State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2020

Name of Facility (as licensed) Chesterfields Health Care Center		
Address (No. & Street, City, State, Zip Code) 132 Main Street, Chester, CT 06412		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2135-C			075028

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	206338		

For Department Use Only

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	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 Chesterfields Health Care Center [facility name], for the cost report period beginning October 1, 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) Elise N. Cecil			Printed Name (Owner) Brian J. Foley	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

Table of Contents

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

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Chesterfields Health Care Center	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 132 Main Street, Chester, CT 06412				
Report Prepared By Apple Health Care, Inc.	Phone Number (860) 678-9755		Date	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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

General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-526-5363	9/30/2020	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Chesterfields Health Care Center	132 Main Street, Chester, CT 06412

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2135-C			075028

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.:
Elise N. Cecil	002134

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

Name	License No.:

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

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	9/30/2020	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

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

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	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
Chesterfields Health Care Center	132 Main Street, Chester, CT 06412	Connecticut

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Brian J. Foley	21 Waterville Road Avon, CT 06001	President	100
Ryan Vess	21 Waterville Road Avon, CT 06001	Secretary	
Names of Stockholders Owning at Least 10% of Shares			
Brian J. Foley	21 Waterville Road Avon, CT 06001	President	100

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

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	9/30/2020	3B	37

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

Owner(s) of Facility

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

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	9/30/2020	4	37

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Brian J. Foley	21 Waterville Rd. Avon, CT 06001	○	⊙		Real Estate Rental	Pg. 22 Line 9	192,000	192,000
Apple Heath Care	21 Waterville Rd. Avon, CT 06001	○	⊙		Management & Accounting Services	Pg. 16 Line m12	194,546	194,546
Corporate Employees	21 Waterville Rd. Avon, CT 06001	○	⊙		Employee Staffing	Pg. 10 Schedule	94,523	94,523
Employees @ various Apple Facilities		○	⊙		Employee Staffing	Pg. 10 Schedule	30,250	30,250
Apple Heath Care	21 Waterville Rd. Avon, CT 06001	○	⊙		Pension Plan (401K)	Pg. 15 Line 1a7	21,435	21,435
Healthport Services	21 Waterville Rd. Avon, CT 06001	○	⊙		Employee Staffing	P.13 11a1/11b1/11c1	11,311	11,311
Aetna	PO Box 88860 Chicago, IL 60695	○	⊙		Group Medical	Pg. 15 Line 1a5	185,882	
Metlife	PO Box 360229 Pittsburgh, PA 15251	○	⊙		Group Dental	Pg. 15 1a5	15,517	
USI	PO Box 62937 Virginia Beach, VA 23466	○	⊙		Property, Liability, & Umbrella Insurance	Pg. 27 Line 14a	80,819	

* Use additional sheets if necessary.

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

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

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	9/30/2020	5	37

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

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

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

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

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

The costs incurred by Apple Health Care, Inc. (a related party) to provide accounting and managerial services to each facility owned by Brian J. Foley are allocated on a per bed basis.

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.

N/A

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

General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	9/30/2020	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
Is a Mileage Log Book Maintained for All Leased Vehicles ?	⊙ Yes	○ No				**Total** ***	

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

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

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	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 Blum Shapiro & Co. PC	29 South Main St. West Hartford, CT 06127
2 Brazee & Huban	35 Wendell Ave. Pittsfield, MA 10202
3 Blum Shapiro & Co. PC	29 South Main St. West Hartford, CT 06127
4	

Services Provided by This Firm (*describe fully*)

1	Preparation of audited financials (disallow Pg. 28)	$ 5,234
2	Preparation of tax returns	$ 2,469
3	Audit - 401K	$ 864
4		$

Charge for Services Provided $ 8,566

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

⊙ Yes ○ No Pg. 15 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1	
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 Pg. 15 1e

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

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	9/30/2020	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	60	60			60	60						
B. On last day of THIS report period	60	60							60	60		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	43	43			43	43						
B. As of midnight of THIS report period	40	40							40	40		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,357	1,357			1,012	1,012			345	345		
B. Medicaid (Conn.)	11,714	11,714			8,738	8,738			2,976	2,976		
C. Medicaid (other states)												
D. Private Pay	3,398	3,398			2,826	2,826			572	572		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	16,469	16,469			12,576	12,576			3,893	3,893		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	16,469	16,469			12,576	12,576			3,893	3,893		

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

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	9/30/2020	9	37

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

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	3	30		7				
Per Diem Rate								
a. One bed rm.				400.00				
b. Two bed rms.	Various Rugs III	206.71		350.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	1,100	1,100		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	3,262	3,262		
D. ***Total Physical Therapy Treatments***	4,362	4,362		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	264	264		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	484	484		
D. ***Total Speech Therapy Treatments***	748	748		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	446	446		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	2,987	2,987		
D. ***Total Occupational Therapy Treatments***	3,433	3,433		

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

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	9/30/2020	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)	84,632	2,103				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	28,552	1,651				
5. Dietary Service						
a. Head Dietitian	9,889	322				
b. Food Service Supervisor	50,830	1,930				
c. Dietary Workers	163,367	10,258				
6. Housekeeping Service						
a. Head Housekeeper	41,892	1,708				
b. Other Housekeeping Workers	87,226	6,166				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	51,046	1,925				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants	48,375	1,948				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	87,116	1,699				
b. RN						
1. Direct Care	425,969	9,326				
2. Administrative**	62,559	1,932				
c. LPN						
1. Direct Care	379,515	11,819				
2. Administrative**						
d. Aides and Attendants	528,131	28,404				
e. Physical Therapists	77,443	1,635				
f. Speech Therapists	25,131	593				
g. Occupational Therapists	93,245	2,076				
h. Recreation Workers	52,481	1,943				
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	45,663	1,301				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	2,343,062	88,738				

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Conneticut Purchasing Consultant	$ 1,896	16				
PatientPing -Admissions Discharge Fee	$ 2,024	16				
Total	$ 3,920	32	$ -	-	$ -	-

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	9/30/2020	11	37

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

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

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	9/30/2020	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* **										
Meghan Nonamaker	68,066				Administrater 10/1/19-7/28/20	1,720	A.2	High View Health 07/29/20-9/30/20	383	17,434
Elise Cecil	16,566				Administrater 07/29/20-9/30/20	383	A.2			
Section IV - Assistant Administrators										

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

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	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						
2. Dentist	6,957	70				
3. Pharmacist	3,786	40				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	24,000					
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
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	3,920	32				
B-13 Total Fees Paid in Lieu of Salaries	38,663	142				

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

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	9/30/2020	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Neighborcare PO Box 78000 Detroit, MI	Pharmacist	○	⊙	
Timothy Tobin 147 Westbrook Rd #1, Essex, CT 06426	Medical Director	○	⊙	
Healthdrive 1 Prestige Drive, Meriden, CT 06450	Dentist	○	⊙	
Connecticut Purchasing Consultants, LLC 88 Ryders Ln, 2nd Fl, Stratford, CT 06614	Purchasing Consultants	○	⊙	
Patientping, Inc., 10 Post Office Square, Boston, MA 02109	Admissions Discharge Fees	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
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		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15 Rev. 9/2018

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	9/30/2020	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	23,718	23,718		
2. Disability Insurance	$				
3. Unemployment Insurance	$	23,622	23,622		
4. Social Security (F.I.C.A.)	$	161,910	161,910		
5. Health Insurance	$	141,988	141,988		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	20,090	20,090		
7. Pensions (Non-Discriminatory)	$	21,435	21,435		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	94,250	94,250		
d. Accounting and Auditing	$	8,566	8,566		
e. Legal (*Services should be fully described on Page 7)*	$				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	7,067	7,067		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	18,306	18,306		
2. Cellular Phones	$				
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	$	319,736	319,736		
Subtotal	$	840,689	840,689		

* 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	$ -	$ -	$ -

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	9/30/2020	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		840,689	840,689		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	2,688	2,688		
2. Holiday Parties for Staff	$	1,334	1,334		
3. Gifts to Staff and Residents	$	4,084	4,084		
4. Employee Travel	$	5,960	5,960		
5. Education Expenses Related to Seminars and Conventions	$	3,761	3,761		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$				
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	855	855		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	1,497	1,497		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	4,994	4,994		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	264	264		
9. Subscriptions	$	5,521	5,521		
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$	194,546	194,546		
13. Other (*Specify*) See Attached Schedule	$	90,899	90,899		
C-14 Total Administrative & General Expenditures	$	1,157,093	1,157,093		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Advertising - Public Relations	$ 855		
Total Other Advertising	$ 855	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	3,744.40		
ACHCA	650.00		
AMERICAN HEALTH CARE ASSOCIATION	600.00		
Total Dues	4,994.40	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Corporate Fees - Non Reimburable	$ 41,387		
Licenses & Fees	$ 2,511		
Pre Employment Screenings	$ 1,326		
System License & Subscritpion Fees	$ 17,469		
Bank Service Charges	$ 8,830		
Legal Fees - Collection/Probate	$ (165)		
IT Service Fees	$ 1,278		
Internet & Cable/Satellite TV	$ 11,341		
Survey Fines & Citations	$ 3,931		
Healthport Indirect	$ 2,714		
Resident Expenses	$ 158		
Prior Period Adj/Account W/O	$ 118		
Total Other Administrative and General	$ 90,899	$ -	$ -

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

Schedule C-1 - Management Services*

Name of Facility Chesterfields Health Care Center	License No. 2135-C	Report for Year Ended 9/30/2020	Page 17 | of 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Apple Health Care, Inc.	194,546	Accounting & Management Services	Pg. 16 m12

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-18 Rev. 9/2018

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
Chesterfields Health Care Center	2135-C	9/30/2020	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	113,946	113,946		
2. Non-Food Supplies	$	11,664	11,664		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	1,034	1,034		
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	126,643	126,643		

2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	135	135		

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.

State of Connecticut
Annual Report of Long-Term Care Facility
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
Chesterfields Health Care Center	2135-C	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. $	1,430	1,430		
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. $	1,176	1,176		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	30,122	30,122		
c. Other (*Specify*)	$				
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	32,728	32,728		

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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-20 Rev. 9/2018

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
Chesterfields Health Care Center	2135-C	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.	$	19,321	19,321		
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)		$	19,321	19,321		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Neighborcare		$	65,641	65,641		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	120,162	120,162		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	1,843	1,843		
f. X-rays and Related Radiological Procedures***		$	10,015	10,015		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	10,018	10,018		
i. Recreation		$	10,851	10,851		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	8,457	8,457		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	226,988	226,988		

* 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)
Nursing Station Supplies	$ 41		
IV Therapy	$ 1,375		
Rehab Service & Supplies	$ 7,041		
Total Other Resident Care	$ 8,457	$ -	$ -

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	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
CWPM, LLC	25 Norton Place, Plainville, CT 06062	○	⊙		Refuse Removal	13,317			22	6f
Unitex	Parkway, Mt Vernon, NY 10550	○	⊙		Laundry	29,233			19	3b
Clarks Landscaping		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Chesterfields Health Care Center	2135-C	9/30/2020	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	65,903	65,903		
b. Heat	$	43,855	43,855		
c. Light & Power	$	34,288	34,288		
d. Water	$	31,045	31,045		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	13,562	13,562		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	188,653	188,653		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	130	130		
d. Movable Equipment	$	8,867	8,867		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	8,997	8,997		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	31,489	31,489		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	31,489	31,489		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	192,000	192,000		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	41,680	41,680		
c. Personal property taxes	$	3,593	3,593		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	277,759	277,759		

* 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)
Refuse Removal	$ 13,562		
Total Other Repairs and Maintenance	$ 13,562	$ -	$ -

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

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	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								
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								
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	35,474		35,474	34,456	S/L	VARIOUS	130	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								130

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			VARIO		346,943		346,943	317,994	S/L	VARIOUS	8,867	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)												
D-3. Subtotal												8,867
E. ***Total Depreciation***												8,997

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:					
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:					
Total additions for Non-Movable Equipmen		$ -		$ -	*
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:					
Total additions for Movable Equipmen		$ -		$ -	*
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**

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

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	9/30/2020	24	37

Item	Date of Acquisition Month	Date of Acquisition Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	VAR			1,161,548	932,444	A		31,489	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									31,489
D. ***Total Amortization***									31,489

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	9/30/2020	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	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	60
6. Square Footage	22,673
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)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)	N/A			
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Chesterfields Health Care Center	2135-C	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*)

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Chesterfields Health Care Center	2135-C	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*) $				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $				
14. Insurance				
a. Insurance on Property (buildings only) $	80,819	80,819		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $				
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	80,819	80,819		
15. ***Total All Expenditures (A-13 thru C-14)*** $	4,491,728	4,491,728		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-28 Rev. 9/2018

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Chesterfields Health Care Center	2135-C	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	$	93,245	93,245		
4.			Other - See attached Schedule	$	6,347	6,347		
Page 13 - Professional Fees								
5.			Resident Care Physicians **	$				
6.	13	B10a	Occupational Therapy	$				
7.			Other - See attached Schedule	$	24,000	24,000		
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.	15	1c	Bad Debts	$	94,250	94,250		
10.	15	1d	Accounting	$	5,234	5,234		
10a.			Legal	$	(165)	(165)		
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.	16	m2/3	Unallowable Advertising *	$	855	855		
19.	15	k1	Income Tax / Corporate Business Tax	$				
20.	16	m10	Fund Raising / Contributions	$				
21.			Unallowable Management Fees	$				
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	65,188	65,188		
Page 18 - Dietary Expenditures								
24.	30	IV1	Meals to employees, guests and others who are not residents	$	125	125		
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)	$	289,078	289,078		

* 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	A12m	Social Service - Marketing	$ 6,347		
Total Other Salaries Adjustment			$ 6,347	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	8a	Medical Director	$ 24,000		
Total Other Fees Adjustments			$ 24,000	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Corporate Fees Non Reimbursable	$ 41,387		
16	1.3	Employee Recognition/Gifts/Parties	$ 4,084		
16	8a	Chamber of Commerce	$ 264		
16	m13	Bank Charges	$ 8,830		
16	m13	Survey Fines & Citations	$ 3,931		
16	m13	Resident Expenses	$ 158		
16	m13	Prior Period Expense/Account W/O	$ 118		
30	IV8	Account W/O	$ 5,050		
30	IV8	Citi refund	$ 132		
30	IV8	Settlement	$ 1,234.26		
Total Other A&G Adjustments			$ 65,188	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-29 Rev. 9/2018

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

Name of Facility	License No.	Report for Year Ended	Page of
Chesterfields Health Care Center	2135-C	9/30/2020	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	289,078	289,078		
Page 20 - Resident Care Supplies***								
27.	20	5a2	Prescription Drugs	$	59,535	59,535		
28.	16	L1	Ambulance/Limousine	$	2,688	2,688		
29.	20	h	X-rays, etc	$	10,015	10,015		
30.	20	f	Laboratory	$	10,018	10,018		
31.			Medical Supplies	$				
32.	20	5e2	Oxygen (non emergency)	$	1,733	1,733		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	8,415	8,415		
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.	30	IV5	Interest Income on Account Rec.	$	338	338		
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)***			$	381,821	381,821		

*** 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)
20	5j	IV Therapy Supplies	$ 1,375		
20	5j	Rehab Service Supplies	$ 7,041		
Total Other Ancillary Costs			$ 8,415	$ -	$ -

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)
27	12D	Interest	$ -		
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			$ -	$ -	$ -

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Chesterfields Health Care Center	2135-C	9/30/2020	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	2,428,069	2,428,069		
b. Medicaid Room and Board Contractual Allowance **	$				
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	431,927	431,927		
b. Medicare Room and Board Contractual Allowance **	$	295,472	295,472		
4. a. Private-Pay Residents and Other	$	1,332,521	1,332,521		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	27,101	27,101		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(32,109)	(32,109)		
c. Prescription Drugs - Non-Medicare	$	2,281	2,281		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(2,281)	(2,281)		
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	$	136,762	136,762		
b. Physical Therapy - Medicare Contractual Allowance **	$	(93,810)	(93,810)		
c. Physical Therapy - Non-Medicare	$	15,911	15,911		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(8,995)	(8,995)		
4. a. Speech Therapy - Medicare	$	31,860	31,860		
b. Speech Therapy - Medicare Contractual Allowance **	$	(18,612)	(18,612)		
c. Speech Therapy - Non-Medicare	$	4,410	4,410		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(1,800)	(1,800)		
5. a. Occupational Therapy - Medicare	$	135,315	135,315		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(112,934)	(112,934)		
c. Occupational Therapy - Non-Medicare	$	18,000	18,000		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(13,905)	(13,905)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	4,575,183	4,575,183		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	125	125		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	338	338		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	498,561	498,561		
V. Total Other Revenue (1 thru 8)	$	499,024	499,024		
VI. Total All Revenue (III +V)	$	5,074,207	5,074,207		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30	Interest Income	242,348	$ 338		
Total Interest Income			$ 338	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV 4	Account W/O	$ 4,530		
30 IV 8	Optimal Dividend	$ 2,486		
30 IV 8	HHS Payment	$ 489,659		
30 IV 8	Unclaimed Property	$ 520		
30 IV 8	Settlement	$ 1,234		
30 IV 8	Citi Refund	$ 132		
Total Other Revenue		$ 498,561	$ -	$ -

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

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	9/30/2020	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 2,481
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 242,348
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 15,868
5. Prepaid Expenses				$ 11,144
a.				
b.				
c.				
d. See Schedule		11,144		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 2,624,983
See Schedule		2,624,983		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,896,824
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	1,161,548		$ 197,615
	Accum. Depreciation	963,933	Net	
5. Non-Movable Equipment	*Historical Cost	35,474		$ 888
	Accum. Depreciation	34,586	Net	
6. Movable Equipment	*Historical Cost	346,943		$ 20,082
	Accum. Depreciation	326,861	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 417,086
See Schedule		417,086		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 635,671

* 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	
31	A5	Prepaid Insurance	$ -
31	A5	Prepaid Property Tax	$ 11,144
31	A5	Other Prepaid Expenses	$ -
31	A5	Prepaid Income Taxes	$ -
Total Prepaid Expenses			$ 11,144

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

Page Ref	Line Ref	Description	
		Due Affiliate (Debit Balance)	$ 2,600,491
		Payroll W/H	8,728.94
		AP Patient Exchange	$ 15,762
Total Other Current Assets (Itemize)			$ 2,624,983

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

Page Ref	Line Ref	Description	
31	B9	Fixed Asset Clearing A/C	$ -
31	B9	Capitalized Refinance Expense	$ -
31	B9	Construction in Progress	$ -
31	B9	Step Up	417,086.00
Total Other Other Fixed Assets (Itemize)			$ 417,086

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
32	D7	Leasehold Deposits	$ 650
32	D7	Deferred Tax Asset	$ -
32	D7	Goodwill	$ -
Total Other Assets			$ 650

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	
		Medicare Acelerated Payments	$ 75,196
		Due Affiliate (Credit Balance)	
		Gemino Revolving AR Loan	$ -
		Accrued PTO	99,966.38
		Payroll W/H	
		Accrued Professional Fees	5,852.44
		Accrued Pension	-
		Accrued Worker Comp	49,852.54
		Accrued Group Insurance	13,398.99
		Accrued Other Expenses	304,638.89
Total Other Current Liabilities (Itemize)			$ 548,905

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

Page Ref	Line Ref	Description	
		A/P Other (Intercompany)	$ 1,981,238
		Dostie Note	$ -
		Marlin Capital Lease	$ -
		Loan Payable Officer	$ -
		Security Deposit/Deferred Revenue	$ 233,834
		State Income Tax Payable	$ -
Total Other Current Liabilities (Itemize)			$ 2,215,072

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	9/30/2020	32	37

Account				Amount
			Total Brought Forward:	$ 3,532,495
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			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 650
See Schedule		650		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 650
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 3,533,145

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

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	9/30/2020	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 241,066
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*)	$ 67,630
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$ 6,517
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*)	$ 548,905
See Schedule 548,905	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 864,119

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

(Carry Total forward to next page)

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	9/30/2020	34	37

Account	Amount
Total Brought Forward:	864,119
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*)	$ 2,215,072
See Schedule 2,215,072	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 2,215,072
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 3,079,191

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	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	$ 2,817,614
	2. Capital Stock	$ 1,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (2,947,137)
	6. Gain or Loss for Period 10/1/2019 thru 9/30/2020	$ 582,478
	7. Total Net Worth	$ 453,954
C.	***Total Reserves and Net Worth***	$ 453,954
D.	***Total Liabilities, Reserves, and Net Worth***	$ 3,533,145

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

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	9/30/2020	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2019			$ (124,661)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 5,074,207
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 4,491,728
D.	Net Income or Deficit			$ 582,478
E.	Balance			$ 457,817
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$ 3,863
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	Brian J Foley	President	3,863	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$ 3,863
H.	***Balance at End of Period*** 09/30/20			$ 453,954

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

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Chesterfields Health Care Center	2135-C	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
Robert Gwizdak

Addres Address	Phone Number
21 Waterville Rd. Avon, CT 06001	

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Susan Southey	(860) 470-7542

Contact Email Address
ssouthey@apple-rehab.com