State of Connecticut

Annual Report of Long-Term Care Facility
Cost Year 2015

Name of Facility (as licensed) The Rosegarden Health & Rehabilitation Center LLC		
Address (No. & Street, City, State, Zip Code) 3584 E Main Street Waterbury CT 06705		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2300			075399A

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	21270		

For Department Use Only

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

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General Information

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The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2015	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 The Rosegarden Health & Rehabilitation Center LLC [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, 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) VERONICA CRETELLA			Printed Name (Owner) Rachel Blass	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility The Rosegarden Health & Rehabilitation Center LLC	Period Covered:		From 10/1/2014	To 9/30/2015
Address of Facility 3584 E Main Street Waterbury CT 06705				
Report Prepared By Burg & Weingarten CPA PC	Phone Number 718-845-6141		Date 2/4/2016	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-384-6400	9/30/2015	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
The Rosegarden Health & Rehabilitation Center LLC	3584 E Main Street Waterbury CT 06705

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2300			075399A

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Type of Ownership (Check appropriate box)

○ Proprietorship ◉ LLC ○ Partnership ○ Profit Corp. ○ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
VERONICA CRETELLA	000796

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
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
The Rosegarden Health & Rehabilitation Center LLC	3584 E Main Street Waterbury CT 06705	Waterbury CT

Name of Partners/Members	Business Address	Title	% Owned
Rachel Blass	600 Bond St Bridgeport CT 06610	Member	25
Norma Loren	600 Bond St Bridgeport CT 06610	Member	25
Gladys Neuman	600 Bond St Bridgeport CT 06610	Member	25
Miriam Stern	600 Bond St Bridgeport CT 06610	Member	25

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
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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
N/A			
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
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ◉ No

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Paradise Realty of Waterbury LLC	600 Bond Street Bridgeport CT 06610	○	◉		Rental of land and building	P22 L 9	300,000	88,476
Bridgeport Healthcare Center Inc	600 Bond Street Bridgeport CT 06610	○	◉		Allocation of costs, Various funding			
Comprehensive Rehabilitation Services LLC	26 Firemans Memorial Dr Suite 205 pomona NY 10970	○	◉		Physical, Occupational & Speech Therapy S	P13 L.5,9,10	71,954	
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					

* 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
The Rosegarden Health & Rehabilitation Cente	2300	9/30/2015	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
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Everbank Commercial Finance	O	⊙	Copier	12/10/14	60 months	1,320	1,041
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					

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

Total *** 1,041

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

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General Information and Questionnaire
Accounting Basis

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Burg & Weingarten CPA PC	149-12 83rd Street Howard Beach NY 11414
2 Zimmet Healthcare Services Group	4006 Rt 9 South Morganville NJ 07751
3	
4	

Services Provided by This Firm (*describe fully*)

1	General accounting, Balance sheet, Trial balance, Audit, Budgeting, Cost Report & etc	$ 38,400
2	Medicare cost report	$ 4,250
3		$
4		$
		Charge for Services Provided $ 42,650

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
⊙ Yes ○ No Page 15 line 1D

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Murtha Cullina LLP	860-240-6000
2 Berchem Moses & Devlin	203-783-1200
3 James Stedrosky LLC	860-567-9111
4	
5	

Address (*No. & Street, City, State, Zip Code*)
1 185 Asylum St Hartford CT 06103
2 75 Broad St Milford CT 06460
3 62 West St PO Box 1529 Litchfield CT 06759
4
5

Services Provided by This Firm (*describe fully*)

1	Title 19 Regulations	$ 11,537
2	All labor matters	$ 18,343
3	Real Estate Tax reductions	$ 7,133
4		$
5		$
		Charge for Services Provided $ 37,013

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
⊙ Yes ○ No Page 15 line 1E

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Schedule of Resident Statistics

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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	82	82			82	82			82	82		
B. On last day of THIS report period	82	82			82	82			82	82		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	66	66			66	66			64	64		
B. As of midnight of THIS report period	64	64			64	64			64	64		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,634	1,634			1,259	1,259			375	375		
B. Medicaid (Conn.)	22,732	22,732			16,965	16,965			5,767	5,767		
C. Medicaid (other states)												
D. Private Pay	56	56			46	46			10	10		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	24,422	24,422			18,270	18,270			6,152	6,152		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	5	5			2	2			3	3		
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	24,427	24,427			18,272	18,272			6,155	6,155		

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Schedule of Resident Statistics (Cont'd)

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

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	5	59		2				
Per Diem Rate								
a. One bed rm.	Various	233.94		305.00				
b. Two bed rms.	Various	233.94		295.00				
c. Three or more bed rms.	Various	233.94		275.00				

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	591	591		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,202	1,202		
2. Restorative Treatments				
C. Other				
D. ***Total Physical Therapy Treatments***	1,793	1,793		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	7	7		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	22	22		
2. Restorative Treatments				
C. Other				
D. ***Total Speech Therapy Treatments***	29	29		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,409	1,409		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,665	1,665		
2. Restorative Treatments				
C. Other				
D. ***Total Occupational Therapy Treatments***	3,074	3,074		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	75,584	2,088				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	190,049	11,795				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	247,784	16,441				
6. Housekeeping Service						
a. Head Housekeeper	46,097	2,663				
b. Other Housekeeping Workers	96,251	7,591				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	45,901	2,321				
b. Other Maintenance Workers	32,887	2,182				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	67,126	5,057				
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	119,964	2,684				
b. RN						
1. Direct Care	486,294	12,948				
2. Administrative**						
c. LPN						
1. Direct Care	931,830	34,750				
2. Administrative**						
d. Aides and Attendants	824,868	57,435				
e. Physical Therapists	50,458	1,165				
f. Speech Therapists	1,577	27				
g. Occupational Therapists	79,390	2,339				
h. Recreation Workers	61,511	3,609				
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	57,435	2,077				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	3,415,006	167,172				

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

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

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

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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
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
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Carla Ward/ Donna Orefice 42 Pepperridge Drive Southington CT 06489/ PO Box 112 Pound	31,259				Administrator 10/1-12/28/14 - 12/29/14-2/27/15	960	A2	Bridgeport Manor	1,560	79,147
Jenner Michael Rose 52 AP Gates Road East Haddam Ct 06423	38,425				Administrator 3/2/15-9/1/15	1,024	A2			
Veronica Cretella 62 Klein Drive Prospect Ct 06712	5,900				Administrator 9/1/15 -9/30/15	104	A2			
Section IV - Assistant Administrators					lessthan365	2088				

*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
The Rosegarden Health & Rehabilitation Center LL	2300	9/30/2015	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian	31,615	564				
2. Dentist	9,122	190				
3. Pharmacist	884	89				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	33,559	448				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	21,600	144				
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	1,295	13				
b. Other						
10. Occupational Therapist						
a. Resident Care	37,460	500				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	6,625	18				
2. Administrative***	47,520	396				
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides	56,610	2,909				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	246,290	5,271				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2015	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Debbie Rescsanski 293 Burr Hall Rd Middlebury CT 06762	Dietary Consultant	○	◉	
Healthdrive Dental 85 Barnes Rd Suite 207 Wallingford CT 06492	Dental Consultant	○	◉	
Lifemed 447 Doughty Blvd Inwood NY 11096	Pharmacy Consultant	○	◉	
Mark Raad MD 464 Wolcott CT 06716	Medical Director	○	◉	
Comprehensive Rehabilitation Services LLC 26 Firemens Dr Suite 205 Pomona NY 10970	Speech Therapy	◉	○	
Comprehensive Rehabilitation Services LLC 26 Firemens Dr Suite 205 Pomona NY 10970	Physical Therapy	◉	○	
Comprehensive Rehabilitation Services LLC 26 Firemens Dr Suite 205 Pomona NY 10970	Occupational Therapy	◉	○	
Towne Nursing 1320 E 17th St Brooklyn NY 11230	Nursing Registry	○	◉	
Hightech Nursing 1 Stafford St Springfield MA 01104	Nursing Registry	○	◉	
Omnicare Pharmacy Dept 781668 PO Box 78000 Detroit MI 48278	Pharmacy Consultant	○	◉	
Omnicare Pharmacy Dept 781668 PO Box 78000 Detroit MI 48278	Nursing Registry	○	◉	
Swallowing Diagnostic LLC 21 Waterville Road Avon CT 06001	Speech Therapy	○	◉	
Lorrarine Mulligan 20 Ameritage Drive Bridgeport CT 06605	Nursing Monitor	○	◉	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

* 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
The Rosegarden Health & Rehabilitation Center	2300	9/30/2015	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	57,773	57,773		
2. Disability Insurance	$	8,529	8,529		
3. Unemployment Insurance	$	114,131	114,131		
4. Social Security (F.I.C.A.)	$	260,337	260,337		
5. Health Insurance	$	114,159	114,159		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	821	821		
7. Pensions (Non-Discriminatory)	$	5,617	5,617		
(not-owners and not-operators)					
8. Uniform Allowance	$	17,772	17,772		
9. Other (*Specify*)	$	428,249	428,249		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	72,851	72,851		
d. Accounting and Auditing	$	42,650	42,650		
e. Legal (*Services should be fully described on Page 7)*	$	37,013	37,013		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	11,102	11,102		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	34,406	34,406		
2. Cellular Phones	$	608	608		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$	250	250		
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	479,236	479,236		
Subtotal	$	1,685,504	1,685,504		

* 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

The Rosegarden Health & Rehabilitation Center LLC
9/30/2015

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Union Welfare Fund	$ 415,791		
Union Training Fund	$ 12,458		
Total	$ 428,249	$ -	$ -

Schedule of Other Taxes

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

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2015	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,685,504	1,685,504		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	1,908	1,908		
5. Education Expenses Related to Seminars and Conventions	$	2,122	2,122		
6. Automobile Expense (*not purchase or depreciation*)	$	410	410		
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	1,673	1,673		
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	$	436	436		
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	205	205		
See Attached Schedule					
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*)	$	30,532	30,532		
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	110,448	110,448		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	1,833,238	1,833,238		

* Do not include Subscriptions, which should go in item 9.
** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
*** Facility should self-disallow the expense on Page 28 of the Cost Report.

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Total Other Advertising	$ -	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Credit Card	$ 205		
Total Dues	$ 205	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Licenses	$ 1,035		
Bank Charges	$ 2,422		
Patient Expense	$ 41		
Non Reimbursable	$ 106,950		
Total Other Administrative and General	$ 110,448	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
The Rosegarden Health & Rehabilitation	2300	9/30/2015	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
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2015	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	226,164	226,164		
2. Non-Food Supplies	$	69,267	69,267		
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)	$	295,431	295,431		

2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
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.

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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
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2015	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	57,209	57,209		
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $	1,266	1,266		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	58,475	58,475		

3F.	Laundry Questionnaire			
G.	Is cost of employee laundry included in 3E?	O Yes	⊙ No	If yes, specify cost.
H.	Did you receive revenue from employees?	O 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?	O Yes	⊙ No	If yes, specify cost.
K.	Did you receive revenue from these people?	O 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Cente	2300	9/30/2015	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	65,056	65,056		
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)		$	65,056	65,056		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	93,103	93,103		
b. Medicine Cabinet Drugs		$	2,881	2,881		
c. Medical and Therapeutic Supplies		$	187,600	187,600		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	24,556	24,556		
f. X-rays and Related Radiological Procedures***		$	1,742	1,742		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***		$	3,256	3,256		
i. Recreation		$	11,274	11,274		
j. Other (Specify)**** See Attached Schedule		$	14,303	14,303		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	338,715	338,715		

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

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
IV Supplies	$ 6,383		
Wound Vac	$ 7,920		
Total Other Resident Care	$ 14,303	$ -	$ -

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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
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2015	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
ADL Data Systems	9 Skyline Drive Hawthorne NY 10532	○	⊙		Computer Software	20,084			16	m.11
Winter Bros	307 White St Danbury Ct 06816	○	⊙		Waste Removal	25,098			22	6.f
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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
The Rosegarden Health & Rehabilitation Cent	2300	9/30/2015	22	37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	41,316	41,316		
b. Heat	$	50,738	50,738		
c. Light & Power	$	64,861	64,861		
d. Water	$	50,216	50,216		
e. Equipment Lease (*Provide detail on page 6*)	$	1,041	1,041		
f. Other (*itemize*)	$	56,045	56,045		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	264,217	264,217		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$				
d. Movable Equipment	$	31,873	31,873		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	31,873	31,873		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	16,700	16,700		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	16,700	16,700		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	300,000	300,000		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	94,956	94,956		
c. Personal property taxes	$	7,611	7,611		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	451,140	451,140		

* Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 24.

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Contracr Service	$ 56,045		
Total Other Repairs and Maintenance	$ 56,045	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2015	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	50,000							
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	3,150,000							
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								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					318,653		318,653	203,024	S/L	5 yrs	25,421	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					114,169						6,452	
D-3. Subtotal												31,873
E. ***Total Depreciation***												31,873

The Rosegarden Health & Rehabilitation Center LLC
9/30/2015

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:					
1/5/2015	Patient Furniture	$ 16,194	15 yrs	$ 810	
4/1/2015	Beds	$ 75,033	10 yrs	$ 3,752	
12/17/2014	Computer	2746	5 yrs	412	
	Heater / Kitchen Equipment / Laundry Equipment	14530	10 yrs	754	
10/20/2014	Wanderguard	3565	5 yrs	654	
7/30/2015	Generator	2101	5 yrs	70	
Total additions for Movable Equipment		$ 114,169		$ 6,452	*
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:					
2/20/2015	Boiler	$ 6,197	20 yrs	$ 156	
3/31/2015	Roof	$ 1,449	10 yrs	$ 72	
3/15/2015	Drywell	1240	15 yrs	41	
8/17/2015	Freezer	2499	15 yrs	83	
9/11/2015	Carpet	4429	15 yrs	130	
Total additions for Leasehold Improvement		$ 15,814		$ 482	*
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
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2015	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				529,049	109,354			16,218	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				15,814				482	
C-4. Subtotal									16,700
D. ***Total Amortization***									16,700

* 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
The Rosegarden Health & Rehabilitati	2300	9/30/2015	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	11/13/04
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	11/13/04
4. Date of Initial Licensure	11/13/04
5. Total Licensed Bed Capacity	82
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)	Variable			
b. Date Mortgage Obtained	11/13/04			
c. Interest Rate for the Cost Year	5.07%			
d. Term of Mortgage (number of years)	20			
e. Amount of Principal Borrowed	3,968,027			
f. Principal balance outstanding as of 9/30/15	1,169,387			
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
The Rosegarden Health & Rehabilitat	2300	9/30/2015			26 | 37

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page of
The Rosegarden Health & Rehabili	2300	9/30/2015	27 | 37

Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (*Specify*)		$	5	5		
A. Item	Rate	Amount				
Copier	5.49%	9,159				
Lender						
Wells Fargo Financial						
Address of Lender						
PO Box 6434 Carol Stream IL 60197						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		$	5	5		
12. D. Other Interest Expense (*Specify*)		$	64,675	64,675		
Insurance 1550 Other 63125						
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)		$	64,680	64,680		
14. Insurance						
a. Insurance on Property (buildings only)		$				
b. Insurance on Automobiles		$	3,577	3,577		
c. Insurance other than Property (as specified above)						
1. Umbrella (*Blanket Coverage*)		$	15,600	15,600		
2. Fire and Extended Coverage		$				
3. Other (*Specify*)		$	78,512	78,512		
Gen Liability, Boiler, Crime, PF Bond, EPLI						
14d. ***Total Insurance Expenditures (14a + b + c)***		$	97,689	97,689		
15. ***Total All Expenditures (A-13 thru C-14)***		$	7,129,937	7,129,937		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2015	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			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.	15	1 c	Bad Debts $	72,851	72,851		
10.			Accounting & Legal $				
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.			Unallowable Advertising * $				
19.	15	k 2	Income Tax / Corporate Business Tax $	250	250		
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	106,950	106,950		
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) $	180,051	180,051		

(Carry Subtotal forward to next page)

* All except "Help Wanted".

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m 13	Non Reimbursable	$ 106,950		
Total Other A&G Adjustments			$ 106,950	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation Center LLC	2300	9/30/2015	29	37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	180,051	180,051		
Page 20 - Resident Care Supplies***							
27.	20	5.a.2	Prescription Drugs $	93,103	93,103		
28.			Ambulance/Limousine $				
29.	20	5.f	X-rays, etc $	1,742	1,742		
30.	20	5.h	Laboratory $	3,256	3,256		
31.			Medical Supplies $				
32.	20	5.e.2	Oxygen (non emergency) $	24,556	24,556		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	17,184	17,184		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			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)*** $	319,892	319,892		

*** 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.

The Rosegarden Health & Rehabilitation Center LLC
9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5 j	IV	$ 6,383		
20	5 j	Wound Vac	$ 7,920		
20	5 b	Emergency Box	$ 2,881		
Total Other Ancillary Costs			$ 17,184	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

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

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation	2300	9/30/2015	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	6,556,880	6,556,880		
b. Medicaid Room and Board Contractual Allowance **	$	(1,411,704)	(1,411,704)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	553,649	553,649		
b. Medicare Room and Board Contractual Allowance **	$				
4. a. Private-Pay Residents and Other	$	43,522	43,522		
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	$	59,923	59,923		
b. Physical Therapy - Medicare Contractual Allowance **	$				
c. Physical Therapy - Non-Medicare	$	19,649	19,649		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$				
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$	603	603		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	110,850	110,850		
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$	50,035	50,035		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	(15,116)	(15,116)		
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	5,968,291	5,968,291		
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)*	$	7	7		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	90,724	90,724		
V. Total Other Revenue (1 thru 8)	$	90,731	90,731		
VI. Total All Revenue (III +V)	$	6,059,022	6,059,022		

* *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)
	Part B Contractual Allowance	$ (15,116)		
Total Other Resident Revenue - Medicare		$ (15,116)	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
33 A 6	Interest Income - IRS Refund		$ 7		
Total Interest Income			$ 7	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Prior Years Work Comp Credit	$ 90,724		
Total Other Revenue		$ 90,724	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitatio	2300	9/30/2015	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 10,490
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 830,681
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 40,349
a. Real Estate & Personal Property Taxes		25,522		
b. Inurance		14,827		
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 881,520
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	544,863		$ 418,809
	Accum. Depreciation	126,054	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	432,822		$ 197,925
	Accum. Depreciation	234,897	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 616,734

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

(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
The Rosegarden Health & Rehabilitatio	2300	9/30/2015	32	37

Account				Amount
			Total Brought Forward:	$ 1,498,254
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost	50,000		
	Accum. Depreciation		Net	$ 50,000
3. Buildings	*Historical Cost	3,150,000		
	Accum. Depreciation		Net	$ 3,150,000
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)				$ 3,200,000
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*)				$ 800,484
Name and Address	Amount	Loan Date		
New Coleman Park	800,484			
7. Other Assets (*itemize*)				$
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 800,484
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 5,498,738

* 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
The Rosegarden Health & Rehabilitation Cent	2300	9/30/2015	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 1,732,807
2. Notes Payable (*itemize*)	$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)	$
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)	$ 225,253
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$ 180,232
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*)	$ 30,061
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 2,168,353

Name of Lender	Purpose	Amount	Date Due

Loans & Exchanges	10,406
Accrued Expenses	19,655

* 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
The Rosegarden Health & Rehabilitation C	2300	9/30/2015	34	37

Account				Amount
			Total Brought Forward:	2,168,353
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*)				$ 4,536,689
Name and Address of Lender	Amount	Loan Date		
Bridgeport Healthcare Inc	3,131,614			
Paradise Realty of Waterbury	1,405,075			
4. Other Long-Term Liabilities (*itemize*)				$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 4,536,689
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 6,705,042

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitati	2300	9/30/2015	35	37

Account		Amount
A. **Reserves**		
1. Reserve for value of leased land		$ 50,000
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized		$ 3,150,000
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		$ 3,200,000
B. **Net Worth**		
1. Owner's Capital		$ (3,335,389)
2. Capital Stock		$
3. Paid-in Surplus		$
4. Treasury Stock		$
5. Cumulated Earnings		$
6. Gain or Loss for Period	10/1/2014 thru 9/30/2015	$ (1,070,915)
7. Total Net Worth		$ (4,406,304)
C. ***Total Reserves and Net Worth***		$ (1,206,304)
D. ***Total Liabilities, Reserves, and Net Worth***		$ 5,498,738

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation	2300	9/30/2015	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2014			$ (3,335,389)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 6,059,022
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 7,129,937
D.	Net Income or Deficit			$ (1,070,915)
E.	Balance			$ (4,406,304)
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*** 09/30/15			$ (4,406,304)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
The Rosegarden Health & Rehabilitation	2300	9/30/2015	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. 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	
Burg & Weingarten CPA PC	
Addres Address	Phone Number
149-12 83rd St Howard Beach NY 11414	718-845-6141