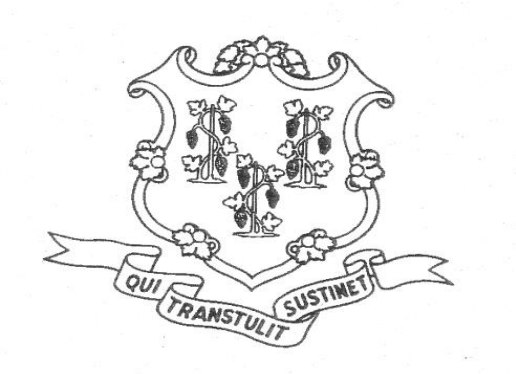
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2023

Name of Facility (as licensed) High Chase, LLC		
Address (No. & Street, City, State, Zip Code) 140 River Rd., Willington, CT 06279		
Type of Facility ☐ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined ☑ (Specify) ☑ Residential Care Home		
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023	

License Numbers:	CCNH / RHNS	(Specify)	Residential Care Home	Medicare Provider
			1871	

Medicaid Provider Numbers:	CCNH / RHNS	(Specify)	Residential Care Home

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	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 High Chase, LLC [facility name], for the cost report period beginning October 1, 2022 and ending September 30, 2023, 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) Kuldip Bhogal			Printed Name (Owner) Jaswinder Bhogal	
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 High Chase, LLC	Period Covered:		From 10/1/2022	To 9/30/2023
Address of Facility 140 River Rd., Willington, CT 06279				
Report Prepared By CJLC LLC	Phone Number 860-610-9009		Date	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-429-7903	9/30/2023	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
High Chase, LLC	140 River Rd., Willington, CT 06279

License Numbers:	CCNH / RHNS	(Specify)	Residential Care Home	Medicare Provider No.
			1871	

Type of Facility (Check appropriate box(es))

☐ Nursing Home (CCNH) & RHNS Combined — Chronic and Convalescent

☑ (Specify) — ☑ Residential Care Home

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.:
Kuldip Bhogal	

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	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

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	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
High Chase, LLC	140 River Rd., Willington, CT 06279	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Kuldip Bhogal	140 River Rd., Willington, CT 06279	Member	50
Jaswinder Bhogal	140 River Rd., Willington, CT 06279	Member	50
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	3B	37

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	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	%**				
J & K Bhogal Realty	91 Chestnut St., Manchester, CT 06040	○	⊙		Rental of Real Property	22/9	81,000	81,000
J & K Bhogal Realty	140 River Rd., Willington, CT	○	⊙		Loan	34/B3	(17,581)	(17,581)
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	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.

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

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

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General Information and Questionnaire
Other Lines of Business

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	6	37

Square footage of entire facility.	0

Outpatient Therapy

Does the Facility provide outpatient therapy services?	No

If yes, please complete the following:

	Square footage of therapy space.

Meals on Wheels

Does the facility provide Meals on Wheels?	No

If yes, please complete the following:

	Square footage of kitchen	
	Number of meals served per week	
No	Are meals included in meals served on page 18 of the Annual Report?	
No	Are direct costs included in the Annual Report?	
	If yes, please state where costs are reported.	
No	Are drivers for the program included in the facility's payroll?	
	If yes, please complete the following:	
		Amount Reported
		Annual Report page and line
	Please state the salary amounts of specific cooks and/or dietary aides	
	Please state where the cooks and/or dietary aides are reported in the Annual Report	

Apartments, Independent Living, Assisted Living

Does the facility have apartments, independent living, and/or assisted living?	No

If yes, please complete the following:

	Square footage of apartments
	Square footage of independent living
	Square footage of assisted living
	Please identify the services provided:

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General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility	License No.	Report for Year Ended	Page	of
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Child Day Care

Does the Facility provide Child Day Care?	No

If yes, please complete the following:

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

Adult Day Care

Does the Facility provide Adult Day Care?	No

If yes, please complete the following:

	Square footage of adult day care space.
	Please state where it is located in relation to the facility.
	Average number of daily participants.
	Number of meals per day provided to adult day care.
	Nature of services provided:

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	8	37

	Total All Levels	Total CCNH / RHNS Level	Total (Specify)	Total Residential Care Home	Period 10/1 Thru 6/30 Total	CCNH / RHNS	(Specify)	Residential Care Home	Period 7/1 Thru 9/30 Total	CCNH / RHNS	(Specify)	Residential Care Home
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	36			36	36			36				
B. On last day of THIS report period	36			36					36			36
2. Number of Residents												
A. As of midnight of PREVIOUS report period	36			36	36			36				
B. As of midnight of THIS report period	36			36					36			36
3. Total Number of Days Care Provided During Period												
A. Medicare												
B. Medicaid (Conn.)	12,161			12,161	9,125			9,125	3,036			3,036
C. Medicaid (other states)												
D. Private Pay	389			389	297			297	92			92
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	12,550			12,550	9,422			9,422	3,128			3,128
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)**	12,550			12,550	9,422			9,422	3,128			3,128

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH / RHNS	(Specify)	Residential Care Home	Lost			Gained			CCNH / RHNS	(Specify)	Residential Care Home	
	(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)	Residential Care Home
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)	Residential Care Home	R.C.H.	ICF-MR
No. of Residents						1	35	
Per Diem Rate								
a. One bed rm.						75.62	80.03	
b. Two bed rms.								
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	(Specify)	Outpatient	Residential Care Home
A. Medicare - Part B					
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other					
D. ***Total Physical Therapy Treatments***					
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B					
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other					
D. ***Total Speech Therapy Treatments***					
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B					
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other					
D. ***Total Occupational Therapy Treatments***					

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	10	37

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

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	Residential Care Home	Adjustment	Hours
A. Salaries and Wages*									
1. Operators/Owners (Complete also Sec. I of Schedule A1)							25,690		1,040
2. Administrator(s) (Complete also Sec. III of Schedule A1)							61,558		2,080
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)							37,048		1,464
5. Dietary Service									
a. Head Dietitian									
b. Food Service Supervisor									
c. Dietary Workers							50,401		1,997
6. Housekeeping Service									
a. Head Housekeeper									
b. Other Housekeeping Workers							106,877		7,662
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance									
b. Other Maintenance Workers							41,867		1,855
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									
12. Professional Care of Residents									
a. Directors and Assistant Director of Nurses									
b. RN									
1. Direct Care									
2. Administrative**									
c. LPN									
1. Direct Care									
2. Administrative**									
d. Aides and Attendants							109,711		5,822
e. Physical Therapists									
f. Speech Therapists									
g. Occupational Therapists									
h. Recreation Workers							19,567		1,117
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									
n. Marketing									
o. Other (Specify) See Attached Schedule									
A-13. Total Salary Expenditures							452,718		23,037

* 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 in the Adjustment column.

Schedule of Other Salaries and Wages (Page 10)

	CCNH / RHNS			(Specify)			Residential Care Home		
Position	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**
Total	$ -	$ -	-	$ -	$ -	-	$ -	$ -	-

Schedule of Other Fees (Page 13)

	CCNH / RHNS			(Specify)			Residential Care Home		
Service	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**
Total	$ -	$ -	-	$ -	$ -	-	$ -	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	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)	Residential Care Home							
Section I - Operators/Owners										
Jaswinder Bhogal			25,690	Pension	Accountig, Records, Etc.	1,040	A1	April Time	2,080	61,540
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	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)	Residential Care Home							
Section III - Administrators* **										
Kuldip Bhogal			61,558	Grp Ins Pension	Administrator	2,080	A2	April Time	1,040	25,690
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	13	37

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	Residential Care Home	Adjustment	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									
3. Pharmacist									
4. Podiatrist									
5. Physical Therapy									
a. Resident Care									
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)									
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									
B-13 Total Fees Paid in Lieu of Salaries									

* 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 in the Adjustment column.

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

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CSP-14 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
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* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended					Page	of
High Chase, LLC	1871	9/30/2023					15	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	$	10,820					10,820	
2. Disability Insurance	$							
3. Unemployment Insurance	$	6,000					6,000	
4. Social Security (F.I.C.A.)	$	35,142					35,142	
5. Health Insurance	$	33,543					33,543	
6. Life Insurance (employees only) (not-owners and not-operators)	$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	9,018					9,018	
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*	$							
d. Accounting and Auditing	$	5,500					5,500	
e. Legal (*Services should be fully described on Page 15b)*	$							
f. Insurance on Lives of Owners and Operators (*Specify*)*	$							
g. Office Supplies	$	2,018					2,018	
h. Telephone and Cellular Phones								
1. Telephone & Pagers	$	2,442					2,442	
2. Cellular Phones	$	1,708					1,708	(208)
i. Appraisal (*Specify purpose and attach copy*)*	$							
j. Corporation Business Taxes (*franchise tax*)	$	4,493					4,493	(4,243)
k. Other Taxes (*Not related to property - See Page 22)*								
1. Income*	$	1,260					1,260	(1,260)
2. Other (*Specify*) See Attached Schedule	$							
3. Resident Day User Fee	$							
Subtotal	$	111,944					111,944	(5,711)

* Facility should self-disallow the expense in the Adjustment column.

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
Total	$ -	$ -	$ -	$ -	$ -	$ -

Schedule of Other Taxes

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
Total	$ -	$ -	$ -	$ -	$ -	$ -

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	15b	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 CJLC LLC	225 Pitkin St., East Hartford, CT 06108
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1 Medicaid Cost Report Preperation	$ 5,500
2	$
3	$
4	$
	Charge for Services Provided $ 5,500

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

⊙ Yes ○ No 15/1d

Legal Services Information

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

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

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

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

⊙ Yes ○ No 15/1e

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

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	16	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
Subtotals Brought Forward:		111,944					111,944	(5,711)
l. Travel and Entertainment								
1. Resident Travel and Entertainment	$							
2. Holiday Parties for Staff	$							
3. Gifts to Staff and Residents	$							
4. Employee Travel	$							
5. Education Expenses Related to Seminars and Conventions	$							
6. Automobile Expense (*not purchase or depreciation*)	$	1,369					1,369	(547)
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*)*** 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	$	126					126	
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	700					700	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$							
9. Subscriptions	$							
10. Contributions*** See Attached Schedule	$							
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$							
12. Administrative Management Services**	$							
13. Other (*Specify*) See Attached Schedule	$	9,525					9,525	
C-14 Total Administrative & General Expenditures	$	123,664					123,664	(6,258)

* 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 expensein the Adjustment column.

Schedule of Other Travel and Entertainment

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
Total Other Travel and Entertainment	$ -	$ -	$ -	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
Total Other Advertising	$ -	$ -	$ -	$ -	$ -	$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
CARCH					$ 700	
Total Dues	$ -	$ -	$ -	$ -	$ 700	$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
Total Contributions	$ -	$ -	$ -	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
DPH License Renewal Fee					$ 727	
Boiler Permit					$ 81	
State of CT Annual Filing Fee					$ 160	
Eastern Highlands Health District					$ 392	
Food Operating License Renewal					$ 126	
Payroll Processing Fee					$ 5,403	
Pension Admin Service					$ 1,460	
Costco Membership					$ 120	
Chase Annual Fee					$ 99	
Background Check					$ 957	
Total Other Administrative and General	$ -	$ -	$ -	$ -	$ 9,525	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
High Chase, LLC	1871	9/30/2023	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 #

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	18	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	$	78,075					78,075	
2. Non-Food Supplies	$	7,834					7,834	
3. Other (*Specify*)_____	$							
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$							
c. Other (*Specify*)_____	$							
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	85,909					85,909	

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

G.	Is cost of employee meals included in 2D?	○ Yes	⊙ No	
H.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	○ Yes	⊙ No	If yes, specify cost.
K.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	○ Yes	⊙ No	If yes, specify cost.
N.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

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

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CSP-19 Rev. 3/2023

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
High Chase, LLC	1871	9/30/2023	19	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
3. Laundry								
a. In-House Processing*	Lbs.							
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $							
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.							
	Amt. $							
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.							
	Amt. $							
4. Repair and/or purchase of linens.***	Lbs.							
	Amt. $							
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	34,457					34,457	
c. Other (*Specify*) Supplies	$	918					918	
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	35,376					35,376	

3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	○ Yes	⊙ No	If yes, specify cost.	
G. Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.	
H. Where is the revenue received reported in the Cost Report?		(Page/Line Item)		
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	○ Yes	⊙ No	If yes, specify cost.	
J. Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.	
K. Where is the revenue received reported in the Cost Report?		(Page/Line Item)		

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3D.

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

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CSP-20 Rev. 3/2023

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
High Chase, LLC	1871	9/30/2023	20	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
4. Housekeeping	Sq. Ft. Serviced by Personnel							
a. In-House Care								
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt. $							
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel							
	Amt. $							
C. Other (*Specify*) $		8,292					8,292	
Supplies								
4D. ***Total Housekeeping Expenditures*** (4a + b + c) $		8,292					8,292	
5. Resident Care (Supplies)**								
a. Prescription Drugs***								
1. Own Pharmacy $								
2. Purchased from $								
b. Medicine Cabinet Drugs $								
c. Medical and Therapeutic Supplies $								
d. Ambulance/Limousine*** $								
e. Oxygen								
1. For Emergency Use $								
2. Other*** $								
f. X-rays and Related Radiological Procedures*** $								
g. Dental (*Not dentists who should be included under salaries or fees*) $								
h. Laboratory*** $								
i. Recreation $		200					200	
j. Direct Management Services* $								
k. Indirect Management Services* $								
l. Cable TV $		2,000					2,000	
m. Other (Specify)**** $								
See Attached Schedule								
n. Physical Therapy Expense $								
o. Speech Therapy Expense $								
5P. ***Total Resident Care Expenditures*** (5a - 5o) $		2,200					2,200	

* 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 in the Adjustment column.

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

Schedule of Other Resident Care

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
Total Other Resident Care	$ -	$ -	$ -	$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	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)	Residential Care Home	Pg	Line
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	22	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	$	33,707					33,707	
b. Heat	$	21,639					21,639	
c. Light & Power	$	13,859					13,859	
d. Water	$	8,925					8,925	
e. Equipment Lease (*Provide detail on page 22b*)	$							
f. Other (*itemize*)	$							
See Attached Schedule								
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	78,131					78,131	
7. Depreciation (*complete schedule page 23**)								
a. Land Improvements	$	561					561	
b. Building & Building Improvements	$							
c. Non-Movable Equipment	$	6,857					6,857	
d. Movable Equipment	$	6,821					6,821	(1,542)
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	14,239					14,239	(1,542)
8. Amortization (*Complete att. Schedule Page 24**)								
a. Organization Expense	$							
b. Mortgage Expense	$							
c. Leasehold Improvements	$	11,021					11,021	
d. Other (*Specify*)	$							
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	11,021					11,021	
9. Rental payments on leased real property less real estate taxes included in item 10b	$	81,000					81,000	
10. Property Taxes								
a. Real estate taxes paid by owner	$	16,724					16,724	
b. Real estate taxes paid by lessor	$							
c. Personal property taxes	$	3,356					3,356	(113)
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	126,340					126,340	(1,655)

* 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	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
Total Other Repairs and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	22b	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.

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
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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	14,193		14,193	7,511	SL	Var	561	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								561
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	53,216		53,216	43,604	SL	Var	5,157	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	8,500		8,500	48,761	SL	5	1,700	
C-4. Subtotal								6,857

	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. 2013 Mercedes		X	4	2015	38,559		38,559	30,847	SL	5	3,856	
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			Vr	Var	21,040		21,040	8,131	SL	Var	1,812	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative												
d. Standard Resident					5,769		5,768	9,943	SL	5	1,153	
e. Specialized Resident												
Total Acquired during this report period					5,769		5,768	9,943			1,153	
D-3. Subtotal												6,821
E. ***Total Depreciation***												14,239

Schedule of Land Improvements Acquired during this report period

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

***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 Improvements		$ -		$ -	*
Deletions:					
Total deletions for Building Improvements		$ -		$ -	**

***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:					
9/25/2023	New Carpet	$ 8,500	5	$ 1,700	
Total additions for Non-Movable Equipment		$ 8,500		$ 1,700	*
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	Pick One Movable Category	Cost	Useful Life	Depreciation	
Additions:						
11/14/2022	Ikea Dresser Drawer	Standard Resident	$ 2,158	5	$ 431	
11/24/2022	Settee	Standard Resident	$ 2,340		$ 468	
1/11/2023	Mattress	Standard Resident	$ 1,271		$ 254	
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
Total additions for Movable Equipment			$ 5,769		$ 1,153	*
Deletions:						
Total deletions for Movable Equipment			$ -		$ -	**

***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 Improvement		$ -		$ -	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	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	Var		200,390	115,955	SL	Var	11,021	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									11,021
D. ***Total Amortization***									11,021

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page of
High Chase, LLC	1871	9/30/2023	25 | 37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	03/31/14
4. Date of Initial Licensure	03/31/14
5. Total Licensed Bed Capacity	36
6. Square Footage	
7. Acquisition Cost	
a. Land	
b. Building	340,000

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)				
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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	26	37

Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage $							
Name of Lender / Rate							
Address of Lender							
2. Second Mortgage $							
Name of Lender / Rate							
Address of Lender							
3. Third Mortgage $							
Name of Lender / Rate							
Address of Lender							
4. Fourth Mortgage $							
Name of Lender / Rate							
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount $							
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expense							
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $							

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	27	37

Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
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) $	9,850					9,850	
b. Insurance on Automobiles $	1,295					1,295	(518)
c. Insurance other than Property (as specified above) 1. Umbrella (*Blanket Coverage*) $	16,705					16,705	
2. Fire and Extended Coverage $							
3. Other (*Specify*) $							
14d. ***Total Insurance Expenditures (14a + b + c)*** $	27,850					27,850	(518)
15. ***Total All Expenditures (A-13 thru C-14)*** $	940,479					940,479	(8,431)

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
High Chase, LLC	1871	9/30/2023	30 | 37

Item		Total	CCNH / RHNS	(Specify)	Residential Care Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	955,212			955,212
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)*	$				
b. Medicare Room and Board Contractual Allowance **	$				
4. a. Private-Pay Residents and Other	$	40,187			40,187
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$				
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$				
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	$				
b. Physical Therapy - Medicare Contractual Allowance **	$				
c. Physical Therapy - Non-Medicare	$				
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$				
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$				
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	28,108			28,108
III. *Total Resident Revenue* (Section I. thru Section II.)	$	1,023,507			1,023,507
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$				
V. Total Other Revenue (1 thru 8)	$				
VI. Total All Revenue (III +V)	$	1,023,507			1,023,507

* *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)	Residential Care Home
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	Residential Care Home
30 6b	ARPA			$ 28,108
Total Other Resident Revenue		$ -	$ -	$ 28,108

Interest Income

Page Ref	Account	Account Balance	CCNH / RHNS	(Specify)	Residential Care Home
Total Interest Income			$ -	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	Residential Care Home
Total Other Revenue		$ -	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 132,774
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 46,132
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 16,633
a. Prepaid Insurance				
b. Prepaid Taxes				
c.				
d. See Schedule		16,633		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 195,540
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	14,193		$ 6,122
	Accum. Depreciation	8,071	Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	200,390		$ 73,415
	Accum. Depreciation	126,976	Net	
5. Non-Movable Equipment	*Historical Cost	61,716		$ 11,255
	Accum. Depreciation	50,461	Net	
6. Movable Equipment	*Historical Cost	26,808		$ 15,711
	Accum. Depreciation	11,097	Net	
7. Motor Vehicles	*Historical Cost	38,559		$ 3,856
	Accum. Depreciation	34,703	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 110,359

* 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	$ 11,566
31	A5	Prepaid Taxes	$ 5,067
Total Prepaid Expenses			$ 16,633

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

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

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
33	A2	N/P PPP	$ 4,000
Total Notes Payable			$ 4,000

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

Page Ref	Line Ref	Description	
33	A12	Due to April Time	$ 7,377
33	A12	Accrued Pension	$ 9,018
33	A12	Resident Funds	$ 5,020
Total Other Current Liabilities (Itemize)			$ 21,415

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

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	32	37

Account				Amount
			Total Brought Forward:	$ 305,898
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*)				$
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 305,898

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 44,520
	2. Notes Payable (*itemize*)				$ 4,000
	See Schedule		4,000		
	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*)				$ 9,204
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 765
	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*)				$ 21,415
	See Schedule		21,415		
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 79,904

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	34	37

Account	Amount
Total Brought Forward:	79,904
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*)	$ (17,581)

Name and Address of Lender	Amount	Loan Date
Related	(17,581)	Open

4. Other Long-Term Liabilities (*itemize*)	$
See Schedule	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ (17,581)
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 62,323

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

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	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. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 160,548
	6. Gain or Loss for Period 10/1/2022 thru 9/30/2023	$ 83,028
	7. Total Net Worth	$ 243,576
C.	***Total Reserves and Net Worth***	$ 243,576
D.	***Total Liabilities, Reserves, and Net Worth***	$ 305,899

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2022			$ 159,164
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 1,023,507
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 940,479
D.	Net Income or Deficit			$ 83,028
E.	Balance			$ 242,192
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period*** 09/30/23			$ 242,192

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
High Chase, LLC	1871	9/30/2023	37	37

Check appropriate category

☐ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	☑ (Specify)	☑ Residential Care Home

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
CJLC LLC

Addres Address	Phone Number
225 Pitkin St., East Hartford, CT 06108	860-610-9009

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
CJLC	860-610-9009

Contact Email Address
annualreports@cjlc.com