# State of Connecticut



# Annual Report of Long-Term Care Facility

Cost Year 2017



| | | |
|---|---|---|
| Name of Facility (as licensed)<br>APRIL TIME RESIDENTIAL CARE HOME, LLC | | |
| Address (No. & Street, City, State, Zip Code)<br>91 CHESTNUT ST., MANCHESTER CT 06040 | | |
| Type of Facility<br>☐ Chronic and Convalescent Nursing Home only (CCNH) | ☐ Rest Home with Nursing Supervision only (RHNS) | ☑ Residential Care Home |
| Report for Year Beginning<br>10/01/16 | Report for Year Ending<br>09/30/17 | |

| License Numbers: | CCNH | RHNS | Residential Care Home | Medicare Provider |
|---|---|---|---|---|
| | | | 1885 | |

| Medicaid Provider Numbers: | CCNH | RHNS | ICF-IID |
|---|---|---|---|
| | | | |

**For Department Use Only**

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

# Table of Contents

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

## General Information

| Name of Facility (as licensed) | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 1885 | 09/30/17 | 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 APRIL TIME RESIDENTIAL CARE HOME, LLC [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, 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 |
|---|---|---|---|---|
| JBhogal | | 1/30/18 | KBhogal | 1/30/2018 |
| Printed Name (Administrator)<br>JASWINDER BHOGAL | | | Printed Name (Owner)<br>KULDIP BHOGAL | |
| Subscribed and Sworn to before me:<br>LEEANN R. MORRONE | State of<br>CT | Date<br>1/30/18 | Signed (Notary Public)<br>LeeAnn R Morrone | Comm. Expires<br>08/31/20 |
| Address of Notary Public<br>166 CEDAR ST NEWINGTON CT 06111 | | | | |

(Notary Seal)

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

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

| **Data Required for Real Wage Adjustment** | | | Page 1A | of 37 |
|---|---|---|---|---|
| Name of Facility<br>APRIL TIME RESIDENTIAL CARE HOME, LLC | Period Covered: | | From 10/01/16 | To 09/30/17 |
| Address of Facility<br>91 CHESTNUT ST., MANCHESTER CT 06040 | | | | |
| Report Prepared By<br>THOMAS W. DANIELE CPA | Phone Number<br>860-666-5942 | | Date<br>01/15/18 | |

| Item | | Total | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|---|
| 1. Dietary wages paid | $ | 46,666 | | | 46,666 |
| 2. Laundry wages paid | $ | 20,333 | | | 20,333 |
| 3. Housekeeping wages paid | $ | 55,648 | | | 55,648 |
| 4. Nursing wages paid | $ | 120,492 | | | 120,492 |
| 5. All other wages paid | $ | 47,255 | | | 47,255 |
| 6. ***Total Wages Paid*** | $ | 290,394 | | | 290,394 |
| 7. Total salaries paid | $ | 86,002 | | | 86,002 |
| 8. ***Total Wages and Salaries Paid*** (As per page 10 of Report) | $ | 376,396 | | | 376,396 |

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

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

# General Information and Questionnaire

## Type of Facility - Organization Structure

| Phone No. of Facility | Report for Year Ended | Page | of |
|---|---|---|---|
| 860-649-4519 | 09/30/17 | 2 | 37 |

| Name of Facility (as shown on license) | Address (*No. & Street, City, State, Zip*) |
|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 91 CHESTNUT ST., MANCHESTER CT 06040 |

| License Numbers: | CCNH | RHNS | Residential Care Home | Medicare Provider No. |
|---|---|---|---|---|
| | | | 1885 | |

Type of Facility (Check appropriate box(es))

☐ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☑ 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.: |
|---|---|
| JASWINDER BHOGAL | |

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

| Name | License No.: |
|---|---|
| | |
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State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-3 Rev. 10/2005

# General Information and Questionnaire
## Partners/Members

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 1885 | 09/30/17 | 3 | 37 |

| Legal Name of Partnership/LLC | Business Address | State(s) and/or Town(s) in Which Registered |
|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 91 CHESTNUT ST., MANCHESTER CT 06040 | CT. |

| Name of Partners/Members | Business Address | Title | % Owned |
|---|---|---|---|
| KULDIP BHOGAL | 91 CHESTNUT ST., MANCHESTER CT 06040 | Member | 50 |
| JASWINDER BHOGAL | 91 CHESTNUT ST., MANCHESTER CT 06040 | Member | 50 |
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State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-3A Rev. 10/2005

# General Information and Questionnaire
## Corporate Owners

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOMI | 1885 | 09/30/17 | 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 |
|---|---|---|
| | | |

| Name of Directors, Officers | Business Address | Title | No. Shares Held by Each |
|---|---|---|---|
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| Names of Stockholders Owning at Least 10% of Shares | | | |
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State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-3B Rev. 10/2005

# General Information and Questionnaire
## Individual Proprietorship

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 1885 | 09/30/17 | 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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State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-4 Rev. 10/2005

# General Information and Questionnaire
## Related Parties*

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 1885 | 09/30/17 | 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, LLC | 91 CHESTNUT ST., MANCHESTER CT 06040 | ○ | ⊙ | | Rent of real property | 22/9 | 84,500 | |
| J & K Bhogal Realty, LLC | 91 CHESTNUT ST., MANCHESTER CT 06040 | ○ | ⊙ | | open loan | 34/b3 | 12,900 | 12,900 |
| Kuldip & Jaswinder | 91 CHESTNUT ST., MANCHESTER CT 06040 | ○ | ⊙ | | open loan | 34/b3 | (86,603) | (86,603) |
| | | ○ | ○ | | | | | |
| | | ○ | ○ | | | | | |
| | | ○ | ○ | | | | | |
| | | ○ | ○ | | | | | |
| | | ○ | ○ | | | | | |
| | | ○ | ○ | | | | | |

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

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

# General Information and Questionnaire
## Basis for Allocation of Costs

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, I | 1885 | 09/30/17 | 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.

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

# General Information and Questionnaire
# Leases (Excluding Real Property)

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

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 1885 | 09/30/17 | 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 | | | | | |
| | O | O | | | | | |
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| | | | | | | **Total** *** | |

Is a Mileage Log Book Maintained for All Leased Vehicles ? O Yes O 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.

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

# General Information and Questionnaire
## Accounting Basis

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CA | 1885 | 09/30/17 | 7 | 37 |

The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

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

**Independent Accounting Firm**

| Name of Accounting Firm | Address (No. & Street, City, State, Zip Code) |
|---|---|
| 1 Daniele & Associates, LLC | 66 Cedar ST., Newington, CT 06111 |
| 2 | |
| 3 | |
| 4 | |

Services Provided by This Firm (*describe fully*)

| | |
|---|---|
| 1 DSS Cost Report, Tax Returns, | $ 10,970 |
| 2 | $ |
| 3 | $ |
| 4 | $ |
| | Charge for Services Provided $ 10,970 |

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 NA | |
| 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

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

# Schedule of Resident Statistics

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 1885 | 09/30/17 | 8 | 37 |

| | Total All Levels | Total CCNH Level | Total RHNS Level | Total Residential Care Home | Period 10/1 Thru 6/30 | | | | Period 7/1 Thru 9/30 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Total | CCNH | RHNS | Residential Care Home | Total | CCNH | RHNS | Residential Care Home |
| 1. Certified Bed Capacity | | | | | | | | | | | | |
| A. On last day of PREVIOUS report period | 34 | | | 34 | 34 | | | 34 | | | | |
| B. On last day of THIS report period | 34 | | | 34 | | | | | 34 | | | 34 |
| 2. Number of Residents | | | | | | | | | | | | |
| A. As of midnight of PREVIOUS report period | 34 | | | 34 | 34 | | | 34 | | | | |
| B. As of midnight of THIS report period | 33 | | | 33 | | | | | 33 | | | 33 |
| 3. Total Number of Days Care Provided During Period | | | | | | | | | | | | |
| A. Medicare | | | | | | | | | | | | |
| B. Medicaid (Conn.) | | | | | | | | | | | | |
| C. Medicaid (other states) | | | | | | | | | | | | |
| D. Private Pay | 853 | | | 853 | 669 | | | 669 | 184 | | | 184 |
| E. State SSI for RCH | 11,198 | | | 11,198 | 8,346 | | | 8,346 | 2,852 | | | 2,852 |
| F. Other (Specify) | | | | | | | | | | | | |
| G. Total Care Days During Period (3A thru F) | 12,051 | | | 12,051 | 9,015 | | | 9,015 | 3,036 | | | 3,036 |
| 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)** | 12,051 | | | 12,051 | 9,015 | | | 9,015 | 3,036 | | | 3,036 |

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

# Schedule of Resident Statistics (Cont'd)

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME | 1885 | 09/30/17 | 9 | 37 |

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

| Date of Change | Place of Change | | | Change in Beds | | | | | | Capacity After Change | | | Reason for Change |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | CCNH (1) | RHNS (2) | Residential Care Home (3) | Lost (1) | Lost (2) | Lost (3) | Gained (1) | Gained (2) | Gained (3) | CCNH | RHNS | Residential Care Home | |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | |

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 | 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 | CCNH | RHNS | CCNH | RHNS | Residential Care Home | R.C.H. | ICF-MR |
| No. of Residents | | | | | | | | |
| Per Diem Rate | | | | | | | | |
| a. One bed rm. | | | | | | | | |
| b. Two bed rms. | | | 70.64 | | | 81.53 | | |
| c. Three or more bed rms. | | | | | | | | |

| | TOTAL | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|
| 7. Total Number of Physical Therapy Treatments | | | | |
| 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*** | | | | |

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

# Report of Expenditures - Salaries & Wages

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 1885 | 09/30/17 | 10 | 37 |

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

| | Total Cost and Hours | | | | | |
|---|---|---|---|---|---|---|
| Item | CCNH | Hours | RHNS | Hours | Residential Care Home | Hours |
| A. Salaries and Wages* | | | | | | |
| 1. Operators/Owners (Complete also Sec. I of Schedule A1) | | | | | 24,800 | 1,040 |
| 2. Administrator(s) (Complete also Sec. III of Schedule A1) | | | | | 61,202 | 2,182 |
| 3. Assistant Administrator (Complete also Sec. IV of Schedule A1) | | | | | | |
| 4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.) | | | | | | |
| 5. Dietary Service | | | | | | |
| a. Head Dietitian | | | | | | |
| b. Food Service Supervisor | | | | | | |
| c. Dietary Workers | | | | | 46,666 | 2,529 |
| 6. Housekeeping Service | | | | | | |
| a. Head Housekeeper | | | | | | |
| b. Other Housekeeping Workers | | | | | 55,648 | 5,927 |
| 7. Repairs & Maintenance Services | | | | | | |
| a. Engineer or Chief of Maintenance | | | | | | |
| b. Other Maintenance Workers | | | | | 33,358 | 2,009 |
| 8. Laundry Service | | | | | | |
| a. Supervisor | | | | | | |
| b. Other Laundry Workers | | | | | 20,333 | 2,111 |
| 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 | | | | | 120,492 | 8,386 |
| e. Physical Therapists | | | | | | |
| f. Speech Therapists | | | | | | |
| g. Occupational Therapists | | | | | | |
| h. Recreation Workers | | | | | 13,897 | 1,059 |
| 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* | | | | | 376,396 | 25,243 |

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

**Schedule of Other Salaries and Wages (Page 10)**

| | CCNH | | RHNS | | Residential Care Home | |
|---|---|---|---|---|---|---|
| **Position** | **$** | **Hours** | **$** | **Hours** | **$** | **Hours** |
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| **Total** | $ - | - | $ - | - | $ - | - |

**Schedule of Other Fees (Page 13)**

| | CCNH | | RHNS | | Residential Care Home | |
|---|---|---|---|---|---|---|
| **Service** | **$** | **Hours** | **$** | **Hours** | **$** | **Hours** |
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| **Total** | $ - | - | $ - | - | $ - | - |

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

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

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 1885 | 09/30/17 | 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 | Residential Care Home | | | | | | | |
| **Section I - Operators/Owners** | | | | | | | | | | |
| Kuldip Bhogal | | | 24,800 | Pension | Facility & Pension | 1,040 | A1 | High Chase LLC | 2,182 | 61,102 |
| | | | | | | | | | | |
| | | | | | | | | | | |
| **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).** | | | | | | | | | | |
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* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

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

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

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

| Name of Facility (as licensed) | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 1885 | 09/30/17 | 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 | Residential Care Home | | | | | | | |
| **Section III - Administrators*** ** | | | | | | | | | | |
| Jaswinder Bhogal | | | 61,202 | Pension & Grp Ins | Administration | 2,182 | A2 | High Chase, LLC | 1,043 | 24,700 |
| | | | | | | | | | | |
| | | | | | | | | | | |
| **Section IV - Assistant Administrators** | | | | | | | | | | |
| | | | | | | | | | | |
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*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

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

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

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

# B. Report of Expenditures - Professional Fees

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 1885 | 09/30/17 | 13 | 37 |

| | Total Cost and Hours | | | | | |
|---|---|---|---|---|---|---|
| **Item** | CCNH | Hours | RHNS | Hours | Residential Care Home | 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 on Page 28.

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

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

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

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 1885 | 09/30/17 | 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.

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-15 Rev. 10/2005

# C. Expenditures Other Than Salaries - Administrative and General

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, L | 1885 | 09/30/17 | 15 | 37 |

| Item | | Total | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|---|
| 1. Administrative and General | | | | | |
| a. Employee Health & Welfare Benefits | | | | | |
| 1. Workmen's Compensation | $ | 13,688 | | | 13,688 |
| 2. Disability Insurance | $ | | | | |
| 3. Unemployment Insurance | $ | 5,371 | | | 5,371 |
| 4. Social Security (F.I.C.A.) | $ | 28,730 | | | 28,730 |
| 5. Health Insurance | $ | 94,576 | | | 94,576 |
| 6. Life Insurance (employees only) (not-owners and not-operators) | $ | | | | |
| 7. Pensions (Non-Discriminatory) (not-owners and not-operators) | $ | 15,746 | | | 15,746 |
| 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 | $ | 10,970 | | | 10,970 |
| e. Legal (*Services should be fully described on Page 7)* | $ | | | | |
| f. Insurance on Lives of Owners and Operators (*Specify*)* | $ | | | | |
| g. Office Supplies | $ | 266 | | | 266 |
| h. Telephone and Cellular Phones | | | | | |
| 1. Telephone & Pagers | $ | 2,357 | | | 2,357 |
| 2. Cellular Phones | $ | 919 | | | 919 |
| i. Appraisal (*Specify purpose and attach copy*)* | $ | | | | |
| j. Corporation Business Taxes (*franchise tax*) | $ | 250 | | | 250 |
| k. Other Taxes (*Not related to property - See Page 22)* | | | | | |
| 1. Income* | $ | 14,482 | | | 14,482 |
| 2. Other (*Specify*) See Attached Schedule | $ | | | | |
| 3. Resident Day User Fee | $ | | | | |
| ***Subtotal*** | $ | 187,355 | | | 187,355 |

* 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

APRIL TIME RESIDENTIAL CARE HOME, LLC
09/30/17



**Schedule of Other Employee Benefits**

| Description | CCNH | RHNS | Residential Care Home |
|---|---|---|---|
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| | | | |
| **Total** | $ - | $ - | $ - |

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**Schedule of Other Taxes**

| Description | CCNH | RHNS | Residential Care Home |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| **Total** | $ - | $ - | $ - |

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

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

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 1885 | 09/30/17 | 16 | 37 |

| Item | | Total | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|---|
| ***Subtotals Brought Forward:*** | | 187,355 | | | 187,355 |
| l. Travel and Entertainment | | | | | |
| 1. Resident Travel and Entertainment | $ | 360 | | | 360 |
| 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*) | $ | 519 | | | 519 |
| 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 | $ | 199 | | | 199 |
| * 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule | $ | | | | |
| 8a. Dues to Chamber of Commerce & Other Non-Allowable Org.*** | $ | 274 | | | 274 |
| 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 | $ | 5,721 | | | 5,721 |
| ***C-14 Total Administrative & General Expenditures*** | $ | 194,428 | | | 194,428 |

* 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 | Residential Care Home |
|---|---|---|---|
| | | | |
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| | | | |
| | | | |
| **Total Other Travel and Entertainment** | $ - | $ - | $ - |

**Schedule of Other Advertising**

| Description | CCNH | RHNS | Residential Care Home |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| **Total Other Advertising** | $ - | $ - | $ - |

**Schedule of Dues**

| Description | CCNH | RHNS | Residential Care Home |
|---|---|---|---|
| | | | |
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| | | | |
| **Total Dues** | $ - | $ - | $ - |

**Schedule of Contributions**

| Description | CCNH | RHNS | Residential Care Home |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| **Total Contributions** | $ - | $ - | $ - |

**Schedule of Other Administrative and General**

| Description | CCNH | RHNS | Residential Care Home |
|---|---|---|---|
| Payroll Processing | | | $ 3,360 |
| Pension Administration | | | $ 992 |
| Licenses | | | $ 220 |
| Rent- Parking Spaces | | | $ 1,149 |
| | | | |
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| | | | |
| **Total Other Administrative and General** | $ - | $ - | $ 5,721 |

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

# Schedule C-1 - Management Services*

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HO | 1885 | 09/30/17 | 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 # |
|---|---|---|---|
| N/A | | | |
| | | | |
| | | | |
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*** In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.**

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-18 Rev. 9/2002

# 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 |
|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 1885 | 09/30/17 | 18 \| 37 |

| Item | | Total | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|---|
| 2. Dietary | | | | | |
| a. In-House Preparation & Service | | | | | |
| 1. Raw Food | $ | 56,595 | | | 56,595 |
| 2. Non-Food Supplies | $ | 3,971 | | | 3,971 |
| 3. Other (*Specify*) _____ | $ | | | | |
| b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)* | $ | | | | |
| c. Management Services** | $ | | | | |
| d. Other (*Specify*) _____ | $ | | | | |
| 2E. ***Total Dietary Expenditures*** (2a + b + c + d) | $ | 60,566 | | | 60,566 |

| 2F. Dietary Questionnaire | Total | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|
| G. Resident Meals: Total no. of meals served per day:* | | | | |

| | | | | |
|---|---|---|---|---|
| H. | Is cost of employee meals included in 2E? | ○ Yes | ⊙ No | |
| I. | Did you receive revenue from employees? | ○ Yes | ⊙ No | If yes, specify amt. |
| J. | Where is the revenue received reported in the Cost Report? (Page/Line Item) | | | |
| K. | Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? | ○ Yes | ⊙ No | If yes, specify cost. |
| L. | Is any revenue collected from these people? | ○ Yes | ⊙ No | If yes, specify amt. |
| M. | Where is the revenue received reported in the Cost Report? (Page/Line Item) | | | |
| N. | Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? | ○ Yes | ⊙ No | If yes, specify cost. |
| O. | Is any revenue collected from employees? | ○ Yes | ⊙ No | If yes, specify amt. |
| P. | 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.
** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-19 Rev. 9/2002

# 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 |
|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 1885 | 09/30/17 | 19 \| 37 |

| Item | | Total | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|---|
| 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. $ | 221 | | | 221 |
| b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)* | $ | | | | |
| c. Management Services** | $ | | | | |
| d. Other (*Specify*) supplies | $ | 1,276 | | | 1,276 |
| 3E. ***Total Laundry Expenditures*** (3a + b + c + d) | $ | 1,497 | | | 1,497 |

| | | | | |
|---|---|---|---|---|
| 3F. | Laundry Questionnaire | | | |
| G. | Is cost of employee laundry included in 3E? | ○ Yes | ⊙ No | If yes, specify cost. |
| 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 laundry provided to persons other than employees or residents included in 3E? | ○ Yes | ⊙ No | If yes, specify cost. |
| K. | Did you receive revenue from these people? | ○ Yes | ⊙ No | If yes, specify amt. |
| L. | 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 3E.

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

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

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-20 Rev. 9/2002

# 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 |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, I | 1885 | 09/30/17 | 20 | 37 |

| Item | | | Total | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|---|---|
| 4. Housekeeping | Sq. Ft. Serviced by Personnel | | | | | |
| a. In-House Care | | | | | | |
| 1. Supplies - Cleaning (*Mops, pails, brooms, etc.*) | Amt. | $ | 8,459 | | | 8,459 |
| b. Purchased Services (*by contract other than through Management Services*) (*Complete Schedule C-2 att. Page 21*) | Sq. Ft. Serviced by Personnel | | | | | |
| | Amt. | $ | | | | |
| c. Management Services* | | $ | | | | |
| d. Other (*Specify*) | | $ | | | | |
| 4E. ***Total Housekeeping Expenditures*** (4a + b + c + d) | | $ | 8,459 | | | 8,459 |
| 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 | | $ | 2,085 | | | 2,085 |
| j. Other (Specify)**** See Attached Schedule | | $ | | | | |
| 5K. ***Total Resident Care Expenditures*** (5a - 5j) | | $ | 2,085 | | | 2,085 |

* 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 | Residential Care Home |
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| **Total Other Resident Care** | $ - | $ - | $ - |

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

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

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 1885 | 09/30/17 | 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 | Residential Care Home | Pg | Line |
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* List all contracted services over $10,000. Use additional sheets if necessary.
** Refer to Page 4 for definition of related.
*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

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

| Name of Facility | License No. | Report for Year Ended | | | Page of |
|---|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME. | 1885 | 09/30/17 | | | 22 \| 37 |
| Item | | Total | CCNH | RHNS | Residential Care Home |
| 6. Maintenance & Operation of Plant | | | | | |
| a. Repairs & Maintenance | $ | 21,447 | | | 21,447 |
| b. Heat | $ | 11,569 | | | 11,569 |
| c. Light & Power | $ | 12,369 | | | 12,369 |
| d. Water | $ | 7,824 | | | 7,824 |
| e. Equipment Lease (*Provide detail on page 6*) | $ | | | | |
| f. Other (*itemize*) | $ | | | | |
| See Attached Schedule | | | | | |
| 6g. ***Total Maint. & Operating Expense*** (6a - 6f) | $ | 53,209 | | | 53,209 |
| 7. Depreciation (*complete schedule page 23**) | | | | | |
| a. Land Improvements | $ | 1,830 | | | 1,830 |
| b. Building & Building Improvements | $ | | | | |
| c. Non-Movable Equipment | $ | (558) | | | (558) |
| d. Movable Equipment | $ | 8,873 | | | 8,873 |
| *7e. ***Total Depreciation Costs*** (7a + b + c + d) | $ | 10,145 | | | 10,145 |
| 8. Amortization (*Complete att. Schedule Page 24**) | | | | | |
| a. Organization Expense | $ | 5,667 | | | 5,667 |
| b. Mortgage Expense | $ | | | | |
| c. Leasehold Improvements | $ | 2,337 | | | 2,337 |
| d. Other (*Specify*) | $ | | | | |
| *8e. ***Total Amortization Costs*** (8a + b + c + d) | $ | 8,004 | | | 8,004 |
| 9. Rental payments on leased real property less real estate taxes included in item 10b | $ | 84,500 | | | 84,500 |
| 10. Property Taxes | | | | | |
| a. Real estate taxes paid by owner | $ | | | | |
| b. Real estate taxes paid by lessor | $ | 19,699 | | | 19,699 |
| c. Personal property taxes | $ | 3,948 | | | 3,948 |
| 11. ***Total Property Expenses*** (7e + 8e + 9 + 10) | $ | 126,296 | | | 126,296 |

* 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 | Residential Care Home |
|---|---|---|---|
| | | | |
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| | | | |
| | | | |
| **Total Other Repairs and Maintenance** | $ - | $ - | $ - |

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

# Depreciation Schedule

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 1885 | 09/30/17 | 23 | 37 |

| Property Item | Historical Cost Exclusive of Land | Less Salvage Value | Cost to Be Depreciated | Accumulated Depreciation to Beginning of Year's Operations | Method of Computing Depreciation | Useful Life | Depreciation for This Year | Totals |
|---|---|---|---|---|---|---|---|---|
| A. **Land Improvements** | | | | | | | | |
| 1. Acquired prior to this report period | 9,150 | | 9,150 | 4,194 | SL | 5 | 1,830 | |
| 2. Disposals (attach schedule) | | | | | | | | |
| 3. Acquired during this report period (attach schedule) | | | | | | | | |
| A-4. Subtotal | | | | | | | | 1,830 |
| 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 | 129,869 | | 129,869 | 119,757 | SL | 5-7 yrs | (558) | |
| 2. Disposals (attach schedule) | | | | | | | | |
| 3. Acquired during this report period (attach schedule) | | | | | | | | |
| C-4. Subtotal | | | | | | | | (558) |

| | 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. 2012 Cadillac SRX6 | x | | 12 | 2012 | 40,901 | | 40,901 | 30,676 | SL | 5 | 8,180 | |
| b. | | | | | | | | | | | | |
| c. | | | | | | | | | | | | |
| d. | | | | | | | | | | | | |
| 2. Movable Equipment | | | | | | | | | | | | |
| a. Acquired prior to this report period | | | | | 130,965 | | 130,965 | 130,041 | SL | 6 | 693 | |
| b. Disposals (attach schedule) | | | | | | | | | | | | |
| c. Acquired during this report period (attach schedule) | | | | | | | | | | | | |
| D-3. Subtotal | | | | | | | | | | | | 8,873 |
| E. ***Total Depreciation*** | | | | | | | | | | | | 10,145 |

APRIL TIME RESIDENTIAL CARE HOME, LLC
09/30/17

**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: | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Total additions for Non-Movable Equipment | | $ - | | $ - | * |
| 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: | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Total additions for Movable Equipment | | $ - | | $ - | * |
| 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

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

# Amortization Schedule*

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 1885 | 09/30/17 | 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. Goodwill | 10 | 2007 | 15 | 85,000 | 51,000 | SL | 6 | 5,667 | |
| 2. | | | | | | | | | |
| 3. | | | | | | | | | |
| A-4. Subtotal | | | | | | | | | 5,667 |
| B. **Mortgage Expense** | | | | | | | | | |
| 1. | | | | | | | | | |
| 2. | | | | | | | | | |
| 3. | | | | | | | | | |
| B-4. Subtotal | | | | | | | | | |
| C. **Leasehold Improvements and Other** | | | | | | | | | |
| 1. Acquired prior to this report period | | | | 90,227 | 33,867 | SL | Vario | 2,337 | |
| 2. Disposals (attach schedule) | | | | | | | | | |
| 3. Acquired during this report period (attach schedule) | | | | | | | | | |
| C-4. Subtotal | | | | | | | | | 2,337 |
| D. ***Total Amortization*** | | | | | | | | | 8,004 |

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

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

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE | 1885 | 09/30/17 | 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 | 10/05/07 |
| 4. Date of Initial Licensure | 10/05/07 |
| 5. Total Licensed Bed Capacity | 34 |
| 6. Square Footage | |
| 7. Acquisition Cost | |
| a. Land | |
| b. Building | |

| **Part B - Owner and Related Parties** | 1st Mortgage | 2nd Mortgage | 3rd Mortgage | 4th Mortgage |
|---|---|---|---|---|
| 1. Financing | | | | |
| a. Type of Financing (e.g., fixed, variable) | | | | |
| b. Date Mortgage Obtained | 10/05/07 | | | |
| c. Interest Rate for the Cost Year | 650.00% | | | |
| d. Term of Mortgage (number of years) | 20 | | | |
| e. Amount of Principal Borrowed | 425,000 | | | |
| f. Principal balance outstanding as of | 255,027 | | | |
| **Complete if Mortgage was Refinanced During Current Cost Year** | | | | |
| g. Type of Financing (e.g., fixed, variable) | | | | |
| h. Date of Refinancing | | | | |
| i. New Interest Rate | | | | |
| j. Term of Mortgage (number of years) | | | | |
| k. Amount of Principal Borrowed | | | | |
| l. Principal Outstanding on Note Paid-Off | | | | |

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

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

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

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

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

| Name of Facility | License No. | Report for Year Ended | | | Page of |
|---|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE | 1885 | 09/30/17 | | | 26 \| 37 |

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

(*Carry Subtotals forward to next page*)

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

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

| Name of Facility | License No. | Report for Year Ended | Page of |
|---|---|---|---|
| APRIL TIME RESIDENTIAL CAF | 1885 | 09/30/17 | 27 \| 37 |

| Item | | | Total | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|---|---|
| Subtotals Brought Forward: | | | | | | |
| 12. C. Movable Equipment<br>1. Automotive Equipment | | $ | 264 | | | 264 |
| A. Item<br>2013 Cadillac SRX6 | Rate<br>4.00% | Amount<br>2,167 | | | | |
| Lender<br>Chase Auto Finance | | | | | | |
| Address of Lender<br>PO Box 78068Phoenix, AZ 85060-8068 | | | | | | |
| 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) | | $ | 264 | | | 264 |
| 12. D. Other Interest Expense (*Specify*)<br>working capital | | $ | 1,873 | | | 1,873 |
| 13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) | | $ | 2,137 | | | 2,137 |
| 14. Insurance | | | | | | |
| a. Insurance on Property (buildings only) | | $ | 16,860 | | | 16,860 |
| b. Insurance on Automobiles | | $ | 1,408 | | | 1,408 |
| c. Insurance other than Property (as specified above)<br>1. Umbrella (*Blanket Coverage*) | | $ | | | | |
| 2. Fire and Extended Coverage | | $ | | | | |
| 3. Other (*Specify*) | | $ | | | | |
| 14d. ***Total Insurance Expenditures (14a + b + c)*** | | $ | 18,268 | | | 18,268 |
| 15. ***Total All Expenditures (A-13 thru C-14)*** | | $ | 843,341 | | | 843,341 |

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-28 Rev. 9/2002

# D. Adjustments to Statement of Expenditures

| Name of Facility | License No. | Report for Year Ended | Page of |
|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 1885 | 09/30/17 | 28 \| 37 |

| Item No. | Page No. | Line No. | Item Description | Total Amount of Decrease | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|---|---|---|
| ***Page 10 - Salaries and Wages*** | | | | | | | |
| 1. | | | Outpatient Service Costs $ | | | | |
| 2. | | | Salaries not related to Resident Care $ | | | | |
| 3. | | | Occupational Therapy $ | | | | |
| 4. | | | Other - See attached Schedule $ | | | | |
| ***Page 13 - Professional Fees*** | | | | | | | |
| 5. | | | Resident Care Physicians ** $ | | | | |
| 6. | | | Occupational Therapy $ | | | | |
| 7. | | | Other - See attached Schedule $ | | | | |
| ***Pages 15 & 16 - Administrative and General*** | | | | | | | |
| 8. | | | Discriminatory Benefits $ | | | | |
| 9. | | | Bad Debts $ | | | | |
| 10. | | | Accounting & Legal $ | | | | |
| 11. | | | Telephone $ | | | | |
| 12. | 15 | 1H2 | Cellular Telephone $ | 919 | | | 919 |
| 13. | | | Life insurance premiums on the life of Owners, Partners, Operators $ | | | | |
| 14. | | | Gifts, flowers and coffee shops $ | | | | |
| 15. | | | Education expenditures to colleges or universities for tuition and related costs for owners and employees $ | | | | |
| 16. | | | Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $ | | | | |
| 17. | | | Automobile Expense (e.g. personal use) $ | | | | |
| 18. | | | Unallowable Advertising * $ | | | | |
| 19. | | | Income Tax / Corporate Business Tax $ | | | | |
| 20. | | | Fund Raising / Contributions $ | | | | |
| 21. | | | Unallowable Management Fees $ | | | | |
| 22. | | | Barber and Beauty $ | | | | |
| 23. | | | Other - See attached Schedule $ | 3,400 | | | 3,400 |
| ***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) $ | 4,319 | | | 4,319 |

* 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 | Residential Care Home |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| **Total Other Salaries Adjustment** | | | $ - | $ - | $ - |

**Schedule of Fees Adjustments**

| Page Ref | Line Ref | Description | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| **Total Other Fees Adjustments** | | | $ - | $ - | $ - |

**Schedule of Other A&G Adjustments**

| Page Ref | Line Ref | Description | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|---|
| 16 | L6 | Auto Expense | | | $ 158 |
| 22 | 10e | Auto Tax | | | $ 243 |
| 22 | 14c | Auto Insurance | | | $ 429 |
| 22 | 7d | Auto Deprec | | | $ 2,490 |
| 22 | 12c1 | Auto Interest | | | $ 80 |
| | | | | | |
| **Total Other A&G Adjustments** | | | $ - | $ - | $ 3,400 |

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-29 Rev. 10/2006

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

| Name of Facility | License No. | Report for Year Ended | Page of |
|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME, LLC | 1885 | 09/30/17 | 29 \| 37 |

| Item No. | Page No. | Line No. | Item Description | Total Amount of Decrease | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|---|---|---|
| | | | Subtotals Brought Forward $ | 4,319 | | | 4,319 |
| ***Page 20 - Resident Care Supplies****** | | | | | | | |
| 27. | | | Prescription Drugs $ | | | | |
| 28. | | | Ambulance/Limousine $ | | | | |
| 29. | | | X-rays, etc $ | | | | |
| 30. | | | Laboratory $ | | | | |
| 31. | | | Medical Supplies $ | | | | |
| 32. | | | Oxygen (non emergency) $ | | | | |
| 33. | | | Occupational Therapy $ | | | | |
| 34. | | | Other - See Attached Schedule $ | | | | |
| ***Page 22 - Maintenance and Property*** | | | | | | | |
| *35.* | | | Excess Movable Equipment Depreciation See Attached Schedule $ | | | | |
| 36. | | | Depreciation on Unallowable Motor Vehicles $ | | | | |
| 37. | | | Unallowable Property and Real Estate Taxes $ | | | | |
| 38. | | | Rental of Building Space or Rooms $ | | | | |
| 39. | | | Other - See Attached Schedule $ | 5,667 | | | 5,667 |
| ***Page 27 - Insurance*** | | | | | | | |
| 40. | | | Mortgage Insurance $ | | | | |
| 41. | | | Property Insurance $ | | | | |
| ***Other - Miscellaneous*** | | | | | | | |
| 42. | | | Research or Experimental Activities $ | | | | |
| 43. | | | Radio and Television Revenue $ | | | | |
| 44. | | | Vending Machine Revenue $ | | | | |
| 45. | | | Purchase Discounts and Allowances $ | | | | |
| 46. | | | Duplications of functions or services $ | | | | |
| 47. | | | Expenditures made for the protection, enhancement or promotion of the providers interest $ | | | | |
| 48. | | | Interest Income on Accounts Rec $ | | | | |
| 49. | | | Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $ | | | | |
| ***Not For Profit Providers Only*** | | | | | | | |
| 50. | | | Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $ | | | | |
| 51. | | | ***Total Amount of Decrease (Items 1 - 50)*** $ | 9,986 | | | 9,986 |

*** 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.

APRIL TIME RESIDENTIAL CARE HOME, LLC
09/30/17

**Schedule of Other Ancillary Costs**

| Page Ref | Line Ref | Description | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|---|
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| | | | | | |
| | | | | | |
| **Total Other Ancillary Costs** | | | $ - | $ - | $ - |

**Schedule of Excess Movable Equipment Depreciation**

| Page Ref | Line Ref | Description | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
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| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| **Total Excess Movable Equipment Depreciation** | | | $ - | $ - | $ - |

**Schedule of Other Property Adjustments**

| Page Ref | Line Ref | Description | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|---|
| 22 | 8a | Goodwill amortization | | | $ 5,667 |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| **Total Other Property Adjustments** | | | $ - | $ - | $ 5,667 |

**Schedule of Other Adjustments**

| Page Ref | Line Ref | Description | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|---|
| | | | | | |
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| | | | | | |
| | | | | | |
| **Total Other Adjustments** | | | $ - | $ - | $ - |

**Schedule of Unallowable Building Interest**

| Page Ref | Line Ref | Description | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
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| | | | | | |
| | | | | | |
| | | | | | |
| **Total Unallowable Building Interest** | | | $ - | $ - | $ - |

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

## F. Statement of Revenue

| Name of Facility / License No. | Report for Year Ended | Page of |
|---|---|---|
| APRIL TIME RESIDENTIAL CARE HC 1885 | 09/30/17 | 30 \| 37 |

| Item | | Total | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|---|
| **I. Resident Room, Board & Routine Care Revenue** | | | | | |
| 1. a. Medicaid Residents (*CT only*) | $ | 800,250 | | | 800,250 |
| 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 | $ | 84,080 | | | 84,080 |
| 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 | $ | | | | |
| **III. *Total Resident Revenue*** (Section I. thru Section II.) | $ | 884,330 | | | 884,330 |
| **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)* | $ | 4 | | | 4 |
| 6. Private Duty Nurses' Fees | $ | | | | |
| 7. Barber, Coffee, Beauty and Gift shops | $ | | | | |
| 8. Other (*Specify*) | $ | | | | |
| ***V. Total Other Revenue*** (1 thru 8) | $ | 4 | | | 4 |
| ***VI. Total All Revenue*** (III +V) | $ | 884,334 | | | 884,334 |

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

**Schedule of Other Non-Medicare Resident Revenue**

**Related Exp**

| Page Ref | Description | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Total Other Resident Revenue** | | $ - | $ - | $ - |

## Interest Income

| Page Ref | Account | Balance | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|---|
| 30 | bank | | | | $ 4 |
| | | | | | |
| | | | | | |
| | | | | | |
| **Total Interest Income** | | | $ - | $ - | $ 4 |

**Schedule of Other Revenue**

| Page Ref | Description | CCNH | RHNS | Residential Care Home |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Total Other Revenue** | | $ - | $ - | $ - |

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

# G. Balance Sheet

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE H | 1885 | 09/30/17 | 31 | 37 |

| Account | | | | Amount |
|---|---|---|---|---|
| **Assets** | | | | |
| A. Current Assets | | | | |
| 1. Cash (*on hand and in banks*) | | | | $ 14,071 |
| 2. Resident Accounts Receivable (Less Allowance for Bad Debts) | | | | $ 55,134 |
| 3. Other Accounts Receivable (Excluding Owners or Related Parties) | | | | $ |
| 4 Inventories | | | | $ |
| 5. Prepaid Expenses | | | | $ 15,201 |
| a. RE & PP Taxes | | 6,428 | | |
| b. Group Ins | | 7,357 | | |
| c. Business Ins | | 1,416 | | |
| d. | | | | |
| 6. Interest Receivable | | | | $ |
| 7. Medicare Final Settlement Receivable | | | | $ |
| 8. Other Current Assets (*itemize*) | | | | $ |
| A-9. ***Total Current Assets*** (Lines A1 thru 8) | | | | $ 84,406 |
| B. Fixed Assets | | | | |
| 1. Land | | | | $ |
| 2. Land Improvements | *Historical Cost | 9,150 | | $ 3,126 |
| | Accum. Depreciation | 6,024 | Net | |
| 3. Buildings | *Historical Cost | | | $ |
| | Accum. Depreciation | | Net | |
| 4. Leasehold Improvements | *Historical Cost | 90,227 | | $ 54,023 |
| | Accum. Depreciation | 36,204 | Net | |
| 5. Non-Movable Equipment | *Historical Cost | 129,869 | | $ 10,670 |
| | Accum. Depreciation | 119,199 | Net | |
| 6. Movable Equipment | *Historical Cost | 130,965 | | $ 231 |
| | Accum. Depreciation | 130,734 | Net | |
| 7. Motor Vehicles | *Historical Cost | 40,901 | | $ 2,045 |
| | Accum. Depreciation | 38,856 | Net | |
| 8. Minor Equipment-Not Depreciable | | | | $ |
| 9. Other Fixed Assets (*itemize*) | | | | $ |
| B-10. ***Total Fixed Assets*** (Lines B1 thru 9) | | | | $ 70,095 |

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

*(Carry Total forward to next page)*

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

# G. Balance Sheet (cont'd)

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE H | 1885 | 09/30/17 | 32 | 37 |

| Account | | | | Amount |
|---|---|---|---|---|
| | | | Total Brought Forward: | $ 154,501 |
| 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 | 85,000 | | |
| | Accum. Depreciation | 56,667 | Net | $ 28,333 |
| 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*) | | | | $ |
| D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7) | | | | $ 28,333 |
| D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8) | | | | $ 182,834 |

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

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

# G. Balance Sheet (cont'd)

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOME | 1885 | 09/30/17 | 33 | 37 |

| Account | | | | | Amount |
|---|---|---|---|---|---|
| **Liabilities** | | | | | |
| A. Current Liabilities | | | | | |
| 1. Trade Accounts Payable | | | | | $ 24,431 |
| 2. Notes Payable (*itemize*) | | | | | $ |
| 3. Loans Payable for Equipment (*Current portion*) (*itemize*) | | | | | $ 5,963 |
| | Name of Lender | Purpose | Amount | Date Due | |
| | Chase Auto | 2012 Cadillac | 2,167 | 09/30/18 | |
| | Huebsh Financial | Laundry Equip | 3,796 | 09/30/18 | |
| 4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*) | | | | | $ 7,336 |
| 5. Accrued Payroll (*Owners and/or Stockholders only*) | | | | | $ |
| 6. Accrued Payroll Taxes Payable | | | | | $ |
| 7. Medicare Final Settlement Payable | | | | | $ |
| 8. Medicare Current Financing Payable | | | | | $ |
| 9. Mortgage Payable (*Current Portion*) | | | | | $ |
| 10. Interest Payable (*Exclusive of Owner and/or Related Parties*) | | | | | $ |
| 11. Accrued Income Taxes* | | | | | $ 15,255 |
| 12. Other Current Liabilities (*itemize*) | | | | | $ 15,746 |
| Pension 15,746 | | | | | |
| A-13. ***Total Current Liabilities*** (Lines A1 thru 12) | | | | | $ 68,731 |

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

*(Carry Total forward to next page)*

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

# G. Balance Sheet (cont'd)

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE HOM | 1885 | 09/30/17 | 34 | 37 |

| Account | Amount |
|---|---|
| Total Brought Forward: | 68,731 |
| **Liabilities (cont'd)** | |
| B. Long-Term Liabilities | |
| 1. Loans Payable-Equipment (*itemize*) | $ 1,313 |

| Name of Lender | Purpose | Amount | Date Due |
|---|---|---|---|
| Huebsh Financial | Laundry Equip | 1,313 | 9/30/18 |

| | |
|---|---|
| 2. Mortgages Payable | $ |
| 3. Loans from Owners or Related Parties (*itemize*) | $ (23,703) |

| Name and Address of Lender | Amount | Loan Date |
|---|---|---|
| J & K Bhogal Realty | (25,000) | open |
| K & J Bhogal | 1,297 | open |

| | |
|---|---|
| 4. Other Long-Term Liabilities (*itemize*) | $ |
| B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4) | $ (22,390) |
| C. ***Total All Liabilities*** (Lines A-13 + B-5) | $ 46,341 |

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

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

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE | 1885 | 09/30/17 | 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 | | $ 92,100 |
| 6. Gain or Loss for Period | 10/01/16 thru 09/30/17 | $ 44,393 |
| 7. Total Net Worth | | $ 136,493 |
| C. ***Total Reserves and Net Worth*** | | $ 136,493 |
| D. ***Total Liabilities, Reserves, and Net Worth*** | | $ 182,834 |

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

# H. Changes in Total Net Worth

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE H( | 1885 | 09/30/17 | 36 | 37 |

| Account | | | Amount |
|---|---|---|---|
| A. Balance at End of Prior Period as shown on Report of 09/30/2016 | | | $ 142,100 |
| B. Total Revenue (*From Statement of Revenue Page 30*) | | | $ 884,334 |
| C. Total Expenditures (*From Statement of Expenditures Page 27*) | | | $ 843,341 |
| D. Net Income or Deficit | | | $ 40,993 |
| E. Balance | | | $ 183,093 |
| F. Additions | | | |
| 1. Additional Capital Contributed (*itemize*) | | | |
| 2. Other (*itemize*) | | | |
| misc adj | | | |
| Auto Adj | 3,400 | | |
| F-3. Total Additions | | | $ 3,400 |
| G. Deductions | | | |
| 1. Drawings of Owners/Operators/Partners (*Specify*) | | | $ |
| Name and Address (*No., City, State, Zip*) | Title | Amount | |
| | | | |
| 2. Other Withdrawings *(Specify)* | | | $ 50,000 |
| Purpose | | Amount | |
| dividend | | 50,000 | |
| 3. Total Deductions | | | $ 50,000 |
| H. ***Balance at End of Period*** | 09/30/17 | | $ 136,493 |

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

# I. Preparer's/Reviewer's Certification

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| APRIL TIME RESIDENTIAL CARE | 1885 | 09/30/17 | 37 | 37 |

*Check appropriate category*

| ☐ Chronic and Convalescent Nursing Home only (CCNH) | ☐ Rest Home with Nursing Supervision only (RHNS) | ☑ 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 |
|---|---|---|
| | CPA | 1/30/18 |

| Printed Name of Preparer | |
|---|---|
| Thomas W. Daniele CPA | |
| **Address** | **Phone Number** |
| 66 Cedar St., Newington CT 06111 | 860-666-5942 |