State of Connecticut

Annual Report of Long-Term Care Facility
Cost Year 2016

Name of Facility (as licensed) Rose Haven	
Address (No. & Street, City, State, Zip Code) 31 North Street, Litchfield, CT 06759	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☑ Residential Care Home	
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016

License Numbers:	CCNH	RHNS	Residential Care Home	Medicare Provider
	1036-C		1774-HFA	07-5346

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

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General Information

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Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR 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 Rose Haven [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 2016, 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) David Bouchard			Printed Name (Owner) Brian J. Foley	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

State of Connecticut

Department of Social Services

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment

Name of Facility	Period Covered:	From	To
Rose Haven		10/1/2015	9/30/2016
Address of Facility: 31 North Street, Litchfield, CT 06759			
Report Prepared By: Apple Health Care, Inc.	Phone Number: (860) 678-9755	Date	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-567-9475	9/30/2016	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Rose Haven	31 North Street, Litchfield, CT 06759

	CCNH	RHNS	Residential Care Home	Medicare Provider No.
License Numbers:	1036-C		1774-HFA	07-5346

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

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

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.:	
David Bouchard		002008

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

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
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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
Rose Haven	31 North Street, Litchfield, CT 06759	Connecticut

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

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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

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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	%**				
Brian J. Foley	21 Waterville Road Avon, CT	○	⦿		Real Estate Rental	Pg. 22 Line 9	384,000	384,000
Apple Health Care	21 Waterville Road Avon, CT	○	⦿		Management & Accounting Services	Pg. 16 Line m12	203,988	203,988
Healthport Services	21 Waterville Road Avon, CT	○	⦿		Employee Staffing	Pg. 10/13 Schedule	12,501	12,501
Allstar Therapy	21 Waterville Road Avon. CT	⦿	○	15%	Therapy Services	Pg. 13 B5/B9/B10	415,653	381,154
Corporate Employees	21 Waterville Road Avon, CT	○	⦿		Employee Staffing	Pg. 10 Schedule	6,768	6,768
Employees @ various Apple Facilities		○	⦿		Employee Staffing	Pg. 10 Schedule	3,432	3,432
Apple Health Care	21 Waterville Road Avon. CT	○	⦿		Pension Plan (401K)	Pg. 15 1a7	7,733	7,733
Aetna	PO Box 88860 Chicago, IL	⦿	○		Group Medical	Pg. 15 1a5	316,150	
Delta Dental	PO Box 23700 Newwark, NJ	⦿	○		Group Dental	Pg. 15 1a5	16,715	

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

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Rose Haven	1036-C	9/30/2016	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes x 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? x 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	%**				
Aetna Ancillary	PO Box 88860 Chicago, IL	X			Group Life & Disability	Pg. 15 1a6	15,660	
Marsh	PO Box 19636 Newark, NJ	X			Property, Liability, & Umbrella Insura	Pg. 27 14a	43,817	
AIG	PO Box 10472 Newark, NJ	X			Worker's Compensation	Pg. 15 1a1	35,192	
Brendan Foley	21 Waterville Rd. Avon, CT		X			##		
Ryan Vess	21 Waterville Rd. Avon, CT		X			##		

* Use additional sheets if necessary.
** Provide the percentage amount of revenue received from non-related parties.
Related expense has been disallowed on Pg. 28 Line 23

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General Information and Questionnaire
Basis for Allocation of Costs

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

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

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

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

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

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

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

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

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
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
						Total ***	

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

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

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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 Blum Shapiro & Co. PC	29 South Main St. West Hartford, CT 06127
2 Brazee & Huban	35 Wendell Avenue Pittsfield, MA 10202
3	
4	

Services Provided by This Firm (*describe fully*)

1 Preparation of audited financials (dissallow Pg. 28)	$ 2,244
2 Preparation of tax returns	$ 2,069
3	$
4	$
	Charge for Services Provided $ 4,312

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

⦿ Yes ○ No Pg. 15 1d

Legal Services Information

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

Address (*No. & Street, City, State, Zip Code*)
1
2
3
4
5

Services Provided by This Firm (*describe fully*)

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

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

⦿ Yes ○ No Pg. 15 1e

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Schedule of Resident Statistics

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	Total All Levels	Total CCNH Level	Total RHNS Level	Total Residential Care Home	Period 10/1 Thru 6/30 Total	Period 10/1 Thru 6/30 CCNH	Period 10/1 Thru 6/30 RHNS	Period 10/1 Thru 6/30 Residential Care Home	Period 7/1 Thru 9/30 Total	Period 7/1 Thru 9/30 CCNH	Period 7/1 Thru 9/30 RHNS	Period 7/1 Thru 9/30 Residential Care Home
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	40	25		15	40	25		15	40	25		15
B. On last day of THIS report period	40	25		15	40	25		15	40	25		15
2. Number of Residents												
A. As of midnight of PREVIOUS report period	37	25		12	37	25		12	37	25		12
B. As of midnight of THIS report period	29	16		13	29	16		13	29	16		13
3. Total Number of Days Care Provided During Period												
A. Medicare	3,180	3,180			2,601	2,601			579	579		
B. Medicaid (Conn.)	3,327	3,327			2,471	2,471			856	856		
C. Medicaid (other states)												
D. Private Pay	1,072	1,072			738	738			334	334		
E. State SSI for RCH	4,637			4,637	3,437			3,437	1,200			1,200
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	12,216	7,579		4,637	9,247	5,810		3,437	2,969	1,769		1,200
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)**	12,216	7,579		4,637	9,247	5,810		3,437	2,969	1,769		1,200

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Schedule of Resident Statistics (Cont'd)

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

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

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

	Medicare	Medicaid		Self-Pay			Other State Assisted	
Item	CCNH	CCNH	RHNS	CCNH	RHNS	Residential Care Home	R.C.H.	ICF-MR
No. of Residents	5	8		3			13	
Per Diem Rate								
a. One bed rm.				441.00			126.10	
b. Two bed rms.	RUGS III	234.87		428.00			3,782.92	
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	Residential Care Home
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	1,795	1,795		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	10,826	10,826		
D. ***Total Physical Therapy Treatments***	12,621	12,621		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	127	127		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	561	561		
D. ***Total Speech Therapy Treatments***	688	688		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,451	1,451		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	10,833	10,833		
D. ***Total Occupational Therapy Treatments***	12,284	12,284		

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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

Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
	Total Cost and 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)	55,228	1,434			29,738	772
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	19,319	1,135			10,403	611
5. Dietary Service						
a. Head Dietitian	17,771	554			10,437	325
b. Food Service Supervisor	7,175	359			4,214	211
c. Dietary Workers	96,192	7,108			56,494	4,174
6. Housekeeping Service						
a. Head Housekeeper	22,936	1,412			11,815	727
b. Other Housekeeping Workers	27,325	2,355			14,077	1,213
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	27,517	1,351			14,176	696
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	29,774	2,365			5,671	450
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants	28,578	1,475			15,388	794
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	81,994	2,096				
b. RN						
1. Direct Care	442,332	11,133				
2. Administrative**	77,833	2,533				
c. LPN						
1. Direct Care	109	4				
2. Administrative**						
d. Aides and Attendants	383,653	26,126			171,726	8,250
e. Physical Therapists	35,687	964				
f. Speech Therapists	1,645	40				
g. Occupational Therapists	11,808	384				
h. Recreation Workers	28,963	1,381			15,596	743
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	20,562	1,254			11,072	675
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	1,416,401	65,461			370,806	19,644

* 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**
Total	$ -	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		Residential Care Home	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Pointright	$ 3,300	33				
0						
Total	$ 3,300	33	$ -	-	$ -	-

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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 CCNH	RHNS	Residential Care Home	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
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
Rose Haven	1036-C	9/30/2016	12	37

Name	Salary Paid CCNH	RHNS	Residential Care Home	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
Section III - Administrators* **										
Mary Gyuricsko	32,800		17,662		Administrator 10/1/2015 - 4/30/2016	1,310	A2			
Kerri Kuhn	19,027		10,246		Administrator 5/1/2016 - 8/28/2016	760	A2	Apple Rehab West Haven	120	5,487
David Bouchard	3,400		1,831		Administrator 8/29/2016 - 9/30/2016	136	A2			
Section IV - Assistant Administrators										

*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.
** Include **all** other employment worked during the cost year.
*** If more than one Administrator is reported, include dates of employment for each.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Rose Haven	1036-C	9/30/2016	13	37

Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
	Total Cost and 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	2,850	84				
3. Pharmacist	6,164	37				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	195,712	3,155				
b. Other						
6. Social Worker	520	4				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	29,100	10				
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	31,838	172				
b. Other						
10. Occupational Therapist						
a. Resident Care	192,064	3,071				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	3,300	33				
B-13 Total Fees Paid in Lieu of Salaries	461,547	6,566				

* 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
Rose Haven	1036-C	9/30/2016	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Allstar Therapy 21 Waterville Rd. Avon, CT	Therapy Services	⦿	○	See Disclosure Pg. 4
Healthport Services 21 Waterville Rd. Avon, CT	Employee Staffing	⦿	○	See Disclosure Pg. 4
Healthdrive Dental	Dentist	○	⦿	
Elizabeth Studinski, LCSW Middletown, CT	Social Worker	○	⦿	
ProHealth Physicians POB 154073, Hartford, CT	Medical Director	○	⦿	
West River Pharmacy	Pharmacist	○	⦿	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
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		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Rose Haven	1036-C	9/30/2016	15	37

Item		Total	CCNH	RHNS	Residential Care Home
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	35,192	30,969		4,223
2. Disability Insurance	$				
3. Unemployment Insurance	$	33,002	29,042		3,960
4. Social Security (F.I.C.A.)	$	119,998	105,598		14,400
5. Health Insurance	$	231,521	203,739		27,783
6. Life Insurance (employees only) (not-owners and not-operators)	$	15,660	13,781		1,879
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	7,733	6,805		928
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*	$	101,452	101,452		
d. Accounting and Auditing	$	4,312	2,803		1,509
e. Legal (*Services should be fully described on Page 7)*	$				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	9,905	6,438		3,467
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	15,334	9,967		5,367
2. Cellular Phones	$				
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	$	78,045	78,045		
Subtotal	$	652,404	588,889		63,516

* 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**

Rose Haven
9/30/2016

Attachment Page 15

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Rose Haven	1036-C	9/30/2016	16	37

Item		Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:		652,404	588,889		63,516
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	3,012	1,958		1,054
2. Holiday Parties for Staff	$	1,425	1,425		
3. Gifts to Staff and Residents	$	5,023	3,265		1,758
4. Employee Travel	$	2,832	1,841		991
5. Education Expenses Related to Seminars and Conventions	$	2,533	1,646		887
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*) See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	240	156		84
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$	12,145	7,894		4,251
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	$	2,258	1,467		790
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	2,386	1,551		835
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	886	576		310
9. Subscriptions	$	3,176	2,065		1,112
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**	$	203,988	132,592		71,396
13. Other (*Specify*) See Attached Schedule	$	34,050	22,960		11,090
C-14 Total Administrative & General Expenditures	$	926,358	768,284		158,074

* 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
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	Residential Care Home
Advertising - Public Relations	$ 7,894		$ 4,251
Total Other Advertising	$ 7,894	$ -	$ 4,251

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
ALTCFM	$ 52		$ 28
CAHCF	$ 1,336		$ 720
Republican American	$ 29		$ 16
American College of Health Care Administrators (Kerri Kuhn)	$ 133		$ 72
Total Dues	$ 1,551	$ -	$ 835

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
Corporate Fees - Non Reimbursable	$ 11,748		$ 6,326
Licenses & Fees	$ 1,492		$ 803
Pre Employment Screening	$ 3,900		$ 2,100
Point Click Care Fees	$ 3,810		$ 2,052
Bank Charges	$ -		
Resident Expenses	$ -		
Prior Period Adj/Account W/O	$ -		
Healthport Indirect	$ 2,363		
Petty Cash	$ 72		$ 39
Prio Period Adj	$ (1,357)		$ (731)
Sales Tax Audit	$ 917		$ 494
Aug 16 Pmt of 2014 Bus Entty	$ 16		$ 9
Total Other Administrative and General	$ 22,960	$ -	$ 11,090

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Schedule C-1 - Management Services*

Name of Facility Rose Haven	License No. 1036-C	Report for Year Ended 9/30/2016	Page of 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 #
Apple Health Care, Inc.	203,988	Accounting & Managerial Services	Pg. 16 m12

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

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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
Rose Haven	1036-C	9/30/2016	18 | 37

Item		Total	CCNH	RHNS	Residential Care Home
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	95,295	60,036		35,259
2. Non-Food Supplies	$	20,340	12,814		7,526
3. Other (*Specify*)______________________	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	1,458	919		540
c. Management Services**	$				
d. Other (*Specify*)__________________________	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	117,093	73,769		43,325

2F. Dietary Questionnaire	Total	CCNH	RHNS	Residential Care Home
G. Resident Meals: Total no. of meals served per day:*	100	63		37

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.

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
Rose Haven	1036-C	9/30/2016	19 | 37

Item		Total	CCNH	RHNS	Residential Care Home
3. Laundry					
a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.	199,611	167,673		31,938
	Amt. $	3,301	2,773		528
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. $	1,311	1,101		210
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)	$	4,612	3,874		738

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.

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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
Rose Haven	1036-C	9/30/2016	20	37

Item			Total	CCNH	RHNS	Residential Care Home
4. Housekeeping a. In-House Care	Sq. Ft. Serviced by Personnel		13,943	9,202		4,741
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	12,423	8,199		4,224
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$	5,105	3,369		1,736
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	17,527	11,568		5,959
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from West River Pharmacy		$	157,709	157,709		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	76,097	49,463		26,634
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	20,277	20,277		
f. X-rays and Related Radiological Procedures***		$	14,679	14,679		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	10,428	10,428		
i. Recreation		$	16,859	10,958		5,901
j. Other (Specify)**** See Attached Schedule		$	13,033	11,785		1,248
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	309,082	275,300		33,782

* 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.

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Schedule of Other Resident Care

Description	CCNH	RHNS	Residential Care Home
Nursing Station Supplies	$ 2,317		$ 1,248
Rehab Service Supplies	$ 5,356		
IV Therapy Supplies	$ 4,113		
Social Service Supplies	$ -		
Total Other Resident Care	$ 11,785	$ -	$ 1,248

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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
Rose Haven	1036-C	9/30/2016	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
		○	◉							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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
Rose Haven	1036-C	9/30/2016	22 | 37

Item		Total	CCNH	RHNS	Residential Care Home
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	66,860	44,127		22,732
b. Heat	$	30,934	20,416		10,517
c. Light & Power	$	34,054	22,476		11,578
d. Water	$	28,780	18,995		9,785
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	11,279	7,444		3,835
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	171,906	113,458		58,448
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	4,009	2,646		1,363
d. Movable Equipment	$	9,138	6,031		3,107
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	13,147	8,677		4,470
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	38,519	25,423		13,097
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	38,519	25,423		13,097
9. Rental payments on leased real property less real estate taxes included in item 10b	$	384,000	253,440		130,560
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	35,839	23,654		12,185
c. Personal property taxes	$	2,776	1,832		944
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	474,282	313,026		161,256

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

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Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	Residential Care Home
Refuse Removal	$ 7,444		$ 3,835
Total Other Repairs and Maintenance	$ 7,444	$ -	$ 3,835

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
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Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	52,707		52,707	17,271	SL	VAR	2,725	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	10,401						1,284	
C-4. Subtotal								4,009

Property Item	Is a mileage logbook maintained? Yes	No	Date of Acquisition Month	Year	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
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					212,694		212,694	183,621	SL	VAR	8,616	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					9,064						522	
D-3. Subtotal												9,138
E. ***Total Depreciation***												13,146

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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:					
8/9/2013	Cables & Wiring - Emergency Generator	$ 7,681.70	20	$ 1,248.13	
8/30/2016	Install Control Assembly on Generator	$ 2,719.23	10	$ 35.61	
Total additions for Non-Movable Equipment		$ 10,401		$ 1,284	*
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:					
5/20/2016	Wiring Equipment for POC Implementation	$ 495.81	5	$ 29.44	
5/20/2016	Wiring Equipment for POC Implementation	$ 731.52	5	$ 43.43	
5/20/2016	Wiring Equipment for POC Implementation	$ 419.19	5	$ 24.88	
6/1/2016	5 Kiosks for POC Implementation	$ 7,417.91	5	$ 423.88	
Total additions for Movable Equipment		$ 9,064		$ 522	*
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:					
12/21/2015	Rubber Membrane Roof Install-Dwn Pymt	20,625.00	10	$ 2,578.17	
12/21/2015	Rubber Membrane Roof Install-Rem Balance	24,749.22	10	$ 3,093.62	
6/20/2016	Install Concrete Stairs and Railings	7,482.84	15	$ 131.91	
9/20/2016	Installation of Mixing Valve on Boiler	1,739.85	10	$ 9.47	
9/20/2016	Installation of Mixing Valve on Boiler	151.55	10	$ 0.83	
Total additions for Leasehold Improvement		$ 54,748		$ 5,814	*
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
Rose Haven	1036-C	9/30/2016	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				937,966	687,812	A		32,705	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				54,748				5,814	
C-4. Subtotal									38,519
D. ***Total Amortization***									38,519

* Straight-line method must be used.
** Specify which of the following bases were used:
A. Minimum of 5 years or 60 months.
B. Life of mortgage; OR
C. Remaining Life of Lease; OR
D. Actual Life if owned by Related Party.

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

Name of Facility	License No.	Report for Year Ended	Page of
Rose Haven	1036-C	9/30/2016	25 | 37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?*

⦿ Yes ○ No

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	40
6. Square Footage	13,943
7. Acquisition Cost	
a. Land	
b. Building	

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

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

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

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

CT Medicaid Cost Report Attachment Page 25

	Original Mortgage	6 Month extension
A. Type of Financing (e.g. fixed, variable)	Fixed	
B. Date of Mortgage Obtained	4/11/2008	extension to 10/13/15
C. Interest Rate For the Cost Year	6.44%	2.08%
D. Term of Mortgage (number of years)	7 Yrs.	6 month
E. Amount of Principal Borrowed	119,500,000	
F. Principal Balance Outstanding as of 9/30/:	100,562,320	12 month extension
		extention to 10/13/16
		2.75%
		12 months

Note: The following facilities are collateralized by this mortgage.

Connecticut Facilities

Brightview Nursing & Retirement Center, Ltd.
Rose Haven, Ltd.
Mary Elizabeth Nursing Center, Inc.
Fowler Nursing Center, Inc.
Waterbury Extended Care Facility, Inc.
Harbor View Nursing Center, Inc.
Liberty Hall Nursing Center
Orchard Grove Specialty Care
Wolcott Hall Nursing Center, Inc.
Hewitt Health and Rehabilitation Center, Inc.
Watrous Nursing Center
Elm Hill Nursing Center, Inc.
Gardner Heights Health Care Center, Inc.
Shelton lakes Health Care Center, Inc.
Highview Health Care Center, Inc.
Westfield Manor Health Care Center, Inc.
TA Coccomo Memorial
Plainville Health Care Center, Inc.
Ledgecrest Health Care Center, Inc.
Ridgeview Health Care Center, Inc.
The Kent, Ltd.
Chesterfields, Ltd.

Out of State Facilities

Watch Hill Manor, Ltd.
The Clipper Home, Inc.

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

Name of Facility	License No.	Report for Year Ended	Page of
Rose Haven	1036-C	9/30/2016	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*)

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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
Rose Haven	1036-C	9/30/2016	27 | 37

Item		Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:					
12. C. Movable Equipment 1. Automotive Equipment	$				
A. Item / Rate / Amount					
Lender					
Address of Lender					
2. Other (*Specify*)	$				
A. Item / Rate / Amount					
Lender					
Address of Lender					
B. Item / Rate / Amount					
Lender					
Address of Lender					
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)	$				
12. D. Other Interest Expense (*Specify*) Interest on Term Note/Tax Collector	$	3,377	3,377		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)	$	3,377	3,377		
14. Insurance a. Insurance on Property (buildings only)	$	43,817	28,919		14,898
b. Insurance on Automobiles	$				
c. Insurance other than Property (as specified above) 1. Umbrella (*Blanket Coverage*)	$				
2. Fire and Extended Coverage	$				
3. Other (*Specify*)	$				
14d. ***Total Insurance Expenditures (14a + b + c)***	$	43,817	28,919		14,898
15. ***Total All Expenditures (A-13 thru C-14)***	$	4,316,809	3,469,524		847,285

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Rose Haven	1036-C	9/30/2016	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.	10	A12g	Occupational Therapy	$	11,808	11,808		
4.			Other - See attached Schedule	$				
Page 13 - Professional Fees								
5.			Resident Care Physicians **	$				
6.	13	B10a	Occupational Therapy	$	192,064	192,064		
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.	15	1c	Bad Debts	$	101,452	101,452		
10.	15	1d/e	Accounting & Legal	$	2,244	1,436		808
11.			Telephone	$				
12.			Cellular Telephone	$				
13.			Life insurance premiums on the life of Owners, Partners, Operators	$				
14.			Gifts, flowers and coffee shops	$				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	$				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	$				
17.			Automobile Expense (e.g. personal use)	$				
18.	16	m2/3	Unallowable Advertising *	$	12,145	7,894		4,251
19.			Income Tax / Corporate Business Tax	$				
20.	16	m10	Fund Raising / Contributions	$				
21.			Unallowable Management Fees	$				
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	24,742	16,082		8,660
Page 18 - Dietary Expenditures								
24.	30	IV1	Meals to employees, guests and others who are not residents	$	540	540		
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)	$	344,995	331,276		13,719

* 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	m13	Corporate Fee - Non Reimbursable	$ 11,748		$ 6,326
16	1.3	Employee Recognition/Gift/Parties	$ 3,265		$ 1,758
16	8a	Chamber of Commerce	$ 576		$ 310
16	m13	Bank Charges	0		
16	m13	Sales Tax Audit	917		494
16	m13	Prior Period Adj/Account W/O	(1,357)		(731)
16	m13	Sales Tax Audit	917		494
16	m13	Aug 16 Pmt of 2014 Bus Entty	16		9
Total Other A&G Adjustments			$ 16,082	$ -	$ 8,660

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

Name of Facility	License No.	Report for Year Ended	Page of
Rose Haven	1036-C	9/30/2016	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	Residential Care Home
			Subtotals Brought Forward	$	344,995	331,276		13,719
Page 20 - Resident Care Supplies*								
27.	20	5a2	Prescription Drugs	$	156,576	156,576		
28.	16	L1	Ambulance/Limousine	$	3,012	3,012		
29.	20	h	X-rays, etc	$	14,679	14,679		
30.	20	f	Laboratory	$	10,428	10,428		
31.			Medical Supplies	$				
32.	20	5e2	Oxygen (non emergency)	$	17,972	17,972		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	9,469	9,469		
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.	30	IV8	Interest Income on Accounts Rec	$	8	8		
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	$	3,377	3,377		
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)***	$	560,516	546,797		13,719

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

Attachment Page 29

Rose Haven
9/30/2016

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
20	5j	IV Therapy Supples	$ 4,113		
20	5j	Rehab Service Supplies	$ 5,356		
Total Other Ancillary Costs			$ 9,469	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
27	12D	Interest on Term Note	$ 1,032		
27	12D	Interest on Property Tax	$ 1,921		
27	12D	Interest on Invoice	$ 380		
27	12D	Aug 16 Pmt of 2014 Bus Entty	$ 43		
Total Other Adjustments			$ 3,377	$ -	$ -

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Rose Haven	1036-C	9/30/2016	30 | 37

Item		Total	CCNH	RHNS	Residential Care Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	1,368,846	774,709		594,138
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)*	$	1,295,305	1,295,305		
b. Medicare Room and Board Contractual Allowance **	$	533,535	533,535		
4. a. Private-Pay Residents and Other	$	471,962	471,962		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	138,150	138,150		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(138,133)	(138,133)		
c. Prescription Drugs - Non-Medicare	$	18,812	18,812		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(18,812)	(18,812)		
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	$	393,927	393,927		
b. Physical Therapy - Medicare Contractual Allowance **	$	(343,880)	(343,880)		
c. Physical Therapy - Non-Medicare	$	48,020	48,020		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(47,810)	(47,810)		
4. a. Speech Therapy - Medicare	$	25,606	25,606		
b. Speech Therapy - Medicare Contractual Allowance **	$	(21,053)	(21,053)		
c. Speech Therapy - Non-Medicare	$	5,355	5,355		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(5,355)	(5,355)		
5. a. Occupational Therapy - Medicare	$	494,326	494,326		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(442,313)	(442,313)		
c. Occupational Therapy - Non-Medicare	$	58,635	58,635		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(58,455)	(58,455)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	3,776,669	3,182,531		594,138
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	540	540		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	8	8		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	792	792		
V. Total Other Revenue (1 thru 8)	$	1,341	1,341		
VI. Total All Revenue (III +V)	$	3,778,009	3,183,872		594,138

* *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	Account Balance	CCNH	RHNS	Residential Care Home
30 IV5	Interest Income	464,932	$ 8		
Total Interest Income			$ 8	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
30 IV5	Sarah Appletree-Payback	$ 792		
Total Other Revenue		$ 792	$ -	$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page of
Rose Haven	1036-C	9/30/2016	31 | 37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 200
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 464,932
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 16,967
5. Prepaid Expenses				$ 19,177
a. Prepaid Insurance				
b. Prepaid Property Tax		10,861		
c. Other Prepaid Expenses		8,316		
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 19,500
Due Affiliate (Debit Balance)		19,500		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 520,776
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	992,714		$ 266,383
	Accum. Depreciation	726,331	Net	
5. Non-Movable Equipment	*Historical Cost	63,108		$ 41,827
	Accum. Depreciation	21,280	Net	
6. Movable Equipment	*Historical Cost	221,758		$ 28,999
	Accum. Depreciation	192,759	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
Fixed Asset Clearing Account				
Construction in Progress				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 337,209

* 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
Rose Haven	1036-C	9/30/2016	32 | 37

Account				Amount
			Total Brought Forward:	$ 857,986
C.	Leasehold or like property recorded for Equity Purposes.			
	1. Land			$
	2. Land Improvements	*Historical Cost		
		Accum. Depreciation	Net	$
	3. Buildings	*Historical Cost		
		Accum. Depreciation	Net	$
	4. Non-Movable Equipment	*Historical Cost		
		Accum. Depreciation	Net	$
	5. Movable Equipment	*Historical Cost		
		Accum. Depreciation	Net	$
	6. Motor Vehicles	*Historical Cost		
		Accum. Depreciation	Net	$
	7. Minor Equipment-Not Depreciable			$
C-8	***Total Leasehold or Like Properties*** (C1 thru 7)			$
D.	Investment and Other Assets			
	1. Deferred Deposits			$
	2. Escrow Deposits			$
	3. Organization Expense	*Historical Cost		
		Accum. Depreciation	Net	$
	4. Goodwill (Purchased Only)			$
	5. Investments Related to Resident Care (*itemize*)			$
	6. Loans to Owners or Related Parties (*itemize*)			$
	Name and Address	Amount	Loan Date	
	7. Other Assets (*itemize*)			$ 628
	Loans Rec. - Officers/Owner			
	Capitalized Refinance Expense			
	Leasehold Deposits		628	
D-8.	***Total Investments and Other Assets*** (Lines D1 thru 7)			$ 628
D-9.	***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$ 858,614

* 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
Rose Haven	1036-C	9/30/2016	33 | 37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 94,238
2. Notes Payable (*itemize*)	$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

Account	Amount
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)	$ 51,638
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$ 8,355
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*)	$ 194,150

Accrued PTO	73,258	Accrued Professional Fee	4,450
Accrued Pension	1,480	Payroll W/H	602
Accrued Worker's Comp	62,330	Exchange	15,090
Accrued Expense Other	35,240	Exchange-Arlene Sheeha	1,700

Account	Amount
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 348,381

* 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
Rose Haven	1036-C	9/30/2016	34 | 37

Account	Amount
Total Brought Forward:	348,381
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

Account	Amount
2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ 1,214,553

Name and Address of Lender	Amount	Loan Date
Brian J. Foley	1,214,553	Demand

Account	Amount
4. Other Long-Term Liabilities (*itemize*)	$
Security Deposits	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 1,214,553
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 1,562,934

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

Name of Facility	License No.	Report for Year Ended	Page	of
Rose Haven	1036-C	9/30/2016	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	$ 3,172,245
	2. Capital Stock	$ 1,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (3,338,766)
	6. Gain or Loss for Period 10/1/2015 thru 9/30/2016	$ (538,799)
	7. Total Net Worth	$ (704,320)
C.	***Total Reserves and Net Worth***	$ (704,320)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 858,614

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Rose Haven	1036-C	9/30/2016	36	37

	Account			Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015		$	(363,342)
B.	Total Revenue (*From Statement of Revenue Page 30*)		$	3,778,009
C.	Total Expenditures (*From Statement of Expenditures Page 27*)		$	4,316,809
D.	Net Income or Deficit		$	(538,799)
E.	Balance		$	(902,141)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Brian J. Foley	200,000		
	2. Other (*itemize*)			
F-3.	Total Additions		$	200,000
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)		$	2,179

Name and Address (*No., City, State, Zip*)	Title	Amount
Brian Foley	President	2,179

2. Other Withdrawings *(Specify)*	$	

Purpose	Amount

	3. Total Deductions		$	2,179
H.	***Balance at End of Period***	09/30/16	$	(704,320)

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Rose Haven	1036-C	9/30/2016	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

Printed Name of Preparer
Robert Gwizdak

Addres Address	Phone Number
21 Waterville Road Avon, CT 06001	(860) 470-7535