State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2019

Name of Facility (as licensed) Cheshire House Nursing & Rehabilitation Center		
Address (No. & Street, City, State, Zip Code) 3396 East Main St., 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 10/1/2018	Report for Year Ending 9/30/2019	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2141c			07-5373

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	6577		

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2019	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 Cheshire House Nursing & Rehabilitation Center [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) David Desell			Printed Name (Owner) Martin Sbriglio	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Cheshire House Nursing & Rehabilitation Center	Period Covered:		From 10/1/2018	To 9/30/2019
Address of Facility 3396 East Main St., Waterbury, CT 06705				
Report Prepared By Ryders Health Management	Phone Number 203-381-1327		Date 1/14/2020	

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.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-381-1381	9/30/2019	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Cheshire House Nursing & Rehabilitation Center	3396 East Main St., Waterbury, CT 06705

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	2141c			07-5373

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.:
David Desell	001861

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

Name	License No.:
N/A	

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2019	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned
N/A			

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Cer	2141c	9/30/2019	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
Cheshire House Nursing & Rehabilitation Center	3396 East Main St., Waterbury, CT 06705	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Martin Sbriglio, RN, NHA	3396 East Main St., Waterbury, CT 06705	Owner	100
Names of Stockholders Owning at Least 10% of Shares			
Martin Sbriglio, RN, NHA	3396 East Main St., Waterbury, CT 06705	Owner	100

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2019	3B	37

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

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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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	%**				
See Attached		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

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

Cheshire House
Cost Report 9/30/2019
List of Related Parties
Page 4 Attachment

Name of Related Individual or Company	Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Services Provided	Indicate Where Costs are Included in Annual Report Page #/ Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%				
Ryders Health Management (RHM)	88 Ryders Lane, Suite 208, Stratford, CT 06614		X		Financial and Managerial Support	16/m12	292,118	295,385
Due from Greentree Manor	4 Greentree Drive, Waterford, CT 06385		X		Loan to Facility	32/D7, 34/B4	170,324	170,324
Due from Mystic Healthcare	475 High St., Mystic, CT 06355		X		Loan to Facility	32/D7, 34/B4	113,999	113,999
Due from DM Realty	88 Ryders Lane, Suite 208, Stratford, CT 06614		X		Loan to Facility	32/D7, 34/B4	10,000	10,000
Due from Lighthouse	88 Ryders Lane, Stratford, CT 06614		X		Loan to Facility	32/D7, 34/B4	4,000	4,000
ValueRx	54 Tuttle Place, Middletown, CT	X			Pharmacy Expenses	20/5a2	353,471	Disallowed
ValueRx	54 Tuttle Place, Middletown, CT	X			House Drugs	20/5b	29,379	29,379
Due to Aaron Manor	3 South Wig Hill Road, Chester, CT 06412		X		Loan from Facility	34/B4	153,886	153,886
Due to Bel-Air Manor	256 New Britain Ave., Newington, CT 06111		X		Loan from Facility	34/B4	288,394	288,394
Due to Chamberlain Manor	7003 Main St., Stratford, CT 06614		X		Loan from Facility	34/B4	1,084,129	1,084,129
Due to Douglas Manor	103 North Rd. Windham, CT 06280		X		Loan from Facility	34/B4	166,863	166,863
Due to Lord Chamberlain	7003 Main St., Stratford, CT 06614		X		Loan from Facility	34/B4	204,044	204,044
Due to CH Realty	3396 East Main St., Waterbury, CT 06705		X		Loan from Facility	34/B4	5,529,213	5,529,213

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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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 (*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.

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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
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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
Wells Fargo	○	⊙	Copy Machines				7,484
BBI Technologies	○	⊙	Copy Machines				5,670
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
Is a Mileage Log Book Maintained for All Leased Vehicles ?		○ Yes	⊙ No			**Total** ***	13,154

* 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.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabil	2141c	9/30/2019	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 Marcum LLP	555 Long Wharf Drive, New Haven, CT 06511
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Corp tax returns, Annual review of the financial statements.	$ 12,358
2		$
3		$
4		$
		Charge for Services Provided $ 12,358

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

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 See Attached	
2	
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)
1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1		$
2		$
3		$
4		$
5		$
		Charge for Services Provided $

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

Cheshire House
Legal Fees
9/30/2019

Vendor	Description	Amount	Allowable Yes	Allowable No
American Arbitration	Arbitrator's Compensation	$ 21.43		$ 21.43
Murtha Cullina	General Consultation	144.00	144.00	
Charlyse Robinson/Perkins & Assoc	Settlement	4,500.00		4,500.00
Jackson Lewis	General Consultation	121.90	121.90	
Joe D'Agostino	Various Matter	10,712.18		10,712.18
Kainen , Escalera & McHale	General Consultation	20,020.14	1,318.50	18,701.64
American Express	ERISA Paperwork	36.00	36.00	
Seiger Gfeller Laurie, LLP	Collections	1,212.49		1,212.49
Carmody Torrance	Partners Pharmacy	627.80		627.80
Total		$ 37,395.94	$ 1,620.40	$ 35,775.54

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	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	75	75			75	75			75	75		
B. On last day of THIS report period	75	75			75	75			75	75		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	63	63			63	63			63	63		
B. As of midnight of THIS report period	71	71			63	63			71	71		
3. Total Number of Days Care Provided During Period												
A. Medicare	5,579	5,579			3,789	3,789			1,790	1,790		
B. Medicaid (Conn.)	10,589	10,589			8,078	8,078			2,511	2,511		
C. Medicaid (other states)												
D. Private Pay	3,396	3,396			2,444	2,444			952	952		
E. State SSI for RCH												
F. Other (Specify)	5,015	5,015			3,873	3,873			1,142	1,142		
G. Total Care Days During Period (3A thru F)	24,579	24,579			18,184	18,184			6,395	6,395		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	179	179			98	98			81	81		
B. Other Bed Reserve Days	53	53			42	42			11	11		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	24,811	24,811			18,324	18,324			6,487	6,487		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Cen	2141c	9/30/2019	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	18	26		27				
Per Diem Rate								
a. One bed rm.	RUGS	259.43		$520 - $393				
b. Two bed rms.								
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	2,133	2,133		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	24,422	24,422		
D. ***Total Physical Therapy Treatments***	26,555	26,555		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	324	324		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	1,631	1,631		
D. ***Total Speech Therapy Treatments***	1,955	1,955		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,783	1,783		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	23,626	23,626		
D. ***Total Occupational Therapy Treatments***	25,409	25,409		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2019	10	37

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	128,170	2,135				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	274,159	13,136				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	56,846	2,192				
c. Dietary Workers	260,482	20,244				
6. Housekeeping Service						
a. Head Housekeeper	26,965					
b. Other Housekeeping Workers	171,890	13,651				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	34,297	1,174				
b. Other Maintenance Workers	101,263	5,363				
8. Laundry Service						
a. Supervisor	33,288	2,135				
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	120,146	2,431				
b. RN						
1. Direct Care	865,593	22,566				
2. Administrative**	245,805	6,278				
c. LPN						
1. Direct Care	792,129	26,121				
2. Administrative**						
d. Aides and Attendants	1,155,104	78,414				
e. Physical Therapists	464,330	12,112				
f. Speech Therapists	80,484	1,597				
g. Occupational Therapists	327,604	8,632				
h. Recreation Workers	108,577	5,318				
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	234,098	8,036				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	59,029	2,682				
A-13. Total Salary Expenditures	5,540,260	234,216				

* 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**
Medical Records	$ 35,158	2,044				
Respiratory Therapy Wages	$ 23,871	638				
Total	$ 59,029	2,682	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Rehab Management Fee	$ 27,152					
Miranda Kilham - MDS Consultant	$ 1,080					
Managed Care Consultant	$ 774					
MDS Consultant	$ 162					
Harmony Healthcare	$ (3,746)					
Total	$ 25,421	-	$ -	-	$ -	-

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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
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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										
Martin Sbriglio, RN, NHA								Ryders Health Management, 88 Ryders Lane, Stratford, CT 06614	2,284	130,000
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.

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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
Cheshire House Nursing & Rehabilitation Center	2141c	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* **										
David Sones 10/1/18 - 2/16/19	54,101			Non Discriminatory	Administrative Oversight	910	A2			
Courtney Young 2/11/19 - 9/30/19	74,069			Non Discriminatory	Administrative Oversight	1,225	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.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2019	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	53,426					
2. Dentist	8,493					
3. Pharmacist	6,906					
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	946					
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	76,400					
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)						
Medical Staff	1,300	13				
9. Speech Therapist						
a. Resident Care	151					
b. Other						
10. Occupational Therapist						
a. Resident Care	138,877					
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	25,421					
B-13 Total Fees Paid in Lieu of Salaries	311,919	13				

* 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.

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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
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2019	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Healthdrive Dental Group, 888 Worcester St., Wellesley, MA 02482	Dental Consultant	○	⊙	
Elizabeth Beisel, 72 Basswood Road, Farmington, CT 06032	Dietician Consultant	○	⊙	
ValueRx	Pharmacy Consultant	⊙	○	Common Ownership
Dr. Peter Giacomazzi, 509 Wolcott Road, Wolcott, CT 06716	Medical Staff	○	⊙	
Dr. George Barchini, 19 Waterbury Road, Thomaston, CT 06787	Medical Staff	○	⊙	
HealthPro, 307 International Circle, Suite 100, Hunt Valley, MD 21030	Rehab Consultant, PT, ST OT	○	⊙	
Miranda Kilham	MDS Consultant	○	⊙	
LP Consulting	Managed Care Consulting	○	⊙	
Celtic Consulting	MDS Consultant	○	⊙	
Harmony Healthcar	PY Expense Reversed	○	⊙	
Deepinder Osahan MD	Medical Staff	○	⊙	
Edmund Quinn	Medical Staff	○	⊙	
He Zhang MD	Medical Staff	○	⊙	
Neil Miller MD	Medical Staff	○	⊙	
Franklin Medical Group	Medical Director	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2019	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	218,679	218,679		
2. Disability Insurance	$				
3. Unemployment Insurance	$				
4. Social Security (F.I.C.A.)	$	467,907	467,907		
5. Health Insurance	$	429,949	429,949		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	(2,686)	(2,686)		
(not-owners and not-operators)					
8. Uniform Allowance	$	23,167	23,167		
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and	$				
Profit Sharing Plans for Owners and					
Operators (Discriminatory)*					
c. Bad Debts*	$	114,485	114,485		
d. Accounting and Auditing	$	12,358	12,358		
e. Legal (*Services should be fully described on Page 7)*	$	37,396	37,396		
f. Insurance on Lives of Owners and	$				
Operators (*Specify*)*					
g. Office Supplies	$	22,318	22,318		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	15,546	15,546		
2. Cellular Phones	$	2,344	2,344		
i. Appraisal (*Specify purpose and*	$				
attach copy)*					
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	314,697	314,697		
Subtotal	$	1,656,159	1,656,159		

* 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)
Total	$ -	$ -	$ -

Schedule of Other Taxes

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

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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
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2019	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,656,159	1,656,159		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	12,524	12,524		
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	1,043	1,043		
5. Education Expenses Related to Seminars and Conventions	$	7,994	7,994		
6. Automobile Expense (*not purchase or depreciation*)	$	1,725	1,725		
7. Other (*Specify*)	$	861	861		
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	4,124	4,124		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	22,538	22,538		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$	10,800	10,800		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	5,389	5,389		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	5,736	5,736		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	930	930		
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)*	$	81,210	81,210		
12. Administrative Management Services**	$	292,118	292,118		
13. Other (*Specify*) See Attached Schedule	$	39,036	39,036		
C-14 Total Administrative & General Expenditures	$	2,142,185	2,142,185		

* 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)
Meals & Entertainment	$ 861		
Total Other Travel and Entertainment	$ 861	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Adv & Pub Rel Donations	$ 22,483		
Charitable Donations	$ 56		
Total Other Advertising	$ 22,538	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 5,672		
American Express	$ 63		
Total Dues	$ 5,736	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Fees & License	$ 2,853		
Physician Care - Employees	$ 21,403		
Bank Charges	$ 12,922		
Bank Charges - Lease	$ 484		
Unemployment Tax Management	$ 1,374		
Total Other Administrative and General	$ 39,036	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
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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 #
Ryders Health Management, 88 Ryders Lane, Suite 208, Stratford, CT 06614	292,118	Financial and Managerial Services	16m12

*** 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.**

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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
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2019	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	152,307	152,307		
2. Non-Food Supplies	$	17,083	17,083		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	169,390	169,390		

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?	○ Yes	⊙ No	
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 meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	○ Yes	⊙ No	If yes, specify cost.
K.	Is any revenue collected from these people?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
N.	Is any revenue collected from employees?	○ Yes	⊙ 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.

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CSP-19 Rev. 9/2018

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
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2019	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	5,725	5,725		
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $				
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	57	57		
c. Other (*Specify*) Laundry Supplies	$	3,423	3,423		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	9,204	9,204		

3E.	Laundry Questionnaire			
F.	Is cost of employee laundry included in 3D?	○ Yes	⊙ No	If yes, specify cost.
G.	Did you receive revenue from employees?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
J.	Did you receive revenue from these people?	○ Yes	⊙ 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.

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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
Cheshire House Nursing & Rehabilitation Cent	2141c	9/30/2019	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.	$				
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$				
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	353,471	353,471		
b. Medicine Cabinet Drugs		$	29,379	29,379		
c. Medical and Therapeutic Supplies		$				
d. Ambulance/Limousine***		$	3,525	3,525		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	51,088	51,088		
f. X-rays and Related Radiological Procedures***		$	22,021	22,021		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	66,893	66,893		
i. Recreation		$	26,962	26,962		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	218,651	218,651		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	771,989	771,989		

* 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)
Physician Care - Patients	$ 33,357		
Medical Supplies	$ 136,311		
Medical Supplements	$ 9,086		
Medical Waste	$ 7,058		
Medical Equipment	$ 2,553		
Medical Equipment - Rental	$ 7,048		
PT Supplies	$ 23,237		
Total Other Resident Care	$ 218,651	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2019	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
ADP	1 ADP Plaza, Milford, CT 06460	○	⊙		Payroll Service	13,558			16	m11
Point Click Care	Unit 4, Mississauga, ON	○	⊙		Software Services	20,899			16	m11
Environmental Systems Corporation	18 Jansen Court, West Hartford, CT 06110	○	⊙		HVAC Servicing	19,341			22	226c
USA Waste & Recycling		○	⊙		Garbage Disposal	22,125				
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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).

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

Name of Facility	License No.	Report for Year Ended	Page of
Cheshire House Nursing & Rehabilitation Cen	2141c	9/30/2019	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	160,988	160,988		
b. Heat	$	6,547	6,547		
c. Light & Power	$	104,152	104,152		
d. Water	$	15,521	15,521		
e. Equipment Lease (*Provide detail on page 6*)	$	13,154	13,154		
f. Other (*itemize*)	$				
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	300,362	300,362		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	200,524	200,524		
b. Building & Building Improvements	$	9,741	9,741		
c. Non-Movable Equipment	$	36,989	36,989		
d. Movable Equipment	$	46,885	46,885		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	294,139	294,139		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$				
9. Rental payments on leased real property less real estate taxes included in item 10b	$	360,000	360,000		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	146,859	146,859		
c. Personal property taxes	$	21,325	21,325		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	822,323	822,323		

* 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)
Total Other Repairs and Maintenance	$ -	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2019	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	385,350		385,350	247,469	S/L	Various		
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	7,373,430		7,373,430	1,817,053	S/L	Various		
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	112,340							
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	473,205		473,205	364,873	S/L	Various		
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	33,700							
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. Jeep		X	12	1995	22,963		22,963	22,963	200/db	5 Years		
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					1,006,348		1,006,348	852,033	Various	Various		
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					31,980							
D-3. Subtotal												
E. ***Total Depreciation***												

Schedule of Land Improvements Acquired during this report period

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

***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:		$ 34,032			
11/12/2018	Remodel Resident Rooms	$ 9,465			
11/12/2018	Repair Walls in Basement	$ 1,064			
12/4/2018	Painting	$ 2,552			
10/1/2018	Basement Project	$ 638			
1/31/2019	Flooring	$ 1,226			
3/5/2019	Flooring	$ 1,531			
3/11/2019	Sheetrock Walls & Painting	$ 1,170			
3/20/2019	Flooring	$ 904			
3/29/2019	Wall Covering	$ 35,361			
4/18/2019	Room Remodel	$ 10,550			
5/20/2019	Flooring	$ 8,200			
5/9/2019	Wall Covering	$ 5,802			
5/9/2019	Overbed Lighting	$ (155)			
8/31/2019	Room Remodel				
Total additions for Building Improvement		$ 112,340		$ -	*
Deletions:					
Total deletions for Building Improvement		$ -		$ -	**

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

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

Schedule of Non-Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
1/14/2019	Access Door	$ 1,574		
2/11/2019	Sprinkler Heads	$ 24,342		
3/15/2019	Heat Seal Machine	$ 3,083		
5/23/2019	Compressor	$ 2,704		
7/24/2019	Generator	$ (3,619)		
9/30/2019	Compressor	5615.28		

Total additions for Non-Movable Equipmen		$ 33,700		$ -	*
Deletions:					
Total deletions for Non-Movable Equipmen		$ -		$ -	**

ttachment Pages 23 24

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

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

Schedule of Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/30/2018	Hoyer Lifts	$ 19,551			
3/5/2019	Chair Recliners	$ 3,548			
5/20/2019	Foot & Leg Rests	$ 872			
5/17/2019	TV	$ 346			
5/31/2019	Beds	$ 3,178			
8/29/2019	Refridgerator	$ 1,303			
6/17/2019	Beds	$ 3,183			
Total additions for Movable Equipmen		$ 31,980		$ -	*
Deletions:					
Total deletions for Movable Equipmen		$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report peri

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

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
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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. Covenants not to Compete	3	94	15 Years	70,563	70,000				
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									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									

* 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitat	2141c	9/30/2019	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	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	03/01/94
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	75
6. Square Footage	23,431
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)	Fixed	Fixed		
b. Date Mortgage Obtained	10/26/05	05/01/12		
c. Interest Rate for the Cost Year	400.00%	400.00%		
d. Term of Mortgage (number of years)	12	5		
e. Amount of Principal Borrowed	2,189,859	4,731,035		
f. Principal balance outstanding as of 9/30/2019				
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.

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

Name of Facility	License No.	Report for Year Ended	Page of
Cheshire House Nursing & Rehabilita	2141c	9/30/2019	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*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Cheshire House Nursing & Rehabili	2141c	9/30/2019	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*) $	36,755	36,755		
Interest Expense				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	36,755	36,755		
14. Insurance				
a. Insurance on Property (buildings only) $	13,088	13,088		
b. Insurance on Automobiles $	1,650	1,650		
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	48,474	48,474		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	63,212	63,212		
15. ***Total All Expenditures (A-13 thru C-14)*** $	10,167,600	10,167,600		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2019	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.	10	12g	Occupational Therapy $	327,604	327,604		
4.			Other - See attached Schedule $	23,871	23,871		
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	b10	Occupational Therapy $	138,877	138,877		
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	114,485	114,485		
10.			Accounting $				
10a.			Legal $	35,776	35,776		
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 * $	22,538	22,538		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	1,791	1,791		
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) $	664,942	664,942		

* 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	12o	Respiratory Therapy Wages	$ 23,871		
Total Other Salaries Adjustment			$ 23,871	$ -	$ -

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	l7	Meals & Entertainment	$ 861		
16	m8a	Chamber of Commerce	$ 930		
Total Other A&G Adjustments			$ 1,791	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2019	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	664,942	664,942		
Page 20 - Resident Care Supplies***								
27.	20	5a1	Prescription Drugs	$	353,471	353,471		
28.	20	5d	Ambulance/Limousine	$	3,525	3,525		
29.	20	5f	X-rays, etc	$	22,021	22,021		
30.	20	5h	Laboratory	$	66,893	66,893		
31.			Medical Supplies	$				
32.	20	500	Oxygen (non emergency)	$	51,088	51,088		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$				
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.			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)***			$	1,161,940	1,161,940		

*** 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

Schedule of Other Ancillary Costs

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

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 - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)

Total Other Adjustments			$ -	$ -	$ -

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct 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			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation	2141c	9/30/2019	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	3,389,563	3,389,563		
b. Medicaid Room and Board Contractual Allowance **	$	(1,165,695)	(1,165,695)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	2,535,164	2,535,164		
b. Medicare Room and Board Contractual Allowance **	$	946,581	946,581		
4. a. Private-Pay Residents and Other	$	4,306,659	4,306,659		
b. Private-Pay Room and Board Contractual Allowance **	$	(1,156,733)	(1,156,733)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	217,723	217,723		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(217,723)	(217,723)		
c. Prescription Drugs - Non-Medicare	$	154,541	154,541		
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	$	515,165	515,165		
b. Physical Therapy - Medicare Contractual Allowance **	$	(515,165)	(515,165)		
c. Physical Therapy - Non-Medicare	$	420,520	420,520		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	84,669	84,669		
b. Speech Therapy - Medicare Contractual Allowance **	$	(84,669)	(84,669)		
c. Speech Therapy - Non-Medicare	$	83,638	83,638		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	561,880	561,880		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(561,880)	(561,880)		
c. Occupational Therapy - Non-Medicare	$	391,800	391,800		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	(0)	(0)		
b. Other *(Specify)* - Non-Medicare	$	46,112	46,112		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	9,952,151	9,952,151		
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)*	$	1	1		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	9,384	9,384		
V. Total Other Revenue (1 thru 8)	$	9,386	9,386		
VI. Total All Revenue (III +V)	$	9,961,536	9,961,536		

* *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	$ 12,171		
	X-Ray - Medicare	$ 17,712		
	Lab - Medicare	$ 51,586		
	Contractuals	$ (81,470)		
Total Other Resident Revenue - Medicare		$ (0)	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Remedy Shared Savings	$ 23,000		
	X-Ray Managed Care	$ 5,418		
	Oxygen Managed Care	$ 5,329		
	lab Managed Care	$ 12,365		
Total Other Resident Revenue		$ 46,112	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Income		$ 1		
Total Interest Income			$ 1	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Café Income	$ 9,384		
Total Other Revenue		$ 9,384	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitatic	2141c	9/30/2019	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ (26,543)
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,404,069
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 3,865
a. Prepaid Expenses		3,865		
b.				
c.				
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 253,204
Loans & Exchanges		(5,086)		
Prepaid Insurance		3,666		
Refunds & 15 Bed Purchase		254,624		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,634,595
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	385,350		$ 306,842
	Accum. Depreciation	78,508	Net	
3. Buildings	*Historical Cost	7,485,770		$ 5,299,879
	Accum. Depreciation	2,185,891	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	516,439		$ 105,187
	Accum. Depreciation	411,252	Net	
6. Movable Equipment	*Historical Cost	1,035,809		$ 135,895
	Accum. Depreciation	899,915	Net	
7. Motor Vehicles	*Historical Cost	22,963		$
	Accum. Depreciation	22,963	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 5,847,803

* 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

Page Ref	Line Ref	Description	
Total Prepaid Expenses			$ -

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Due from Greentree Mano	$ 170,324
		Due from Mystic Healthcare	$ 113,999
		Due from DM Realty	$ 10,000
		Due from Lighthouse	$ 4,000
Total Other Assets			$ 298,323

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	
		Due to Aaron Manor	$ 153,886
		Due to Bel-Air Manor	$ 288,394
		Due to Chamberlain Manor	$ 1,084,129
		Due to Douglas Manor	166863.2
		Due to Lord Chamberlain	204043.61
		Due to CH Realty	5529213.39
Total Other Current Liabilities (Itemize)			$ 7,426,528

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitati	2141c	9/30/2019	32	37

Account				Amount
			Total Brought Forward:	$ 7,482,398
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost	5,563		
	Accum. Depreciation		Net	$ 5,563
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*)				$ 298,323
See Schedule		298,323		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 303,885
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 7,786,283

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Cen	2141c	9/30/2019	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 1,067,327
2. Notes Payable (*itemize*)					$
See Schedule					
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*)					$ 142,446
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$
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*)					$ 207,922
Patient Fund	12,446	Accrued PTO	100,482		
Accrued Expenses	15,523				
Accrued User Fee	57,187				
AFLAC - Individual	22,283	See Schedule			
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 1,417,694

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Ce	2141c	9/30/2019	34	37

Account	Amount
Total Brought Forward:	1,417,694
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ 7,426,528
See Schedule	7,426,528	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 7,426,528
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 8,844,223

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

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitati	2141c	9/30/2019	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*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	$
B.	**Net Worth**	
	1. Owner's Capital	$ (89,373)
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (762,504)
	6. Gain or Loss for Period 10/1/2018 thru 9/30/2019	$ (206,063)
	7. Total Net Worth	$ (1,057,940)
C.	***Total Reserves and Net Worth***	$ (1,057,940)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 7,786,283

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitatio	2141c	9/30/2019	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2018			$
B.	Total Revenue (*From Statement of Revenue Page 30*)			$
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$
D.	Net Income or Deficit			$
E.	Balance			$
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*** 09/30/19			$

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation	2141c	9/30/2019	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. 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
Ryders Health Management

Addres Address	Phone Number
88 Ryders Lane, Suite 208, Stratford, CT 06614	203-381-1381

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Elizabeth Maglio	203-381-1381

Contact Email Address
emaglio@rydershealth.com