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	A4	In-House Counsel related to owner 100% disallowed	\$ 57,217		
10	A4	Director of Financial Analysis Non-Facility work disallowed	\$ 2,876		
Total Other Salaries Adjustment			\$ 60,093	\$ -	\$ -

Schedule of Fees Adjustments

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	L2	Employee Parties & Food	\$ 6,867		
16	L3	Employee Gifts	\$ 11,980		
16	L7	BOD Fees	\$ 15,000		
16	M8	Rotary Dues	\$ 110		
16	M8	Chamber Dues	\$ 150		
16	M3	Marketing	\$ 15,859		
16	M13	Penalties	\$ 3,000		
29B		Outpatient Therapy Overhead	\$ 526		
29C		Pharmacy Overhead	\$ 2,739		
29D		Business Park utilities/maintenance/related to sub-lease	\$ 2,666		
16		Administrative Consultant - Medicare	\$ 18,630		
Total Other A&G Adjustments			\$ 77,527	\$ -	\$ -

State of Connecticut

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

Name of Facility			License No.	Report for Year Ended		Page of	
CSC Enterprises, Inc d/b/a Branford Hills Health Care Ctr			997C	9/30/2019		29 37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 1,241,246	1,241,246		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$ 572,685	572,685		
28.			Ambulance/Limousine	\$			
29.			X-rays, etc	\$ 21,852	21,852		
30.			Laboratory	\$ 91,400	91,400		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$ 34,759	34,759		
33.			Occupational Therapy	\$ 60	60		
34.			Other - See Attached Schedule	\$ 46,255	46,255		
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	\$ 1,364	1,364		
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 18,043	18,043		
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)			\$ 2,027,664	2,027,664			

*** 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	Line Ref	Description	CCNH	RHNS	(Specify)
20	5J	Patient Personal Needs	\$ (2,228)		
20	5J	IV Supplies	\$ 50,248		
29	34	EKG Med A	\$ (13)		
29	31	Prothrombin-Med B	\$ (1,752)		
Total Other Ancillary Costs			\$ 46,255	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14B	Auto Insurance	\$ 5,311		
29B		Outpatient Therapy Overhead	\$ 222		
29B		Outpatient Therapy Fair Rent	\$ 302		
29C		Pharmacy Overhead	\$ 1,155		
29C		Pharmacy Fair Rent	\$ 1,572		
29D		Business Park Rent Related to Sub-Lease	\$ 9,481		
Total Other Property Adjustments			\$ 18,043	\$ -	\$ -

Schedule of Other - Indirect Adjustments

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

Schedule of Other - Miscellaneous Administrative Adjustments

Schedule of Other - Direct Adjustments

Attachment Page 29

Schedule of Unallowable Building Interest

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended 9/30/2019			Page 30	of 37
Item		Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 21,936,382	21,936,382				
b. Medicaid Room and Board Contractual Allowance **	\$ (9,351,731)	(9,351,731)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents(<i>all inclusive</i>)	\$ 1,731,336	1,731,336				
b. Medicare Room and Board Contractual Allowance **	\$ 347,011	347,011				
4. a. Private-Pay Residents and Other	\$ 4,495,337	4,495,337				
b. Private-Pay Room and Board Contractual Allowance **	\$ 62,107	62,107				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 557,878	557,878				
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$ 706,130	706,130				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
2. a. Medical Supplies - Medicare	\$ 335	335				
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$ 1,293,970	1,293,970				
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$ 1,043,216	1,043,216				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 249,724	249,724				
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$ 215,474	215,474				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 1,635,843	1,635,843				
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$ 995,603	995,603				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$ 82,852	82,852				
b. Other (<i>Specify</i>) - Non-Medicare	\$ (5,726,084)	(5,726,084)				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 20,275,383	20,275,383				
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ 1,684	1,684				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ (154,966)	(154,966)				
V. Total Other Revenue (1 thru 8)	\$ (153,282)	(153,282)				
VI. Total All Revenue (III +V)	\$ 20,122,101	20,122,101				

* 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)
	Oxygen Medicare A	\$ 4,205		
	Xray Medicae A	\$ 20,949		
	Labs Med A	\$ 76,136		
	EKG Med A	\$ 13		
	OP Medicare Contractural Allowance	\$ (31,168)		
	OP Con Allow MCR B Sequester	\$ (11,246)		
	Prothrombin Med B	\$ 1,752		
	Retroactive Medicare Settlement	\$ 1,531		
	Respiratory Therapy Med A	\$ 20,680		
	Total Other Resident Revenue - Medicare	\$ 82,852	\$ -	\$ -

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

Page Ref	Description	CCNH	RHNS	(Specify)
	Lab Revenue - Medicaid	\$ 490		
	Respiratory HMO	\$ 19,440		
	Xray Medicaid	\$ 2,786		
	Oxygen - HMO	\$ 3,989		
	Contractual Allowances	\$ (5,843,667)		
	OP Contract Allowance	\$ (14,852)		
	Lab - HMO Current Year	\$ 100,270		
		\$ 5,460		
	Total Other Resident Revenue	\$ (5,726,084)	\$ -	\$ -

Interest Income**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Income - Investments	\$ 1,684			
	Total Interest Income	\$ 1,684	\$ -	\$ -	

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Dividend Income - Investments	\$ 9,457		
	Investment Change in FMV	\$ (16,688)		
	Investment Management Fees	\$ (4,795)		
	Investment Income capital Gains/(losses)	\$ 10,286		
	Other Revenue & Deductions	\$ 1,557		
	Rental Income BHHCC Pharmacy	\$ 5,214		
	Value add fee BHHCC Pharmacy	\$ (12,000)		
	Barber & Beautician	\$ 2,351		
	Mgmt Fees Blackstone Assoc	\$ (49,900)		
	Mgmt Fees Trison LLC	\$ (49,900)		
	Mgmt Fees Minetta LLC	\$ (49,900)		
	Gain/(loss) on disposal of assets	\$ (648)		
	Total Other Revenue	\$ (154,966)	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2019	31	37
		Account	Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	861,320
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	4,269,338
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	6,072
4. Inventories			\$	160,900
5. Prepaid Expenses			\$	84,510
a.				
b.				
c.				
d. See Schedule		84,510		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	75,033
Employee Loans & Advances		8,389		
IRS Section 759 Deposit		66,644		
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	5,457,173
B. Fixed Assets			\$	
1. Land			\$	
2. Land Improvements	*Historical Cost	340,641	\$	130,987
	Accum. Depreciation	209,654	Net	
3. Buildings	*Historical Cost		\$	
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	4,572,940	\$	1,516,903
	Accum. Depreciation	3,056,037	Net	
5. Non-Movable Equipment	*Historical Cost	181,006	\$	
	Accum. Depreciation	181,006	Net	
6. Movable Equipment	*Historical Cost	1,623,162	\$	400,471
	Accum. Depreciation	1,222,691	Net	
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	236,208
See Schedule		236,208		
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	2,284,569

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

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

Page Ref	Line Ref	Description	
Total Other Current Assets (Itemize)			\$ -

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

Schedule of Other Assets Page 32 Line D7

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			\$ -

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			\$ -

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2019	32	37
Account		Amount		
		Total Brought Forward:		
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements	*Historical Cost Accum. Depreciation	Net	\$	
3. Buildings	*Historical Cost Accum. Depreciation	Net	\$	6,746,906
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)			\$	6,746,906
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)			\$	141,154
Name and Address	Amount	Loan Date		
Stephen J Shelton 161 Denison Dr Guilford CT/Christian B Shelton 216 Devonshire Lane	141,154			
7. Other Assets (itemize)			\$	73,948
Deposits	19,523			
See Schedule	54,425			
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	215,102
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	14,703,750

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

G. Balance Sheet (cont'd)

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility CSC Enterprises, Inc d/b/a Branford Hills He	License No. 997C	Report for Year Ended 9/30/2019	Page 34	of 37
Account		Amount		
Total Brought Forward:		1,839,865		
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				
3. Loans from Owners or Related Parties (<i>itemize</i>)				
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				
C. Total All Liabilities (Lines A-13 + B-5)				
		1,839,865		

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

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2019	35	37
		Account	Amount	
A. Reserves				
1. Reserve for value of leased land			\$	6,746,906
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	6,746,906
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	5,620,863
6. Gain or Loss for Period	10/1/2018	thru	9/30/2019	\$ 495,116
7. Total Net Worth			\$	6,116,979
C. Total Reserves and Net Worth				\$ 12,863,885
D. Total Liabilities, Reserves, and Net Worth				\$ 14,703,750

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
CSC Enterprises, Inc d/b/a Branford Hill	997C	9/30/2019	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2018				\$ 6,705,730		
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 20,122,101		
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 19,623,317		
D. Net Income or Deficit				\$ 495,116		
E. Balance				\$ 7,204,514		
F. Additions						
1. Additional Capital Contributed (<i>itemize</i>)						
2. Other (<i>itemize</i>)						
CR vs FS Depreciation/Amortization				(11,004)		
F-3. Total Additions				\$ (11,004)		
G. Deductions						
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)				\$		
Name and Address (No., City, State, Zip)		Title	Amount			
2. Other Withdrawings (<i>Specify</i>)				\$		
Purpose		Amount				
3. Total Deductions				\$		
H. Balance at End of Period				\$ 7,193,510		

I. Preparer's/Reviewer's Certification

Name of Facility CSC Enterprises, Inc d/b/a Branford Hills	License No. 997C	Report for Year Ended 9/30/2019	Page 37	of 37
<i>Check appropriate category</i>				
<input type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
Printed Name of Preparer		
Renee P Grailich		
Address		Phone Number
189 Alps Road Branford, CT 06405		203-483-4402
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number
Renee P Grailich		203-483-4402
Contact Email Address		
rgrailich@bhcc.com		