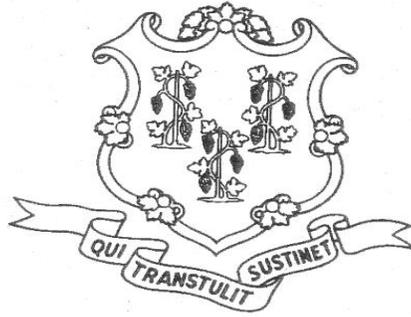


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2023

Name of Facility (as licensed) Gardner Heights Health Care Center	
Address (No. & Street, City, State, Zip Code) 172 Rocky Rest Road, Shelton CT 06484	
Type of Facility Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <span style="margin-left: 150px;"><input type="checkbox"/> (Specify)</span> <span style="margin-left: 150px;"><input type="checkbox"/> (Specify)</span>	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

License Numbers:	CCNH / RHNS 2296-C	(Specify)	(Specify) 07-5368	Medicare Provider
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Medicaid Provider Numbers:	CCNH / RHNS 9969	(Specify) 91520	(Specify)
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**General Information**

Name of Facility (as licensed) Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2023	Page 1	of 37
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**Administrator's/Owner's Certification**

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Gardner Heights Health Care Center [facility name], for the cost report period beginning October 1, 2022 and ending September 30, 2023, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator)			Printed Name (Owner) Brian Foley		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

# Table of Contents

General Information - Administrator's/Owner's Certification	1
General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
General Information and Questionnaire - Type of Facility - Organization Structure	2
General Information and Questionnaire - Partners/Members	3
General Information and Questionnaire - Corporate Owners	3A
General Information and Questionnaire - Individual Proprietorship	3B
General Information and Questionnaire - Related Parties	4
General Information and Questionnaire - Basis for Allocation of Costs	5
General Information and Questionnaire - Other Lines of Business	6
General Information and Questionnaire - Other Lines of Business (Continued)	7
Schedule of Resident Statistics	8
Schedule of Resident Statistics (Cont'd)	9
A. Report of Expenditures - Salaries & Wages	10
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B. Report of Expenditures - Professional Fees	13
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C. Expenditures Other than Salaries - Administrative and General	15
C. Expenditures Other than Salaries (Cont'd) - Administrative and General	16
Schedule C-1 - Management Services	17
C. Expenditures Other than Salaries (Cont'd) - Dietary	18
C. Expenditures Other than Salaries (Cont'd) - Laundry	19
C. Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
Depreciation Schedule	23
Amortization Schedule	24
C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C. Expenditures Other than Salaries (Cont'd) - Interest	26
C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
F. Statement of Revenue	30
G. Balance Sheet	31
G. Balance Sheet (Cont'd)	32
G. Balance Sheet (Cont'd)	33
G. Balance Sheet (Cont'd)	34
G. Balance Sheet (Cont'd) - Reserves and Net Worth	35
H. Changes in Total Net Worth	36
I. Preparer's/Reviewer's Certification	37

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Gardner Heights Health Care Center		Period Covered:	From 10/1/2022	To 9/30/2023
Address of Facility 172 Rocky Rest Road, Shelton CT 06484				
Report Prepared By Apple Health Care, Inc.		Phone Number (860) 678-9755	Date	
Item	Total	CCNH / RHNS	(Specify)	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

**General Information and Questionnaire**  
**Type of Facility - Organization Structure**

		Phone No. of Facility	Report for Year Ended 9/30/2023	Page 2	of 37
Name of Facility (as shown on license) Gardner Heights Health Care Center		Address (No. & Street, City, State, Zip) 172 Rocky Rest Road, Shelton CT 06484			
License Numbers:	CCNH / RHNS 2296-C	(Specify)	(Specify) 07-5368	Medicare Provider No.	
Type of Facility (Check appropriate box(es))					
Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input type="checkbox"/> (Specify)					
Type of Ownership (Check appropriate box)					
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust					
If this facility opened or closed during report year provide:			Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?					
<input type="radio"/> Yes <input checked="" type="radio"/> No                   If "Yes," explain fully.					
<b>Administrator</b>					
Name of Administrator Whitney Carter			Nursing Home Administrator's License No.:	2157	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		



**General Information and Questionnaire**  
**Corporate Owners**

Name of Facility Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2023	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address	State(s) in Which Incorporated		
Gardner Heights Health Care Center	172 Rocky Rest Road, Shelton CT 06484	Connecticut		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Brian Foley	21 Waterville Rd. Avon, CT 06001	President	100	
Ryan Vess	21 Waterville Rd. Avon, CT 06001	Secretary		
Names of Stockholders Owning at Least 10% of Shares				
Brian Foley	21 Waterville Rd. Avon, CT 06001	President	100	



**General Information and Questionnaire  
 Related Parties\***

Name of Facility Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2023	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?  Yes  No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Brian J. Foley	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Real Estate Rental	Pg. 22 Line 9	432,000	432,000
Apple Health Care	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Management & Accounting Services	Pg. 16 Line m12	396,664	396,664
Corporate Employees	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	143,201	143,201
Healthport	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule		
Employees @ various Apple facilities		<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	52,861	52,861
Apple Health Care	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Pension Plan (401K)	Pg. 15 Line 1a7	133,434	133,434
Lucent	424 Church St. Nashville, TN 37219	<input checked="" type="radio"/>	<input type="radio"/>		Group Medical	Pg. 15 Line 1a5	320,857	
Delta Dental	148 Eastern Blvd Glastonbury, CT 06033	<input checked="" type="radio"/>	<input type="radio"/>		Group Dental	Pg. 15 Line 1a5	22,955	
USI	PO Box 62937 Virginia Beach, VA 23466	<input checked="" type="radio"/>	<input type="radio"/>		Property, Liability, & Umbrella Insurance	Pg. 27 Line 14a	220,505	

\* Use additional sheets if necessary.

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

**General Information and Questionnaire  
 Related Parties\***

Name of Facility Gardner Heights Health Care Center		License No. 2296-C	Report for Year Ended 9/30/2023		Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business associator <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input checked="" type="radio"/> Yes <input type="radio"/> 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	%**				
Reliance Standard	2001 Market St. Philadelphia, PA	✘			Group Life & Disability	Pg. 15 1a6	4,965	
AIG	PO Box 10472 Newark, NJ	✘			Worker's Compensation	Pg. 15 1a1	115,052	
Swallowing Diagnostics	21 Waterville Road Avon, CT	✘		83%	Diagnostic Services	Pg 20 5f	2,160	2,037
Ryan Vess	21 Waterville Road Avon, CT		✘			##		
Tarah Foley	21 Waterville Road Avon, CT		✘			##		
Paula Meunier	21 Waterville Road Avon, CT		✘			##		
Kayla Foley	21 Waterville Road Avon, CT		✘			##		
Patricia Hyyppa	21 Waterville Road Avon, CT		✘			##		
Reino Hyyppa	21 Waterville Road Avon, CT		✘			##		
Robert Wooley	21 Waterville Road Avon, CT		✘			##		
CRS Landscape & Excavation		✘			Landscaping	Pg. 31 B9	4,786	4,786

\* 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

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2023	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

N/A

**General Information and Questionnaire**  
**Other Lines of Business**

Name of Facility Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2023	Page 6	of 37
Square footage of entire facility.		64,365		
<b>Outpatient Therapy</b>				
Does the Facility provide outpatient therapy services?		No		
<i>If yes, please complete the following:</i>				
Square footage of therapy space.				
<b>Meals on Wheels</b>				
Does the facility provide Meals on Wheels?		No		
<i>If yes, please complete the following:</i>				
Square footage of kitchen				
Number of meals served per week				
No	Are meals included in meals served on page 18 of the Annual Report?			
No	Are direct costs included in the Annual Report?			
<i>If yes, please state where costs are reported.</i>				
No	Are drivers for the program included in the facility's payroll?			
<i>If yes, please complete the following:</i>				
Amount Reported				
Annual Report page and line				
Please state the salary amounts of specific cooks and/or dietary aides				
Please state where the cooks and/or dietary aides are reported in the Annual Report				
<b>Apartments, Independent Living, Assisted Living</b>				
Does the facility have apartments, independent living, and/or assisted living?		No		
<i>If yes, please complete the following:</i>				
Square footage of apartments				
Square footage of independent living				
Square footage of assisted living				
Please identify the services provided:				

**General Information and Questionnaire**  
**Other Lines of Business (Continued)**

Name of Facility Gardner Heights Heal	License No. 2296-C	Report for Year Ended 9/30/2023	Page 7	of 37
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**Child Day Care**

Does the Facility provide Child Day Care?  No

*If yes, please complete the following:*

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

**Adult Day Care**

Does the Facility provide Adult Day Care?  No

*If yes, please complete the following:*

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

### Schedule of Resident Statistics

Name of Facility Gardner Heights Health Care Center			License No. 2296-C		Report for Year Ended 9/30/2023				Page 8	of 37		
	Total All Levels	Total CCNH / RHNS Level	Total (Specify)	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH / RHNS	(Specify)	(Specify)	Total	CCNH / RHNS	(Specify)	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	130	130			130	130						
B. On last day of THIS report period	130	130							130	130		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	99	99			99	99						
B. As of midnight of THIS report period	102	102							102	102		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,422	1,422			1,173	1,173			249	249		
B. Medicaid (Conn.)	33,066	33,066			24,573	24,573			8,493	8,493		
C. Medicaid (other states)												
D. Private Pay	3,266	3,266			2,573	2,573			693	693		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	37,754	37,754			28,319	28,319			9,435	9,435		
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. <b>Total Resident Days (3G + 4A + 4B)</b>	37,754	37,754			28,319	28,319			9,435	9,435		

### Schedule of Resident Statistics (Cont'd)

Name of Facility Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2023	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?  Yes  No  
 If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change	
	CCNH / RHNS	(Specify)	(Specify)	Lost			Gained			CCNH / RHNS	(Specify)	(Specify)		
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH / RHNS	(Specify)	(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)	(Specify)
1st change			
2nd change			
3rd change			
4th change			

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	(Specify)	R.C.H.	ICF-MR
No. of Residents	5	88		9				
Per Diem Rate								
a. One bed rm.				425.00				
b. Two bed rms.	RUGS	#####		415.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B	4,526	4,526			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other	8,438	8,438			
<b>D. Total Physical Therapy Treatments</b>	<b>12,964</b>	<b>12,964</b>			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	596	596			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other	2,230	2,230			
<b>D. Total Speech Therapy Treatments</b>	<b>2,826</b>	<b>2,826</b>			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	1,808	1,808			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other	6,534	6,534			
<b>D. Total Occupational Therapy Treatments</b>	<b>8,342</b>	<b>8,342</b>			

**Annual Report of Long-Term Care Facility**

CSP-10 Rev. 3/2023

**Report of Expenditures - Salaries & Wages**

Name of Facility Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2023	Page 10	of 37
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Are time records maintained by all individuals receiving compensation?  Yes  No

Item	Total Cost and Hours									
	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours	
<b>A. Salaries and Wages*</b>										
1. Operators/Owners (Complete also Sec. I of Schedule A1)										
2. Administrator(s) (Complete also Sec. III of Schedule A1)	115,391		2,086							
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)										
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	94,628		2,697							
5. Dietary Service										
a. Head Dietitian	7,714		185							
b. Food Service Supervisor	64,762		1,995							
c. Dietary Workers	384,833		20,737							
6. Housekeeping Service										
a. Head Housekeeper	54,430		2,125							
b. Other Housekeeping Workers	223,599		13,695							
7. Repairs & Maintenance Services										
a. Engineer or Chief of Maintenance										
b. Other Maintenance Workers	130,673		5,559							
8. Laundry Service										
a. Supervisor										
b. Other Laundry Workers	30,966		1,874							
9. Barber and Beautician Services										
10. Protective Services										
11. Accounting Services										
a. Head Accountant										
b. Other Accountants	192,664		5,560							
12. Professional Care of Residents										
a. Directors and Assistant Director of Nurses	146,243		2,195							
b. RN										
1. Direct Care	620,960		10,714							
2. Administrative**	207,293		4,384							
c. LPN										
1. Direct Care	1,168,829		30,755							
2. Administrative**										
d. Aides and Attendants	1,914,803		87,633							
e. Physical Therapists	286,320		6,157							
f. Speech Therapists	66,596		1,287							
g. Occupational Therapists	148,457	(148,457)	3,569							
h. Recreation Workers	102,683		5,073							
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	137,771	(16,612)	3,906							
n. Marketing										
o. Other (Specify) See Attached Schedule										
<i>A-13. Total Salary Expenditures</i>	6,099,615	(165,069)	212,184							

\* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

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

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



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

Name of Facility				License No.	Report for Year Ended			Page	of	
Gardner Heights Health Care Center				2296-C	9/30/2023			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	(Specify)	(Specify)							
<b>Section I - Operators/Owners</b>										
<b>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).</b>										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
Gardner Heights Health Care Center				2296-C	9/30/2023			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	(Specify)	(Specify)							
<b>Section III - Administrators***</b>										
Whitney Carter	115,391				Administrator 10/1/22-9/30/2023	2,086	A2			
<b>Section IV - Assistant Administrators</b>										

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

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

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

**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended						Page	of
Gardner Heights Health Care Center	2296-C	9/30/2023						13	37
Total Cost and Hours									
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>									
1. Dietitian									
2. Dentist	10,920		146						
3. Pharmacist	15,807		211						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care									
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	30,000		191						
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) Detail needed									
9. Speech Therapist									
a. Resident Care	2,256		23						
b. Other									
10. Occupational Therapist									
a. Resident Care									
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care									
2. Administrative***									
b. LPN									
1. Direct Care									
2. Administrative***									
c. Aides									
d. Other									
12. Other (Specify) See Attached Schedule	2,036		27						
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>61,019</b>		<b>596</b>						

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

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

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



**C. Expenditures Other Than Salaries - Administrative and General**

Name of Facility	License No.	Report for Year Ended					Page	of
Gardner Heights Health Care Center	2296-C	9/30/2023					15	37
Item	Total Including Adjustment	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
<b>I. Administrative and General</b>								
<b>a. Employee Health &amp; Welfare Benefits</b>								
1. Workmen's Compensation	\$ 115,052	115,052						
2. Disability Insurance	\$							
3. Unemployment Insurance	\$ 50,577	50,577						
4. Social Security (F.I.C.A.)	\$ 443,303	443,303						
5. Health Insurance	\$ 248,511	248,511						
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 4,965	4,965						
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 133,434	133,434						
8. Uniform Allowance	\$							
9. Other ( <i>Specify</i> ) See Attached Schedule	\$							
<b>b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*</b>	\$							
<b>c. Bad Debts*</b>	\$	(18,084)	18,084					
<b>d. Accounting and Auditing</b>	\$ 4,157	16,902	(12,746)					
<b>e. Legal (<i>Services should be fully described on Page 15b</i>)</b>	\$							
<b>f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*</b>	\$							
<b>g. Office Supplies</b>	\$ 14,234	14,234						
<b>h. Telephone and Cellular Phones</b>								
1. Telephone & Pagers	\$ 59,017	59,017						
2. Cellular Phones	\$							
<b>i. Appraisal (<i>Specify purpose and attach copy</i>)*</b>	\$							
<b>j. Corporation Business Taxes (<i>franchise tax</i>)</b>	\$							
<b>k. Other Taxes (<i>Not related to property - See Page 22</i>)</b>								
1. Income*	\$ 57,471	57,471						
2. Other ( <i>Specify</i> ) See Attached Schedule	\$							
3. Resident Day User Fee	\$ 757,328	757,328						
<b>Subtotal</b>	\$ 1,888,048	1,882,710	5,338					

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

(Carry Subtotals forward to next page)



**General Information and Questionnaire**  
**Accounting Basis**

Name of Facility Gardner Heights Health Care Cente	License No. 2296-C	Report for Year Ended 9/30/2023	Page 15b	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

- Accrual     Cash     Modified Cash

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

**Independent Accounting Firm**

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Clifton Larson Allen LLP (CLA)	29 South Main Street West Hartford, CT 06127
2 Brazee & Huban	35 Wendell Ave. Pittsfield, MA 10202
3 Clifton Larson Allen LLP (CLA)	29 South Main Street West Hartford, CT 06127
4	

Services Provided by This Firm (*describe fully*)

1 Preparation of audited financials	\$ 12,746
2 Preparation of Tax Returns	\$ 3,181
3 Audit 401K	\$ 975
4	\$
	Charge for Services Provided
	\$ 16,902

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

- Yes     No    Pg. 15 Line 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

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

Name of Facility	License No.	Report for Year Ended				Page	of
Gardner Heights Health Care Center	2296-C	9/30/2023				16	37
Item	Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
<b>Subtotals Brought Forward:</b>	1,888,048	1,882,710	5,338				
<b>i. Travel and Entertainment</b>							
1. Resident Travel and Entertainment	\$ (0)	4,806	(4,806)				
2. Holiday Parties for Staff	\$ 2,523	2,523					
3. Gifts to Staff and Residents	\$ (0)	23,479	(23,479)				
4. Employee Travel	\$ 4,217	4,217					
5. Education Expenses Related to Seminars and Conventions	\$ 3,379	3,379					
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$						
7. Other ( <i>Specify</i> ) See Attached Schedule	\$						
<b>m. Other Administrative and General Expenses</b>							
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$ 591	591					
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$						
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 0	6,872	(6,872)				
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	\$ 3,834	3,834					
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 10,033	10,033					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	600	(600)				
9. Subscriptions	\$ 1,984	1,984					
10. Contributions*** See Attached Schedule	\$						
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$						
12. Administrative Management Services**	\$ 396,664	396,664					
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 59,756	164,009	(104,253)				
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 2,371,028	2,505,700	(134,672)				

\* 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 in the Adjustment column.

Schedule of Other Travel and Entertainment

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Advertising - Public Relations	\$ 6,872	\$ (6,872)				
<b>Total Other Advertising</b>	\$ 6,872	\$ (6,872)	\$ -	\$ -	\$ -	\$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
CAHCF	\$ 10,033					
<b>Total Dues</b>	\$ 10,033	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
	\$ -					
<b>Total Contributions</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Corporate Fees - Non Reimbursable	\$ 96,861	\$ (96,891)				
Licenses & Fees	\$ 3,100					
Pre Employment Screenings	\$ 6,372					
System License & Subscription Fees	\$ 50,313					
Bank Service Charges	\$ 5,278	\$ (5,278)				
Legal Fees - Collection/Probate	\$ 1,884	\$ (1,884)				
IT Service Fees	\$ -					
Resident Expenses	\$ -					
Survey Fines & Citations	\$ -					
Donation - Govenors Ball	\$ 200	\$ (200)				
<b>Total Other Administrative and General</b>	\$ 164,009	\$ (104,253)	\$ -	\$ -	\$ -	\$ -

**Schedule C-1 - Management Services\***

Name of Facility Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2023	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.	396,664	Accounting and Management Services	Pg. 16 Line m12

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

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

Name of Facility		License No.	Report for Year Ended				Page	of
Gardner Heights Health Care Center		2296-C	9/30/2023				18	37
Item	Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	\$ 267,837	267,837						
2. Non-Food Supplies	\$ 29,847	29,847						
3. Other (Specify) _____	\$							
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 6,267	6,267						
c. Other (Specify) _____	\$							
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 303,952</b>	<b>303,952</b>						
2E. Dietary Questionnaire		Total	CCNH / RHNS	(Specify)		(Specify)		
F. Resident Meals:	Total no. of meals served per day:*	310	310					
G. Is cost of employee meals included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No							
H. Did you receive revenue from employees?	<input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.			
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)								
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.			
K. Is any revenue collected from these people?	<input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.			
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)								
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.			
N. Is any revenue collected from employees?	<input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.			
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)								

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

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

Name of Facility Gardner Heights Health Care Center		License No. 2296-C	Report for Year Ended 9/30/2023				Page 19	of 37
Item		Including Adjustment s	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
3. Laundry								
a. In-House Processing*	Lbs.							
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	2,794	2,794					
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. \$	2,319	2,319					
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$	114,878	114,878					
c. Other (Specify)	\$							
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	<b>\$</b>	<b>119,991</b>	<b>119,991</b>					
<b>3E. Laundry Questionnaire</b>								
F.	Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.				
G.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.				
H.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)						
I.	Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.				
J.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.				
K.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)						

\* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3D.

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

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

Name of Facility		License No.	Report for Year Ended				Page	of	
Gardner Heights Health Care Center		2296-C	9/30/2023				20	37	
Item			Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4.	Housekeeping	Sq. Ft. Serviced by Personnel	64,365	64,365					
a.	In-House Care								
	1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	39,774	39,774					
b.	Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )	Sq. Ft. Serviced by Personnel	64,365	64,365					
		Amt. \$							
	C. Other ( <i>Specify</i> )	\$							
4D.	<b>Total Housekeeping Expenditures</b> (4a + b + c)	\$	39,774	39,774					
5.	Resident Care (Supplies)**								
a.	Prescription Drugs***								
	1. Own Pharmacy	\$							
	2. Purchased from Neighborcare	\$	6,740	80,830	(74,091)				
b.	Medicine Cabinet Drugs	\$							
c.	Medical and Therapeutic Supplies	\$	176,401	176,401					
d.	Ambulance/Limousine***	\$							
e.	Oxygen								
	1. For Emergency Use	\$							
	2. Other***	\$	7,082	16,046	(8,964)				
f.	X-rays and Related Radiological Procedures***	\$	(0)	13,116	(13,116)				
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$							
h.	Laboratory***	\$	(1)	10,434	(10,434)				
i.	Recreation	\$	19,261	19,261					
j.	Direct Management Services*	\$							
k.	Indirect Management Services*	\$							
l.	Cable TV	\$	22,922	22,922					
m.	Other (Specify)**** See Attached Schedule	\$	355	26,529	(26,174)				
n.	Physical Therapy Expense	\$							
o.	Speech Therapy Expense	\$							
5P.	<b>Total Resident Care Expenditures</b> (5a - 5o)	\$	232,759	365,538	(132,779)				

\* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.  
 \*\* Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.  
 \*\*\* Facility should self-disallow the expense in the Adjustment column.  
 \*\*\*\* ICFMR's should provide a detailed schedule of all Day Program Costs.



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

Name of Facility Gardner Heights Health Care Center			License No. 2296-C		Report for Year Ended 9/30/2023				Page of 21   37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH / RHNS	(Specify)	(Specify)	Pg	Line
EMSL Analytical, Inc	165 Gracey Ave, Meriden, CT 06451	<input type="radio"/>	<input checked="" type="radio"/>		Environmental Lab Testing	15,660			22	6a
Facility Compliance Services LLC	1492 Berlin Turnpike, Berlin, CT 06037	<input type="radio"/>	<input checked="" type="radio"/>		Fire/Compliance Management Service	55,550			22	6a
Saucier Mechanical Svcs	148 Norton St Plantsville, CT 06479	<input type="radio"/>	<input checked="" type="radio"/>		HVAC/Electrical Contractor	23,807			22	6a
Susan Fernandes-Miguel (Miguel & Sons)	39 Knorr Road, Monroe, CT 06468	<input type="radio"/>	<input checked="" type="radio"/>		Landscaping/Snow Removal	25,311			22	6a
Water Boy, LLC	70 Comstock Trail, East Hampton, CT 06424	<input type="radio"/>	<input checked="" type="radio"/>		Water Treatment Supplier	24,407			22	6a
CWPM, LLC	25 Norton Place Plainville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		Refuse Removal	29,958			22	6f
Unitex Textile Rental Svc	Mount Vernon, NY 10550	<input type="radio"/>	<input checked="" type="radio"/>		Laundry Services	114,878			19	3b
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

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

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

Name of Facility	License No.	Report for Year Ended					Page	of
Gardner Heights Health Care Center	2296-C	9/30/2023					22	37
Item		Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	\$	289,898	289,898					
b. Heat	\$	70,111	70,111					
c. Light & Power	\$	55,429	55,429					
d. Water	\$	22,497	22,497					
e. Equipment Lease ( <i>Provide detail on page 22b</i> )	\$							
f. Other ( <i>itemize</i> )	\$	36,095	36,095					
See Attached Schedule								
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	\$	474,030	474,030					
7. Depreciation ( <i>complete schedule page 23*</i> )								
a. Land Improvements	\$							
b. Building & Building Improvements	\$							
c. Non-Movable Equipment	\$							
d. Movable Equipment	\$	10,810	10,810					
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	\$	10,810	10,810					
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )								
a. Organization Expense	\$							
b. Mortgage Expense	\$							
c. Leasehold Improvements	\$	49,314	49,314					
d. Other ( <i>Specify</i> )	\$							
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	\$	49,314	49,314					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	432,000	432,000					
10. Property Taxes								
a. Real estate taxes paid by owner	\$							
b. Real estate taxes paid by lessor	\$	48,132	48,132					
c. Personal property taxes	\$	2,940	2,940					
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	\$	543,196	543,196					

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



## 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 Gardner Heights Health Care Center			License No. 2296-C			Report for Year Ended 9/30/2023		Page 22b	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed		
	Yes	No							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input checked="" type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
Is a Mileage Log Book Maintained for All Leased Vehicles ?								<input type="radio"/> Yes	<input type="radio"/> No
								<b>Total ***</b>	

\* 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.

### Depreciation Schedule

Name of Facility Gardner Heights Health Care Center			License No. 2296-C		Report for Year Ended 9/30/2023			Page 23	of 37			
Property Item			Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals		
<b>A. Land Improvements</b>												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal												
<b>B. Building and Building Improvements</b>												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
B-4. Subtotal												
<b>C. Non-Movable Equipment</b>												
1. Acquired prior to this report period			10,294		10,294	10,294	SL	Various				
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							
<b>D. Movable Equipment</b>												
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					Var	Var	739,239	739,239	696,880	SL	Various	10,057
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative							18,108	18,108		SL	Various	753
d. Standard Resident												
e. Specialized Resident												
Total Acquired during this report period							18,108	18,108				753
D-3. Subtotal												10,810
<b>E. Total Depreciation</b>												10,810



## Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
<b>Additions:</b>					
1/19/2023	20 Bed Ends	Administrative	\$ 2,231	12	\$ 69
1/19/2023	10 Electric Beds	Administrative	\$ 12,185	12	\$ 374
2/27/2023	Five Mattresses	Administrative	\$ 2,050	5	\$ 144
5/12/2023	Fortigate 60F Firewall	Administrative	\$ 1,642	3	\$ 166
		PICK A CATEGORY			
		PICK A CATEGORY			
<b>Total additions for Movable Equipment</b>			\$ 18,108		\$ 753 *
<b>Deletions:</b>					
<b>Total deletions for Movable Equipment</b>			\$ -		\$ - **

\*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
5/23/2023	Oil Lines to Tank	\$ 2,589	10	\$ 76
5/23/2023	Oil Lines to Tank	\$ 2,830	10	\$ 83
5/23/2023	Oil Lines to Tank	\$ 3,072	10	\$ 90
<b>Total additions for Leasehold Improvement</b>		\$ 8,491		\$ 250 *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Amortization Schedule\***

Name of Facility Gardner Heights Health Care Center			License No. 2296-C		Report for Year Ended 9/30/2023			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period	Var	Var		1,308,053	978,905			49,064	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	Var	Var		8,491				250	
C-4. Subtotal									49,314
<b>D. Total Amortization</b>									49,314

\* 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 Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2023	Page 25	of 37	
<b>11. Property Questionnaire</b>					
<b>Part A</b>					
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description	Total				
1. Date Land Purchased					
2. Date Structure Completed					
3. If <b>NOT</b> Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	130				
6. Square Footage	64,365				
7. Acquisition Cost					
a. Land					
b. Building					
<b>Part B - Owner and Related Parties</b>		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)	Fixed				
b. Date Mortgage Obtained	04/21/22				
c. Interest Rate for the Cost Year	4.50%				
d. Term of Mortgage (number of years)	25 years				
e. Amount of Principal Borrowed	4,963,942				
f. Principal balance outstanding as of _____	4,785,786				
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>					
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					
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	

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

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

Name of Facility		License No.	Report for Year Ended				Page	of
Gardner Heights Health Care Center		2296-C	9/30/2023				26	37
Item		Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
12. Interest								
A. Building, Land Improvement & Non-Movable Equipment								
1. First Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
2. Second Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
3. Third Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
4. Fourth Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
B. CHEFA Loan Information								
1. Original Loan Amount		\$						
2. Loan Origination Date								
3. Interest Rate %								
4. Term								
5. CHEFA Interest Expense								
12 B7. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$						

*(Carry Subtotals forward to next page)*

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

Name of Facility		License No.		Report for Year Ended				Page	of	
Gardner Heights Health Care Cente		2296-C		9/30/2023				27	37	
Item				Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:										
12. C. Movable Equipment										
1. Automotive Equipment				\$						
A. Item		Rate	Amount							
Lender										
Address of Lender										
2. Other (Specify)				\$						
A. Item		Rate	Amount							
Lender										
Address of Lender										
B. Item		Rate	Amount							
Lender										
Address of Lender										
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$						
12. D. Other Interest Expense (Specify)				\$						
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$						
14. Insurance										
a. Insurance on Property (buildings only)				\$ 220,505	220,505					
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)				\$ 220,505	220,505					
15. Total All Expenditures (A-13 thru C-14)				\$ 10,300,800	10,733,319	(432,519)				

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended		Page	of
Gardner Heights Health Care Center	2296-C	9/30/2023		30	37
Item	Total	CCNH / RHNS	(Specify)	(Specify)	
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 8,493,837	8,493,837			
b. Medicaid Room and Board Contractual Allowance **	\$				
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 626,875	626,875			
b. Medicare Room and Board Contractual Allowance **	\$ 179,390	179,390			
4. a. Private-Pay Residents and Other	\$ 1,774,746	1,774,746			
b. Private-Pay Room and Board Contractual Allowance **	\$				
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 56,853	56,853			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (55,588)	(55,588)			
c. Prescription Drugs - Non-Medicare	\$ 4,742	4,742			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (4,742)	(4,742)			
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	\$ 336,620	336,620			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (312,438)	(312,438)			
c. Physical Therapy - Non-Medicare	\$ 117,124	117,124			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (36,845)	(36,845)			
4. a. Speech Therapy - Medicare	\$ 81,135	81,135			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (77,043)	(77,043)			
c. Speech Therapy - Non-Medicare	\$ 37,455	37,455			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (7,420)	(7,420)			
5. a. Occupational Therapy - Medicare	\$ 249,075	249,075			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (236,658)	(236,658)			
c. Occupational Therapy - Non-Medicare	\$ 126,305	126,305			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (55,455)	(55,455)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 11,297,968	11,297,968			
<b>IV. Other Revenue*</b>					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income ( <i>Specify</i> )	\$				
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 219,037	219,037			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 219,037	219,037			
<b>VI. Total All Revenue</b> (III +V)	\$ 11,517,005	11,517,005			

\* 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)	(Specify)
<b>Total Other Resident Revenue - Medicare</b>		\$ -	\$ -	\$ -

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

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
<b>Total Other Resident Revenue</b>		\$ -	\$ -	\$ -

**Interest Income**

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
Pg 30 IV5	Interest on A/R	1,096,486	\$ -		
<b>Total Interest Income</b>			\$ -	\$ -	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
30 IV8	Account W/O	\$ 6,306		
30 IV8	Covid Deferred Revenue	\$ 176,005		
30 IV8	Rebates	\$ 13,208		
30IV8	Dividends	\$ 6,260		
30 IV8	West River Settlement	\$ 14,390		
30 IV8	Covid Grant - Air Purifier	\$ 2,868		
<b>Total Other Revenue</b>		\$ 219,037	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Gardner Heights Health Care Center	2296-C	9/30/2023	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	500
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,096,486
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	(2,561)
4. Inventories			\$	27,066
5. Prepaid Expenses			\$	19,714
a. _____				
b. _____				
c. _____				
d. See Schedule		19,714		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	2,672,064
_____				
_____				
See Schedule		2,672,064		
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	3,813,269
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 <u>1,316,544</u>		\$	288,325
	Accum. Depreciation <u>1,028,219</u>	Net		
5. Non-Movable Equipment	*Historical Cost <u>10,294</u>		\$	
	Accum. Depreciation <u>10,294</u>	Net		
6. Movable Equipment	*Historical Cost <u>757,347</u>		\$	49,658
	Accum. Depreciation <u>707,690</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	28,925
_____				
See Schedule		28,925		
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	366,908

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

(Carry Total forward to next page)



### G. Balance Sheet (cont'd)

Name of Facility Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2023	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	4,180,177
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 <b>Total Leasehold or Like Properties</b> (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 ( <i>itemize</i> )			\$	
_____				
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	
Name and Address		Amount	Loan Date	
_____				
7. Other Assets ( <i>itemize</i> )			\$	24,169
_____				
See Schedule			24,169	
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	24,169
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$	4,204,346

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

**G. Balance Sheet (cont'd)**

Name of Facility Gardner Heights Health Care Center		License No. 2296-C	Report for Year Ended 9/30/2023	Page 33	of 37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	516,129
2. Notes Payable ( <i>itemize</i> )				\$	
_____					
_____					
See Schedule					
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$	115,621
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	15,769
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable ( <i>Current Portion</i> )				\$	
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities ( <i>itemize</i> )				\$	969,048
_____					
_____					
See Schedule				969,048	
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>				\$	<b>1,616,567</b>

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

(Carry Total forward to next page)

### G. Balance Sheet (cont'd)

Name of Facility Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2023		Page 34	of 37
Account				Amount	
Total Brought Forward:				1,616,567	
<b>Liabilities (cont'd)</b>					
B. Long-Term Liabilities					
1. Loans Payable-Equipment ( <i>itemize</i> )					
				\$	
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$	
Name and Address of Lender	Amount	Loan Date			
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$ 275,513	
See Schedule		275,513			
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 275,513	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 1,892,080	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Gardner Heights Health Care Center	2296-C	9/30/2023	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
<b>B. Net Worth</b>				
1. Owner's Capital			\$	1,470,000
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	57,580
6. Gain or Loss for Period			\$	783,686
	10/1/2022	thru	9/30/2023	
7. Total Net Worth			\$	2,312,266
<b>C. Total Reserves and Net Worth</b>			\$	2,312,266
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	4,204,346

### H. Changes in Total Net Worth

Name of Facility Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2023	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2022			\$	1,536,711
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$	11,517,005
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$	10,733,319
D. Net Income or Deficit			\$	783,686
E. Balance			\$	2,320,397
F. Additions				
1. Additional Capital Contributed ( <i>itemize</i> )				
2. Other ( <i>itemize</i> )				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )			\$	8,131
Name and Address ( <i>No., City, State, Zip</i> )		Title	Amount	
Brian Foley		President	8,131	
2. Other Withdrawings ( <i>Specify</i> )			\$	
Purpose		Amount		
3. Total Deductions			\$	8,131
H. <b>Balance at End of Period</b>			\$	2,312,266
				09/30/23

### I. Preparer's/Reviewer's Certification

Name of Facility Gardner Heights Health Care Center	License No. 2296-C	Report for Year Ended 9/30/2023	Page 37	of 37
<i>Check appropriate category</i>				
Chronic and Convalescent Nursing <input checked="" type="checkbox"/> Home (CCNH) & RHNS Combined	<input type="checkbox"/> (Specify)	<input type="checkbox"/> (Specify)		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
Address Address		Phone Number		
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number		
Contact Email Address				