State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2020

Name of Facility (as licensed) Cheshire House Nursing & Rehabiliation 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 10/201/2019	Report for Year Ending 9/30/2020

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 & Rehabiliation Center	2141c	9/30/2020	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 & Rehabiliation Center [facility name], for the cost report period beginning 10/201/2019 and ending September 30, 2020, 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) Nicole Lewis			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 & Rehabiliation Center	Period Covered:		From 10/201/201	To 9/30/2020
Address of Facility 3396 East Main St., Waterbury, CT 06705				
Report Prepared By Ryders Health Management	Phone Number 203-381-1327		Date 11/19/2019	

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
203-381-1327	9/30/2020	2	37

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

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	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.:	
Nicole Lewis		2125

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
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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 & Rehabiliation Cen	2141c	9/30/2020	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 & Rehabiliation Center	2141c	9/30/2020	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.

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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				6,816
BBI Technologies	○	⊙	Copy Machines				7,741
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
						Total ***	14,557

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No

* 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	9/30/2020	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	$ 9,594
2		$
3		$
4		$
		Charge for Services Provided $ 9,594

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

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Schedule of Resident Statistics

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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						
B. On last day of THIS report period	75	75							75	75		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	71	71			71	71						
B. As of midnight of THIS report period	63	63							63	63		
3. Total Number of Days Care Provided During Period												
A. Medicare	5,902	5,902			4,531	4,531			1,371	1,371		
B. Medicaid (Conn.)	9,350	9,350			7,527	7,527			1,823	1,823		
C. Medicaid (other states)												
D. Private Pay	2,422	2,422			1,509	1,509			913	913		
E. State SSI for RCH												
F. Other (Specify)	4,643	4,643			3,350	3,350			1,293	1,293		
G. Total Care Days During Period (3A thru F)	22,317	22,317			16,917	16,917			5,400	5,400		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	152	152			135	135			17	17		
B. Other Bed Reserve Days	80	80			72	72			8	8		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	22,549	22,549			17,124	17,124			5,425	5,425		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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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	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	13	22		28				
Per Diem Rate								
a. One bed rm.	Various			520 - 430				
b. Two bed rms.		260.13		501 - 393				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	1,913	1,913		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	17,727	17,727		
D. ***Total Physical Therapy Treatments***	19,640	19,640		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	235	235		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	1,825	1,825		
D. ***Total Speech Therapy Treatments***	2,060	2,060		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,842	1,842		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	17,743	17,743		
D. ***Total Occupational Therapy Treatments***	19,585	19,585		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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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)	110,313	2,096				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	212,673	9,166				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	63,921	2,148				
c. Dietary Workers	251,604	18,024				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	176,777	10,993				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	59,743	1,946				
b. Other Maintenance Workers	44,114	2,238				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	73,325	4,550				
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	96,018	2,039				
b. RN						
1. Direct Care	882,826	20,429				
2. Administrative**	275,340	2,293				
c. LPN						
1. Direct Care	838,556	30,262				
2. Administrative**						
d. Aides and Attendants	1,108,097	62,186				
e. Physical Therapists	393,649	10,103				
f. Speech Therapists	89,831	1,899				
g. Occupational Therapists	295,702	8,165				
h. Recreation Workers	98,485	4,302				
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	245,210	8,455				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	74,469	3,099				
A-13. Total Salary Expenditures	5,390,652	204,393				

* 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	$ 37,034	2,115				
Respiratory Therapy	$ 37,435	984				
Total	$ 74,469	3,099	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Rehab Management Fee	$ 44,132	588				
Infection Control Consulting	$ 12,342	82				
PDPM Consulting	$ 1,323	9				
Total	$ 57,797	679	$ -	-	$ -	-

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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	2,970	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).										
Margaret Sbrilglio								Ryders Health Management, 88 Ryders Lane, Stratford, CT 06614	1,040	26,000

* 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
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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 III - Administrators* **										
Courtney Young 10/1/2019 - 12/24/2019	26,479			Non Discriminatory	Administrative Oversight	423	A2			
David Desell 12/30/2019 - 7/5/2020	59,303			Non Discriminatory	Administrative Oversight	1,139	A2			
Nicole Lewis 6/22/20 - 9/30/20	24,531			Non Discriminatory	Administrative Oversight	534	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 & Rehabiliation Center	2141c	9/30/2020	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	45,624	912				
2. Dentist	9,975	67				
3. Pharmacist	4,681	94				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	84,300	562				
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	300	3				
9. Speech Therapist						
a. Resident Care	1,035	14				
b. Other						
10. Occupational Therapist						
a. Resident Care	93,821	1,251				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	10,000					
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	57,797	679				
B-13 Total Fees Paid in Lieu of Salaries	307,533	3,582				

* 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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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 & Rehabiliation Center	2141c	9/30/2020	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 Meisel, 72 Basswood Road, Farmington, CT 06032	Dietician Consultant	○	⊙	
ValueRx	Pharmacy Consultant	⊙	○	Common Ownership
Dr. Peter Giacomazzi, 509 Wolcott Rd, Wolcott, CT 06716	Medical Staff	○	⊙	
Dr. George Barchini, 19 Waterbury Rd, Thomaston, CT 06787	Medical Staff	○	⊙	
HealthPro, 307 International Circle, Sutie 100, Hunt Valley, MD 21030	Rehab Consultant, PT, ST, OT	○	⊙	
Dedicated Nursing	Nurse Pool	○	⊙	
Celtic Consulting	PDPM Consulting	○	⊙	
Deepinder Osahan MD	Medical Staff	○	⊙	
Edmund Quinn	Medical Staff	○	⊙	
He Zhang MD	Medical Staff	○	⊙	
Neil Miller MD	Medical Staff	○	⊙	
Franklin Medical Group	Medical Director	○	⊙	
Karen Tayol Healthcare	Infection Control Consulting	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

* 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 & Rehabiliation Center	2141c	9/30/2020	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	162,947	162,947		
2. Disability Insurance	$				
3. Unemployment Insurance	$				
4. Social Security (F.I.C.A.)	$	458,702	458,702		
5. Health Insurance	$	398,018	398,018		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	5,338	5,338		
(not-owners and not-operators)					
8. Uniform Allowance	$	22,055	22,055		
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	169,078	169,078		
d. Accounting and Auditing	$	9,594	9,594		
e. Legal (*Services should be fully described on Page 7)*	$	21,803	21,803		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	12,657	12,657		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	13,861	13,861		
2. Cellular Phones	$	2,957	2,957		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$	250	250		
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	264,053	264,053		
Subtotal	$	1,541,312	1,541,312		

* 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 & Rehabiliation Center	2141c	9/30/2020	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,541,312	1,541,312		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	7,314	7,314		
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	1,106	1,106		
5. Education Expenses Related to Seminars and Conventions	$	3,939	3,939		
6. Automobile Expense (*not purchase or depreciation*)	$	974	974		
7. Other (*Specify*)	$	974	974		
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	2,652	2,652		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	5,543	5,543		
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	$	4,431	4,431		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	6,107	6,107		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	865	865		
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)*	$	71,765	71,765		
12. Administrative Management Services**	$	304,629	304,629		
13. Other (*Specify*) See Attached Schedule	$	34,919	34,919		
C-14 Total Administrative & General Expenditures	$	1,997,329	1,997,329		

* 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	$ 974		
Total Other Travel and Entertainment	$ 974	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Adv & Pub Relations	$ 5,543		
Total Other Advertising	$ 5,543	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 5,264		
American Express	$ 93		
AHCA	$ 750		
Total Dues	$ 6,107	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Physician Care - Employees	$ 16,177		
Bank Charges	$ 15,230		
Bank Charges - Lease	$ 484		
Unemployment Tax Management	$ 1,374		
Salon License	$ 100		
Pool License	$ 200		
Food License	$ 100		
Facility License	$ 815		
CLIA Lab Program	$ 180		
Annual Report	$ 20		
Elevator License	$ 240		
Total Other Administrative and General	$ 34,919		
		$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Cheshire House Nursing & Rehabiliation	2141c	9/30/2020	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 #
Ryders Health Management, 88 Ryders Lane, Sutie 208, Stratford, CT 06614	304,629	Financial and Managerial Services	

*** 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 & Rehabiliation Center	2141c	9/30/2020	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	141,902	141,902		
2. Non-Food Supplies	$	16,648	16,648		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____ Dietary Equipment	$	472	472		
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	159,022	159,022		

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 & Rehabiliation Center	2141c	9/30/2020	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. $	5,381	5,381		
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)*	$				
c. Other (*Specify*) Laundry Supplies	$	3,084	3,084		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	8,465	8,465		

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 & Rehabiliation Cente	2141c	9/30/2020	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.	$	38,049	38,049		
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)		$	38,049	38,049		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from ValueRx		$	294,015	294,015		
b. Medicine Cabinet Drugs		$	42,649	42,649		
c. Medical and Therapeutic Supplies		$				
d. Ambulance/Limousine***		$	2,827	2,827		
e. Oxygen						
1. For Emergency Use		$	47,612	47,612		
2. Other***		$				
f. X-rays and Related Radiological Procedures***		$	22,453	22,453		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	51,545	51,545		
i. Recreation		$	17,607	17,607		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	204,534	204,534		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	683,242	683,242		

* 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	$ (4,875)		
Medical Supplies	$ 167,135		
Medical Supplements	$ 8,715		
Medical Waste	$ 245		
Medical Equipment -Rental	$ 11,004		
Medical Supplies - Medicare	$ (616)		
PT Supplies	$ 22,926		
Total Other Resident Care	$ 204,534	$ -	$ -

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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 & Rehabiliation Center	2141c	9/30/2020	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		27,479			16	m11
Point Click Care	Unit 4, Mississauga, ON	○	⊙	Software Services		32,362			16	m11
USA Waste & Recycling		○	⊙	Garbage Disposal		23,559			22	6c
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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 & Rehabiliation Cent	2141c	9/30/2020			22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	223,648	223,648		
b. Heat	$	11,805	11,805		
c. Light & Power	$	100,265	100,265		
d. Water	$	23,816	23,816		
e. Equipment Lease (*Provide detail on page 6*)	$	15,492	15,492		
f. Other (*itemize*)	$				
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	375,026	375,026		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	10,014	10,014		
b. Building & Building Improvements	$	203,076	203,076		
c. Non-Movable Equipment	$	23,716	23,716		
d. Movable Equipment	$	46,949	46,949		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	283,755	283,755		
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	$	21,457	21,457		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	812,071	812,071		

* 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 & Rehabiliation Center	2141c	9/30/2020	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		S/L	Various		
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	51,067							
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	7,485,770		7,485,770		S/L	Various		
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	506,905		506,905		S/L	Various		
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	5,283							
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					1,038,328		1,038,328		Various	Various		
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					34,290							
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:					
7/1/2020	Paving and Line Striping	$ 42,638			
7/23/2020	Landscaping - Trees/Bushes/Gravel	$ 8,429			
Total additions for Land Improvement		$ 51,067		$ -	*
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:					
Total additions for Building Improvement		$ -		$ -	*
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:					
4/13/2020	Hot Water Storage Tank	$ 3,790			
9/4/2020	Generator Speed Sensor	$ 1,493			
Total additions for Non-Movable Equipmen		$ 5,283		$ -	*
Deletions:					
Total deletions for Non-Movable Equipmen		$ -		$ -	**

***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:					
1/17/2020	Computers	$ 3,669			
6/20/2020	12 Step on Cans	$ 2,996			
6/26/2020	Wet/Dry Vac	1979.12			
6/30/2020	Floor Machine	1304.62			
9/1/2020	Nurse Call System	23250			
9/30/2020	Thermal Printer	1091.39			
Total additions for Movable Equipmen		$ 34,290		$ -	*
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
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11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	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			
b. Date Mortgage Obtained	09/20/17			
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)	10			
e. Amount of Principal Borrowed	5,334,405			
f. Principal balance outstanding as of 9/30/2020	4,761,451			
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 & Rehabiliat	2141c	9/30/2020	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	9/30/2020	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*) $	112,227	112,227		
Interest Expense & Finance Charges				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	112,227	112,227		
14. Insurance				
a. Insurance on Property (buildings only) $	14,386	14,386		
b. Insurance on Automobiles $	1,892	1,892		
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	54,700	54,700		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	70,978	70,978		
15. ***Total All Expenditures (A-13 thru C-14)*** $	9,954,595	9,954,595		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Cheshire House Nursing & Rehabiliation Center	2141c	9/30/2020	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	A12g	Occupational Therapy $	295,702	295,702		
4.			Other - See attached Schedule $	37,435	37,435		
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	B10a	Occupational Therapy $	93,821	93,821		
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	147,078	147,078		
10.			Accounting $				
10a.			Legal $	17,647	17,647		
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.	16	L7	Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $	974	974		
17.			Automobile Expense (e.g. personal use) $				
18.	16	m3	Unallowable Advertising * $	5,543	5,543		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	865	865		
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) $	599,065	599,065		

* 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 Salaries	$ 37,435		
Total Other Salaries Adjustment			$ 37,435	$ -	$ -

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	m8	Chambe of Commerce	$ 865		
Total Other A&G Adjustments			$ 865	$ -	$ -

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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 & Rehabiliation Center	2141c	9/30/2020	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	599,065	599,065		
Page 20 - Resident Care Supplies***								
27.			Prescription Drugs	$				
28.	20	5d	Ambulance/Limousine	$	2,827	2,827		
29.	20	5f	X-rays, etc	$	22,453	22,453		
30.	20	5h	Laboratory	$	51,545	51,545		
31.			Medical Supplies	$				
32.	20	50	Oxygen (non emergency)	$	47,612	47,612		
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)***			$	723,502	723,502		

*** 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 & Rehabiliation	2141c	9/30/2020	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	3,519,074	3,519,074		
b. Medicaid Room and Board Contractual Allowance **	$	(1,106,864)	(1,106,864)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	2,704,541	2,704,541		
b. Medicare Room and Board Contractual Allowance **	$	1,045,787	1,045,787		
4. a. Private-Pay Residents and Other	$	3,218,572	3,218,572		
b. Private-Pay Room and Board Contractual Allowance **	$	(871,378)	(871,378)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	319,787	319,787		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(319,787)	(319,787)		
c. Prescription Drugs - Non-Medicare	$	38,574	38,574		
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	$	366,816	366,816		
b. Physical Therapy - Medicare Contractual Allowance **	$	(366,816)	(366,816)		
c. Physical Therapy - Non-Medicare	$	339,768	339,768		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	109,371	109,371		
b. Speech Therapy - Medicare Contractual Allowance **	$	(109,371)	(109,371)		
c. Speech Therapy - Non-Medicare	$	79,368	79,368		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	383,285	383,285		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(383,285)	(383,285)		
c. Occupational Therapy - Non-Medicare	$	352,426	352,426		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	(0)	(0)		
b. Other *(Specify)* - Non-Medicare	$	49,663	49,663		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	9,369,529	9,369,529		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	650	650		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	788	788		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$				
V. Total Other Revenue (1 thru 8)	$	1,438	1,438		
VI. Total All Revenue (III +V)	$	9,370,968	9,370,968		

* *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	$ 16,208		
	X-Ray - Medicare A	$ 21,615		
	Lab - Medicare A	$ 44,559		
	Contractuals - Medicare A	$ (82,382)		
Total Other Resident Revenue - Medicare		$ (0)	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Remedy Shared Savings	$ 47,715		
	X-Ray - Managed Care	$ 838		
	Oxygen - Managed Care	$ 158		
	Lab - Managed Care	$ 953		
Total Other Resident Revenue		$ 49,663	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Income		$ 788		
Total Interest Income			$ 788	$ -	$ -

Schedule of Other Revenue

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

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabiliatio	2141c	9/30/2020	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 1,654,959
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,158,484
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 71,002
a. Prepaid Expenses		69,773		
b. Prepaid Insurance		2,530		
c. Refunds		(1,301)		
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ (1,171,423)
Medicaid Adv $136,711 Medicare Adv $683K		(819,711)		
Loans & Exchanges		(600,239)		
15 Bed Purchase		248,527		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,713,022
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	427,988		$ 339,466
	Accum. Depreciation	88,522	Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	7,485,770		$ 5,096,803
	Accum. Depreciation	2,388,967	Net	
5. Non-Movable Equipment	*Historical Cost	521,722		$ 86,754
	Accum. Depreciation	434,968	Net	
6. Movable Equipment	*Historical Cost	1,063,819		$ 116,956
	Accum. Depreciation	946,863	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)				$ 5,639,979

* 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 Lighthouse Home Care	$ 7,900
		Due from Lighthouse Home Healthcare	$ 15,000
Total Other Assets			$ 22,900

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 Chamberlain Manor	$ 1,146,129
		Due to Lord Chamberlain	$ 53,034
		Due to CH Realty	$ 5,445,714
		Due to DM Realty	13000
Total Other Current Liabilities (Itemize)			$ 6,657,877

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabiliatio	2141c	9/30/2020	32	37

	Account				Amount
			Total Brought Forward:		$ 7,353,001
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	75,563		
		Accum. Depreciation	70,000	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*)				$ 348,590
	Due from Greentree Manor		138,594		
	Due from Mystic Healthcare		187,096		
	See Schedule		22,900		
D-8.	***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 354,152
D-9.	***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 7,707,153

* 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 & Rehabiliation Cent	2141c	9/30/2020	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 613,876
2. Notes Payable (*itemize*)					$ 1,105,550
Note Payable - HealthPro			31,503		
Note Payable - ServPro			60,547		
PPP Loan			1,013,500		
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*)					$ 152,539
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*)					$ 388,091
Patient Fund	20,291	Accrued PTO	92,315		
Accrued Expenses	29,126				
Accrued User Fee	223,487				
AFLAC - Individual	22,872	See Schedule			
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 2,260,055

* 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 & Rehabiliation Ce	2141c	9/30/2020	34	37

Account	Amount
Total Brought Forward:	2,260,055
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*)		$ 7,101,664
Due to M. Sbriglio	35,600	
Due to Aaron Manor	143,364	
Due to Bel-Air Manor	264,822	
See Schedule	6,657,877	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 7,101,664
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 9,361,719

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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 & Rehabiliatic	2141c	9/30/2020	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	$ (981,567)
	6. Gain or Loss for Period 10/201/2019 thru 9/30/2020	$ (583,626)
	7. Total Net Worth	$ (1,654,566)
C.	***Total Reserves and Net Worth***	$ (1,654,566)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 7,707,153

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabiliation	2141c	9/30/2020	36	37

Account	Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2019	$
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*** 09/30/20	$

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabiliation	2141c	9/30/2020	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	203-381-1327

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Elizabeth Maglio	203-381-1327

Contact Email Address
emaglio@rydershealth.com