

State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) Cheshire House Nursing & Rehabilitation Center	
Address (No. & Street, City, State, Zip Code) 3396 East Main St., Waterbury, CT 06705	
Type of Facility <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH 2141c	RHNS	(Specify)	Medicare Provider 07-5373
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Medicaid Provider Numbers:	CCNH 6577	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) Cheshire House Nursing & Rehabilitation Center	License No. 2141c	Report for Year Ended 9/30/2021	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Cheshire House Nursing & Rehabilitation Center [facility name], for the cost report period beginning October 1, 2020 and ending September 30, 2021, 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) Jeff Turner			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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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 Cheshire House Nursing & Rehabilitation Center	Period Covered:	From 10/1/2020	To 9/30/2021	
Address of Facility 3396 East Main St., Waterbury, CT 06705				
Report Prepared By Ryders Health Management	Phone Number 203-381-1327	Date 1/24/2022		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-381-1327		Report for Year Ended 9/30/2021	Page 2	of 37
Name of Facility (as shown on license) Cheshire House Nursing & Rehabilitation Center		Address (No. & Street, City, State, Zip) 3396 East Main St., Waterbury, CT 06705		
License Numbers:	CCNH 2141c	RHNS (Specify)	Medicare Provider No. 07-5373	
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Jeff Turner		Nursing Home Administrator's License No.:	001613	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name N/A		License No.:	N/A	

General Information and Questionnaire
Corporate Owners

Name of Facility Cheshire House Nursing & Rehabilitation Center	License No. 2141c	Report for Year Ended 9/30/2021	Page 3A	of 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	

General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2021	3B	37

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

Owner(s) of Facility

N/A

**General Information and Questionnaire
Related Parties***

Name of Facility Cheshire House Nursing & Rehabilitation Center	License No. 2141c	Report for Year Ended 9/30/2021	Page 4	of 37
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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		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Cheshire House Nursing & Rehabilitation Center	License No. 2141c	Report for Year Ended 9/30/2021	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

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
Cheshire House Nursing & Rehabilitation Center		2141c	9/30/2021			6	37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
Wells Fargo	<input type="radio"/>	<input checked="" type="radio"/>	Copy Machine				8,393
BBI Technologies	<input type="radio"/>	<input checked="" type="radio"/>	Copy Machine				7,514
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
						Total ***	15,907

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.

General Information and Questionnaire
Accounting Basis

Name of Facility Cheshire House Nursing & Rehabil	License No. 2141c	Report for Year Ended 9/30/2021	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:
 Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm 1 Marcum, LLP 2 3 4	Address (No. & Street, City, State, Zip Code) 555 Long Wharf Drive, New Haven, CT 06511
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Services Provided by This Firm (*describe fully*)

1 Corp tax returns, annual review of the financial statements	\$ 4,831
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 4,831

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 1 See Attached 2 3 4 5	Telephone Number
--	------------------

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

Schedule of Resident Statistics

Name of Facility Cheshire House Nursing & Rehabilitation Center			License No. 2141c		Report for Year Ended 9/30/2021				Page 8	of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	90	90			90	90						
B. On last day of THIS report period	90	90							90	90		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	63	63			63	63						
B. As of midnight of THIS report period	61	61							61	61		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,763	4,763			3,659	3,659			1,104	1,104		
B. Medicaid (Conn.)	10,457	10,457			7,347	7,347			3,110	3,110		
C. Medicaid (other states)												
D. Private Pay	2,286	2,286			1,826	1,826			460	460		
E. State SSI for RCH												
F. Other (Specify) Managed Care	5,223	5,223			3,903	3,903			1,320	1,320		
G. Total Care Days During Period (3A thru F)	22,729	22,729			16,735	16,735			5,994	5,994		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	167	167			130	130			37	37		
B. Other Bed Reserve Days	56	56			53	53			3	3		
5. Total Resident Days (3G + 4A + 4B)	22,952	22,952			16,918	16,918			6,034	6,034		

Annual Report of Long-Term Care Facility

Schedule of Resident Statistics (Cont'd)

Name of Facility Cheshire House Nursing & Rehabilitation Cen			License No. 2141c			Report for Year Ended 9/30/2021			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> 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			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
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	RHNS	CCNH	RHNS	(Specify)	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR			
No. of Residents	11		37			13							
Per Diem Rate													
a. One bed rm.	Various		303.97										
b. Two bed rms.													
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									1,500	1,500			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									19,997	19,997			
D. Total Physical Therapy Treatments									21,497	21,497			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									910	910			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									1,573	1,573			
D. Total Speech Therapy Treatments									2,483	2,483			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									1,382	1,382			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									19,326	19,326			
D. Total Occupational Therapy Treatments									20,708	20,708			

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility Cheshire House Nursing & Rehabilitation Center	License No. 2141c	Report for Year Ended 9/30/2021	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> 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)	106,577	2,140				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	233,169	11,138				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	60,228	2,030				
c. Dietary Workers	288,747	18,616				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	155,832	9,516				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	50,422	1,864				
b. Other Maintenance Workers	49,324	2,620				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	103,951	6,372				
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	98,343	1,871				
b. RN						
1. Direct Care	1,066,279	20,617				
2. Administrative**						
c. LPN						
1. Direct Care	996,329	34,729				
2. Administrative**						
d. Aides and Attendants	1,094,726	63,476				
e. Physical Therapists	454,861	12,105				
f. Speech Therapists	89,980	1,957				
g. Occupational Therapists	340,065	8,728				
h. Recreation Workers	77,468	3,527				
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	253,213	8,841				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	35,441	2,130				
<i>A-13. Total Salary Expenditures</i>	5,554,954	212,276				

* 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)

Position	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Medical Records	\$ 35,441	2,130				
Total	\$ 35,441	2,130	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Rehab Management Fee	\$ 11,457					
Infection Control Consultant	\$ 3,081					
Total	\$ 14,538	-	\$ -	-	\$ -	-

**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
Cheshire House Nursing & Rehabilitation Center				2141c	9/30/2021				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										
Martin Sbriglio, RN, NHA								Ryders Health Management, 88 Ryders Lane, Stratford, CT 06614	3,721	145,922
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 Sbriglio								Ryders Health Management, 88 Ryders Lane, Stratford, CT 06614	340	8,565

* 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.

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
Cheshire House Nursing & Rehabilitation Center				2141c	9/30/2021			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***										
Nicole Lewis 10/1/20 - 3/8/21	35,174			Non Discriminatory	Administrative	927	A2			
Ted Vinci 3/8/21 - 4/6/21	7,092			Non Discriminatory	Administrative	1,128	A2			
James Murphy 4/5/21 - 9/30/21	64,311			Non Discriminatory	Administrative	1,085	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.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2021	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	43,063					
2. Dentist	6,113					
3. Pharmacist	5,693					
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	91,300					
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	3,507					
b. Other						
10. Occupational Therapist						
a. Resident Care	1,998					
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	14,538					
B-13 Total Fees Paid in Lieu of Salaries	156,212					

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

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

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

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

Name of Facility Cheshire House Nursing & Rehabilitation Center		License No. 2141c	Report for Year Ended 9/30/2021	Page 14	of 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	<input type="radio"/>	<input checked="" type="radio"/>		
Elizabeth Meisel, 72 Basswood Road, Farmington, CT 06032	Dietician Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
ValueRx	Pharmacy Consultant	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
Dr. Peter Giacomazzi, 509 Wolcott Rd, Wolcott, CT 06716	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. George Barchini, 19 Waterbury Rd., Thomaston, CT 06787	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
HealthPro, 307 International Circle, Suite 100, Hunt Valley, MD 21030	Rehab Consultant, PT, ST & OT	<input type="radio"/>	<input checked="" type="radio"/>		
Dedicated Nursing	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Karen Taylow Healthcare	Infection Control Consulting	<input type="radio"/>	<input checked="" type="radio"/>		
Deepinder Osahan MD	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
Edmund Quinn	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
He Zhang MD	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
Neil Miller MD	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
Franklin Medical Group	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2021	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 224,648	224,648		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$			
4. Social Security (F.I.C.A.)	\$ 486,538	486,538		
5. Health Insurance	\$ 340,487	340,487		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 8,768	8,768		
8. Uniform Allowance	\$ 21,171	21,171		
9. Other (<i>Specify</i>) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 190,534	190,534		
d. Accounting and Auditing	\$ 4,831	4,831		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 25,624	25,624		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 17,276	17,276		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 14,394	14,394		
2. Cellular Phones	\$ 3,705	3,705		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$			
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$			
2. Other (<i>Specify</i>) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 302,814	302,814		
Subtotal	\$ 1,640,789	1,640,789		

* 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	\$ -	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended		Page	of
Cheshire House Nursing & Rehabilitation Center	2141c	9/30/2021		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:	1,640,789	1,640,789			
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 7,321	7,321			
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 6,922	6,922			
5. Education Expenses Related to Seminars and Conventions	\$ 5,126	5,126			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 285	285			
7. Other (<i>Specify</i>) See Attached Schedule	\$ 3,991	3,991			
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 11,481	11,481			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 7,789	7,789			
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	\$ 4,382	4,382			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 6,439	6,439			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 886	886			
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 103,074	103,074			
12. Administrative Management Services**	\$ 348,805	348,805			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 51,258	51,258			
C-14 Total Administrative & General Expenditures	\$ 2,209,347	2,209,347			

* 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	\$ 3,991		
Total Other Travel and Entertainment	\$ 3,991	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Adv & Pub Rel Donations	\$ 7,789		
Total Other Advertising	\$ 7,789	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 5,672		
AAPACN	\$ 17		
AHCA	\$ 750		
Total Dues	\$ 6,439	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Fees & License	\$ 1,555		
Physician Care - Employees	\$ 22,797		
Bank Charges	\$ 16,488		
Bank Charges - Lease	\$ 484		
Fines & Penalties	\$ 6,595		
Unemployment Tax Management	\$ 1,391		
A/R Support	\$ 1,898		
American Express Fee	\$ 50		
Total Other Administrative and General	\$ 51,258	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Cheshire House Nursing & Rehabilitation	2141c	9/30/2021	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, Suite 208, Stratford, CT 06614	348,805	Financial and Managerial Services	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.**

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

Name of Facility		License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Center		2141c	9/30/2021	18	37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 154,556	154,556		
2.	Non-Food Supplies	\$ 20,338	20,338		
3.	Other (<i>Specify</i>) _____	\$			
b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)					
c. Other (<i>Specify</i>) _____					
2D. Total Dietary Expenditures (2a + b + c + d)		\$ 174,894	174,894		
2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F.	Resident Meals: Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No					
H. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
K. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)					

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Cheshire House Nursing & Rehabilitation Center		2141c	9/30/2021		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. \$	8,782	8,782		
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 (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)		\$				
c. Other (<i>Specify</i>) Laundry Supplies		\$	4,608	4,608		
3D. Total Laundry Expenditures (3a + b + c)		\$	13,389	13,389		
3E. Laundry Questionnaire						
F.	Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
H.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
I.	Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
K.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
 All allocations should add to total recorded in 3D.
 *** Pounds of Laundry only required for multi-level facilities.

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

Name of Facility		License No.	Report for Year Ended		Page	of
Cheshire House Nursing & Rehabilitation Cent		2141c	9/30/2021		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
1.	Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	37,065	37,065		
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$				
C.	Other (<i>Specify</i>)	\$				
4D.	Total Housekeeping Expenditures (4a + b + c)	\$	37,065	37,065		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from ValueRx	\$	335,661	335,661		
b.	Medicine Cabinet Drugs	\$	39,635	39,635		
c.	Medical and Therapeutic Supplies	\$				
d.	Ambulance/Limousine***	\$	14,155	14,155		
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	49,304	49,304		
f.	X-rays and Related Radiological Procedures***	\$	30,717	30,717		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	74,208	74,208		
i.	Recreation	\$	11,700	11,700		
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	228,237	228,237		
5M.	Total Resident Care Expenditures (5a - 5j)	\$	783,618	783,618		

* 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	\$ 10,678		
Medical Supplies	\$ 166,456		
Medical Supplements	\$ 9,337		
Medical Waste	\$ 209		
Medical Equipment - Rental	\$ 24,594		
PT Supplies	\$ 16,963		
Total Other Resident Care	\$ 228,237	\$ -	\$ -

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

Name of Facility Cheshire House Nursing & Rehabilitation Center			License No. 2141c		Report for Year Ended 9/30/2021			Page of 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	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Services	25,773			16	m11
Point Click Care		<input type="radio"/>	<input checked="" type="radio"/>		Software Services	39,641			16	m11
USA Waste & Recycling		<input type="radio"/>	<input checked="" type="radio"/>		Garbage Disposal	29,692			22	6c
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Cheshire House Nursing & Rehabilitation Cen	2141c	9/30/2021			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 158,212	158,212				
b. Heat	\$ 8,319	8,319				
c. Light & Power	\$ 99,850	99,850				
d. Water	\$ 19,014	19,014				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 16,827	16,827				
f. Other (<i>itemize</i>)	\$					
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 302,222	302,222				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$ 10,014	10,014				
b. Building & Building Improvements	\$ 203,977	203,977				
c. Non-Movable Equipment	\$ 20,083	20,083				
d. Movable Equipment	\$ 48,373	48,373				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 282,447	282,447				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*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	\$ 146,392	146,392				
c. Personal property taxes	\$ 21,396	21,396				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 810,235	810,235				

* 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	\$ -	\$ -	\$ -

Depreciation Schedule

Name of Facility Cheshire House Nursing & Rehabilitation Center			License No. 2141c		Report for Year Ended 9/30/2021			Page 23	of 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	88,522	S/L	Various	9,741				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			42,638		42,638		S/L	Various	273				
A-4. Subtotal										10,015			
B. Building and Building Improvements													
1. Acquired prior to this report period			7,487,247		7,487,247	2,388,967	S/L	Various	203,089				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			24,374		4,374		S/L	Various	888				
B-4. Subtotal										203,977			
C. Non-Movable Equipment													
1. Acquired prior to this report period			521,722		521,722	434,968	S/L	Various	18,135				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			37,776		37,776		S/L	Various	1,948				
C-4. Subtotal										20,083			
		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/dc	5 Years		
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period						1,063,819		1,063,819	946,863	S/L	Various	47,361	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)						11,316		11,316		S/L	Various	1,012	
D-3. Subtotal													48,373
E. Total Depreciation													282,448

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
7/1/2020	Outside Paving & Concrete	\$ 42,638	39	\$ 273
Total additions for Land Improvement		\$ 42,638		\$ 273 *
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:				
4/12/2021	Maglock Installation	\$ 5,690	10	\$ 261
5/18/2021	Fire Sprinkler Heads	\$ 11,288	10	\$ 423
5/13/2021	Outlet Installations	\$ 2,473	10	\$ 93
6/22/2021	Boiler Shutoff Switch	\$ 1,011	10	\$ 29
7/22/2021	Outlet Installations	\$ 3,913	10	\$ 82
Total additions for Building Improvement		\$ 24,374		\$ 888 *
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 period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
2/25/2021	Hot Water Storage Tank	\$ 5,890	5	\$ 687
2/28/2021	Generator Starter	\$ 3,215	5	\$ 375
2/28/2021	Generator Starter	2727.44	5	318.2
6/30/2021	Gazebo	2616.2	10	43.6
8/13/2021	Generator Control Panel	19790.15	5	494.75
9/13/2021	AC Unit	3536.9	5	29.47
Total additions for Non-Movable Equipment		\$ 37,776		\$ 1,948 *
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
12/5/2020	Electrostatic Sprayer	\$ 1,738	5	\$ 290
3/12/2021	Commercial Washer	\$ 2,595	10	\$ 141
4/28/2021	Bladder Scanner	\$ 2,658	5	\$ 221
5/3/2021	TV	\$ 1,521	5	\$ 127
5/6/2021	Hot Food Table	\$ 2,804	5	\$ 234
Total additions for Movable Equipmen		\$ 11,316		\$ 1,012 *
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 period

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

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

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
Cheshire House Nursing & Rehabilitation Center			2141c		9/30/2021			24	37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1. 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.

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

Name of Facility Cheshire House Nursing & Rehabilitat	License No. 2141c	Report for Year Ended 9/30/2021	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> 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
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
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 9/30/21		4,524,366		
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
Part C - Arms-Length Leases for Real Property Improvements Only				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility		License No.	Report for Year Ended			Page	of
Cheshire House Nursing & Rehabilita		2141c	9/30/2021			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)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Cheshire House Nursing & Rehabil		2141c		9/30/2021		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) Interest Expense				\$	120,655	120,655	
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	120,655	120,655	
14. Insurance							
a. Insurance on Property (buildings only)				\$	16,580	16,580	
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$	78,771	78,771	
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. Total Insurance Expenditures (14a + b + c)				\$	95,350	95,350	
15. Total All Expenditures (A-13 thru C-14)				\$	10,257,942	10,257,942	

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Center				2141c	9/30/2021	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	12g	Occupational Therapy	\$ 340,065	340,065		
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$ 1,998	1,998		
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 190,534	190,534		
10.			Accounting	\$			
10a.			Legal	\$ 21,039	21,039		
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	m3	Unallowable Advertising *	\$ 7,789	7,789		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 11,472	11,472		
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)				\$ 572,897	572,897		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	17	Meals & Entertainment	\$ 3,991		
16	m8a	Chamber of Commerce	\$ 886		
16	m13	Fines & Penalties	\$ 6,595		
Total Other A&G Adjustments			\$ 11,472	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Center				2141c	9/30/2021	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 572,897	572,897		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 335,661	335,661		
28.	20	5d	Ambulance/Limousine	\$ 14,155	14,155		
29.	20	5f	X-rays, etc	\$ 30,717	30,717		
30.	20	5h	Laboratory	\$ 74,208	74,208		
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 49,304	49,304		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 10,963	10,963		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 1,087,905	1,087,905		

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

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	51	PT Supplies	\$ 10,963		
Total Other Ancillary Costs			\$ 10,963	\$ -	\$ -

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			\$ -	\$ -	\$ -

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			\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Cheshire House Nursing & Rehabilitation	2141c	9/30/2021		30	37
Item	Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 3,541,140	3,541,140			
b. Medicaid Room and Board Contractual Allowance **	\$ (1,039,345)	(1,039,345)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 2,163,630	2,163,630			
b. Medicare Room and Board Contractual Allowance **	\$ 1,001,990	1,001,990			
4. a. Private-Pay Residents and Other	\$ 3,797,772	3,797,772			
b. Private-Pay Room and Board Contractual Allowance **	\$ (1,149,023)	(1,149,023)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 318,088	318,088			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (318,088)	(318,088)			
c. Prescription Drugs - Non-Medicare	\$ 48,554	48,554			
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	\$ 369,857	369,857			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (369,857)	(369,857)			
c. Physical Therapy - Non-Medicare	\$ 422,973	422,973			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$ 92,297	92,297			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (92,297)	(92,297)			
c. Speech Therapy - Non-Medicare	\$ 99,687	99,687			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 366,804	366,804			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (366,804)	(366,804)			
c. Occupational Therapy - Non-Medicare	\$ 430,686	430,686			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other (<i>Specify</i>) - Medicare	\$ 0	0			
b. Other (<i>Specify</i>) - Non-Medicare	\$ 5,038	5,038			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 9,323,102	9,323,102			
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$ 679	679			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 372,575	372,575			
V. Total Other Revenue (1 thru 8)	\$ 373,254	373,254			
VI. Total All Revenue (III +V)	\$ 9,696,355	9,696,355			

* 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	\$ 8,849		
	X-Ray - Medicare	\$ 28,403		
	Lab - Medicare	\$ 62,363		
	Contractuals	\$ (99,614)		
	Total Other Resident Revenue - Medicare	\$ 0	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	X-Ray Managed Care	\$ 1,016		
	Oxygen - Managed Care	\$ 180		
	Lab - Managed Care	\$ 3,842		
	Total Other Resident Revenue	\$ 5,038	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Income		\$ 679		
	Total Interest Income		\$ 679	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Café Income	\$ 400		
	Medicaid - CRF Grant	\$ 52,000		
	Medicare - PRF Grant	\$ 320,175		
	Total Other Revenue	\$ 372,575	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitati	2141c	9/30/2021	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	212,037
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,621,873
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	2,775
a. Prepaid Expenses	2,775			
b. _____				
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	(245,917)
Medicaid Advances	(34,673)			
Medicare Advances	(307,774)			
Loans & Exchanges	(150,663)			
See Schedule	247,192			
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,590,768
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	427,988	\$	329,452
	Accum. Depreciation	98,536		Net
3. Buildings	*Historical Cost	7,511,621	\$	4,918,676
	Accum. Depreciation	2,592,944		Net
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation			Net
5. Non-Movable Equipment	*Historical Cost	559,498	\$	104,447
	Accum. Depreciation	455,051		Net
6. Movable Equipment	*Historical Cost	1,075,135	\$	79,899
	Accum. Depreciation	995,236		Net
7. Motor Vehicles	*Historical Cost	22,963	\$	
	Accum. Depreciation	22,963		Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	5,432,475

* 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	
		Prepaid Insurance	\$ 3,148
		Refunds	\$ (4,483)
		15 Bed Purchase	\$ 248,527
Total Other Current Assets (Itemize)			\$ 247,192

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 Health	\$ 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	\$ 1,154,910
		Due to Lord Chamberlain	\$ 72,191
		Due to CH Realty	\$ 5,329,562
		Due to DM Realty	13000
Total Other Current Liabilities (Itemize)			\$ 6,569,663

Annual Report of Long-Term Care Facility

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitati	2141c	9/30/2021	32	37
Account			Amount	
Total Brought Forward:			\$	7,023,242
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 <u>75,563</u>	
Accum. Depreciation <u>70,000</u>			Net	
			\$	5,563
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address		Amount	Loan Date	
_____		_____	_____	
7. Other Assets (<i>itemize</i>)			\$	407,326
Due from Greentree Manor		197,330		
Due from Mystic Healthcare		187,096		
See Schedule		22,900		
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	412,888
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	7,436,131

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

Annual Report of Long-Term Care Facility

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G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation Cen		2141c	9/30/2021	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	776,042
2. Notes Payable (<i>itemize</i>)				\$	

See Schedule					
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	74,204
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	554,511
Patient Fund		35,311	Aflac - Individual	4,549	
Accrued Expenses		41,633	Accrued PTO	116,584	
Accrued User Fee		354,125			
Accrued 401k Withholding		2,310	See Schedule		
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	1,404,757

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Cheshire House Nursing & Rehabilitation C	License No. 2141c	Report for Year Ended 9/30/2021	Page 34	of 37
Account			Amount	
Total Brought Forward:			1,404,757	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 6,985,102
Due to M. Sbriglio, CEO		35,600		
Due to Aaron Manor		144,144		
Due to Bel-Air Manor		235,694		
See Schedule		6,569,663		
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 6,985,102
C. Total All Liabilities (Lines A-13 + B-5)				\$ 8,389,859

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

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitati	2141c	9/30/2021	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 (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	(89,373)
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(302,767)
6. Gain or Loss for Period			\$	(561,588)
	10/1/2020	thru	9/30/2021	
7. Total Net Worth			\$	(953,728)
C. Total Reserves and Net Worth			\$	(953,728)
D. Total Liabilities, Reserves, and Net Worth			\$	7,436,131

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Cheshire House Nursing & Rehabilitation	2141c	9/30/2021	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2020			\$	(392,140)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	9,696,355
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	10,257,942
D. Net Income or Deficit			\$	(561,588)
E. Balance			\$	(953,728)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period			\$	(953,728)

I. Preparer's/Reviewer's Certification

Name of Facility Cheshire House Nursing & Rehabilitation	License No. 2141c	Report for Year Ended 9/30/2021	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Ryders Health Management				
Address 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				