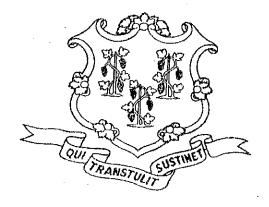
State of Connecticut



15/26

Annual Report of Long-Term Care Facility

Cost Year 2015

						,	<u> </u>	
Name of Facility (as	licensed)			··-				
APRIL TIME RESII	•	E HOME, LL	.C			į į	JAN	1 1 2016
Address (No. & Stre			····	·		i		, , , , , , , , , , , , , , , , , , , ,
91 CHESTNUT ST.	MANCHESTE	R CT. 06040				Dar-	LOFO	OCIAL SERVICES
Type of Facility								ATAL PATE SET FING
Chronic and (Convalescent		Rest Home wit	h Nursing	Ţ			
☐ Nursing Hom	e only			_	-	Resident	ial Ca	re Home
(CCNH)			(RHNS)					
Report for Year Beg	inning		Report for Yea	r Ending				
10/01/14	-		09/30/15					
License Numbers:		CCNH	RHNS	Resid	ential Care 1885	Home	Me	dicare Provider
Medicaid Provider N	umbers:	CC	CNH	RI	INS		IC:	F-IID
For Department Us	e Only							·
Sequence Number Assigned	Signed and Notarized	Date Received	Sequence N Assign		Signed	and Notar	ized	Date Received

RECEIVED

JAN 19 2016

MYERS & STAUFFER LC

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
APRIL TIME RESIDENTIAL CARE HOME, LLC	1885	09/30/15	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for APRIL TIME RESIDENTIAL CARE HOME, LLC [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

			1 1 (/	
Signed (Administrator)		Date	Signed (Owner)	Date ,
Thigh		1/13/16	Whole	1/13/2016
Printed Name (Administrator)		' '	Printed Name (Owner)	
JASWINDER BHOGAL			KULDIP BHOGAL	
Subscribed and Sworn	State of	Date	Signed (Notary Public)	Comm. Expires
to before me:	No.	/ /	11/1/20	
LECANN RIMORRONE	U	1/13/16	Telland / Women	8 13/120
Address of Notary Public		6	X ,	
Le G CEDAR SI	NEWING	78N CT	06111	

(Notary Seal)

State of Connecticut Department of Social Services

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adju	stm	ent		Page	of
				1A	37
Name of Facility		Period Cov	ered:	From	То
APRIL TIME RESIDENTIAL CARE HOME, LLC				10/01/14	09/30/15
Address of Facility				<u> </u>	
91 CHESTNUT ST. MANCHESTER CT. 06040					
Report Prepared By		Phone Num	ber	Date	
THOMAS W. DANIELE CPA		860-666-59	42	01/07/15	
Item		Total	CCNH	RHNS	Residentia 1 Care
Dietary wages paid	\$	· · · · · · · · · · · · · · · · · · ·	CCIVII	KIINS	Home
Laundry wages paid	\$	36,727			36,727
		27,916		<u> </u>	27,916
Housekeeping wages paid	\$	38,990			38,990
4. Nursing wages paid	\$	114,031			114,031
5. All other wages paid	\$	58,217			58,217
6. Total Wages Paid	\$	275,881			275,881
7. Total salaries paid	\$	86,238			86,238
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$	362,119			362,119

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

			cility	Report for Y	ear Ended		of	
NICP 112 (1	860	-649-4519		09/30/15		2	37	
Name of Facility (as shown on license)				Street, City, St				
APRIL TIME RESIDENTIAL CARE HOME, LLC	<u> </u>			ST. MANCH				_
License Numbers:		RHNS	Resi	dential Care H		Medicare F	rovider No	١,
Type of Facility (Check appropriate box(es))			<u> </u>		1885			
	ъ	. **						
Chronic and Convalescent Nursing Home only (CCNH)		t Home with			Residenti	ial Care Hon	ne	
	Sup	ervision only	(RH	NS)				
Type of Ownership (Check appropriate box)								
O Proprietorship	0	Profit Corp.	0	Non-Profit Co	rp. O	Government	O Trust	
			Date	Opened	Date Clos	sed		٦
If this facility opened or closed during report year provi	de:							
Hos though how we have			L		<u> </u>			_
Has there been any change in ownership or operation during this report year?	^	V	•	NT.	Y C 113 7 11	1 1 0 11		
or operation during this report year?		Yes	<u> </u>	No	If "Yes,"	explain fully	/	4
·								
								ŀ
								ı
Administrator			····		·			╡
Name of Administrator				Nursing H	ome	······································		\dashv
JASWINDER BHOGAL				Administra				
				License 1	l l			
Other Operators/Owners who are assistant administrator	rs (full	or part time)	of th	is facility.	 L			┪
Name				License 1	No.:			٦
								٦
								١
						····		
								1
								١
	· · · · · · · · · · · · · · · · · · ·							
					1			1

General Information and Questionnaire Partners/Members

Name of Facility APRIL TIME RESIDENTIAL	CARE HOME LLC	License No.	Report for Y 09/30/15	ear Ended	Page of 3		
Legal Name of Partnership/LLC APRIL TIME RESIDENTIAL CARE HOME, LLC		Business 91 CHESTNUT MANCHESTE	Address ΓST.		nd/or Town(s) in h Registered		
Name of Partners/Members	Business Ac	ldress		 Title	% Owned		
KULDIP BHOGAL	91 CHESTNUT ST. M CT. 06040	ANCHESTER	Member		50		
JASWINDER BHOGAL	91 CHESTNUT ST. M CT. 06040	ANCHESTER	Member		50		
				,			
			·				

General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year En	ded	Page of
APRIL TIME RESIDENTIAL CARE HOM		09/30/15		3A 37
If this facility is owned or operated as a corpo				
Legal Name of Corporation	Busines	s Address	State(s) in Whi	ch Incorporated
N/A				
Name of Directors, Officers	Busines	s Address	Title	No. Shares
		~ 1 . www. • us	1110	Held by Each
		<u></u>		
		:		
Names of Stockholders Owning at Least				
10% of Shares				
			·	
	····			
			1	

General Information and Questionnaire Individual Proprietorship

Name of Facility APRIL TIME RESIDENTIAL CARE HOME, LL	License No.	Report for Year Ended 09/30/15	Page of	
If this facility is owned or operated as an individua	al proprietorship p	rovide the following informat	3B 37	/
Ow	ner(s) of Facility	tovide the following informat	ion.	
	,			
-				
			,	
·				
		, , , , , , , , , , , , , , , , , , ,		
	,			
·				

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General Information and Questionnaire Related Parties*

Name of Facility APRIL TIME RESIDEN	Name of Facility APRIL TIME RESIDENTIAL CARE HOME, LLC	License No.	No. 1885	Report for Year Ended 09/30/15	ar Ended		Page 4	of 37
Are any individuals rece	Are any individuals receiving compensation from the facility related through	acility re	roug			If "Yes," provide the Name/Address and	e Name/Add	ress and
marriage, ability to cont	marriage, ability to control, ownership, family or business association?	ess assoc		⊙ Yes (O No	complete the information on Page 11 of the report.	nation on Pag	ge 11 of the report.
Are any individuals or c	Are any individuals or companies which provide goods or services,	or servi	ces,					
including the rental of prelated through family a	including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business	to this fa	cility, or business		• Yes O No			
association to any of the	association to any of the owners, operators, or officials of this facility?	of this fa	cility?			If "Yes," provide the following information:	e following i	nformation:
	A SAN THE SAN	;				1,11	-	
		Good	Also Provides Goods/Services to			Indicate Where		
Name of Related	Business	Non-R	Non-Related Parties		Description of Goods/Services	in Annual Report	Cost	Actual Cost to the
Individual or Company		Yes	No %**	,	Provided	Page #/Line#	Reported	Related Party
J&K Bhogal Realty, LLC	91 CHESTNUT ST. MANCHESTER CT. 06040	0	•	Rent		22/9	91,000	
J & K Bhogal Realty, LLC	91 CHESTNUT ST. MANCHESTER CT. 06040	0	0	Loan		34/b3	80,741	
Kuldip & Jawinder Bhogal	91 CHESTNUT ST. MANCHESTER CT. 06040	0	•	Loan		34/b3	59,102	
		0	0					
		0	0					
		0	0					
		0	0					
		0	0					
		0	0					

^{*} Use additional sheets if necessary.

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

General Information and Questionnaire Basis for Allocation of Costs

Name of Facility	License N	0.	Report for Year Ended	Page	of			
APRIL TIME RESIDENTIAL CARE HOME,			09/30/15	5	37			
If the facility is licensed as CDH and/or RCH o	r provides	AIDS or TB	I services with special Medicai	d rates, cos	sts			
must be allocated to CCNH and RHNS as follo	ws:		•	,				
Item		Method of Allocation						
Dietary		Number of	meals served to residents					
Laundry		Number of	pounds processed					
Housekeeping		Number of	square feet serviced					
			hours of routine care provided					
Nursing			classification, i.e., Director (or					
			Nurses, Licensed Practical Nu	rses, Aides	and			
		Attendants						
Direct Resident Care Consultants			hours of resident care provided	1 by EACH	I			
			(See listing page 13)					
Maintenance and operation of plant	··· · · · · · · · · · · · · · · · · ·	Square feet						
Property costs (depreciation)		Square feet						
Employee health and welfare		Gross salar						
Management services Appropriate cost center involved								
All other General Administrative expenses	 		rect and Allocated Costs					
The preparer of this report must answer the foll	owing ques	tions applic	able to the cost information pro	ovided.				
1. In the preparation of this Report, were all	O Yes	O No	If "No," explain fully why suc	h allocatior	ı was			
costs allocated as required?	0 103	O 110	not made.					
2. Explain the allocation of related company ex	penses and	attach copy	of appropriate supporting data					
•								
3. Did the Facility appropriately allocate and se	lf-disallow	direct and is	ndirect costs to non-nursing ho	me cost cer	nters?			
(e.g., Assisted Living, Home Health, Outpatie	ent Services	s, Adult Day	/ Care Services, etc.)					
	⊙ Yes	U 110	If "No," explain fully why such not made.	ı allocation	was			
					ľ			
- NATIONAL CONTRACTOR OF THE C								

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General Information and Questionnaire Leases (Excluding Real Property)

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

οĘ 37 Amount Claimed Page 9 of Lease Amount Annual Report for Year Ended Term of Lease 09/30/15 Date of Lease** Description of Items Leased 1885 License No. Related * to Ν̈́ Operators, 0 0 0 0 0 0 0 0 0 Owners, Officers 0 Yes APRIL TIME RESIDENTIAL CARE HOME, LLC 0 0 0 0 0 0 0 0 0 0 Name and Address of Lessor Name of Facility

Is a Mileage Log Book Maintained for All Leased Vehicles?

Total ***

% 0

O Yes

^{*} 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.

General Information and Questionnaire Accounting Basis

Name of Facility	License No.	Report for Year Ended		Page	of
APRIL TIME RESIDENTIAL CAI		09/30/15		7	37
The records of this facility for the p	period covered by this report	were maintained on the following basis:			
	Modified Cash				
Is the accounting basis for this		7.7.4			· · · · ·
	Yes	If "No," explain.			
previous period? O	No				
Independent Accounting Firm	700		***	· · · · · · · · · · · · · · · · · · ·	P
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)			
1 Daniele & Associates, LLC		66 Cedar St., Newington, CT. 06111			
2		oo coda sti, rowington, c1, borri			
3					
4					
Services Provided by This Firm (de.	scribe fully)		'		***************************************
1 Cost Report Tax Return, IRS,DRS &	DSS Representation		\$	14,705	
2			\$		
3			\$		
4			\$		
			Charge for	Services Pro	ovided
			\$	14,705	
Are These Charges Reflected in the Expend	liture Portion of This Report? If Y	es, Specify Expense Classification and Line No.			
	15/1D				
Legal Services Information	· · · · · · · · · · · · · · · · · · ·				
Name of Legal Firm or Independent	Attorney		Telephone	Number	
1 NA					
2 3					
4					
5					
Address (No. & Street, City, State, Z	Zin Code \		···		
1					
2					
3					
4					
5					
Services Provided by This Firm (des	scribe fully)				
1		-	\$		
2	· · · · · · · · · · · · · · · · · · ·		\$		
3	The state of the s		\$		
4		Market and the second s	\$		
5			\$		
		10	Charge for	Services Pro	vided
			\$		
	iture Portion of This Report? If Your 15/1E	es, Specify Expense Classification and Line No.			
⊙ Yes O No	13/115				

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Schedule of Resident Statistics

Name of Facility APRIL TIME RESIDENTIAL CARE HOME, LLC			License No.	No. 1885		-	Report fo 09/30/15	Report for Year Ended 09/30/15	-6		Page 8	of 37
						Period 10/1 Thru 6/30	1 Thru 6/	30		Period 7/1 Thru 9/30	Thru 9/3	0
	Total All	Total	Total	Total								
	Levels	Level	Level	Care Home	Total	CCNH	RHNS	Residential Care Home	Total	HNOU	PHAIS	Residential
1. Certified Bed Capacity										17.155	CV TY N	Care inome
A. On last day of PREVIOUS report period	34			34	34			34				
B. On last day of THIS report period	34			34					24			
2. Number of Residents									†			4
A. As of midnight of PREVIOUS report period	33			33	33			33	•			-
B. As of midnight of THIS report period	32			32					23			
3. Total Number of Days Care Provided During Period									75			32
A. Medicare									.,	•	•	
B. Medicaid (Conn.)												
C. Medicaid (other states)												
D. Private Pay	1,925			1,925	1.465			1 465	460			777
E. State SSI for RCH	9,953			9.953	7.376			7.376	E C			004
F. Other (Specify)								2	1			1/6,4
G. Total Care Days During Period (3A thru F)	11,878			11.878	8 841			8 8/11	2.027			1000
								10,0	/50,5			150.5
4. 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)	11,878			11,878	8,841			8,841	3,037			3 037

Schedule of Resident Statistics (Cont'd)

Name of Fac	ility			Licer	ise No.		-		Repor	t for Year	Ended		Page	of
APRIL TIM	E RESID	ENTIA	L CARE HOME		1885					09/30/15	i		9	37
1			in the certified t		pacity du	ring t	he repo	ort yea	r?	0	Yes	0	No	
11 11 11	, provid		f Change	1011,	Cl	nange	in Bed	s		Car	nacity Aft	er Change	<u>T</u>	
'	ļ	1 1000	Residential			инье	500			Ca	pacity 711	Change	1	
Date of	CCNH	RHNS	Care Home	<u> </u>	Lost			Gaine	d					
Change	1											Residential		
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Care Home	Reason i	or Change
	 							ļ						
				H						1			ļ	
Z 10.1								·				·	<u> </u>	
			in certified bed			the re	eport y	ear (as	repor	ted in item	1 4 above)	provide the nur	nber of	
RESID	ENT DA	YS for	90 days following	ig the	change.							·	T	
			G! 1 5											
1 st ob a			Change in Re	esiden	t Days					CC	NH	RHNS	Residentia	Care Home
1st char 2nd cha									.					
3rd cha														
4th cha										<u> </u>				
6. Number	of Resid	lents and	d Rates on Septe	mber			ar			1				
		ļ	Medicare		Medi	caid		·		Se	lf-Pay		Other Sta	te Assisted
								1				Residential		
λI C1	Item		CCNH	С	CNH	RI	INS	CC	NH	RH	INS	Care Home	R.C.H.	ICF-MR
Per Die	Residents			3 3 X X 20		vermen	ii	engyeia	282490	BOOK BURNING	SAPUAROS SARE	5	27	
a. One				N. C. S.	1720/250	建納牌		44000	3431247			T. Transaction of the Contract		
	bed rms.											90,00	71,00	
c. Thre	e or more	,										80,00	71,00	
bed	rms.													
		•												
														Residential
			l Therapy Treat	ments						TO	ΓAL	CCNH	RHNS	Care Home
	Medica		usive of Part B)			· · · ·			-	A POLICE DE LA COMPANIA DE LA COMPA	XXXXXXXXX	Yazara kata kata		
ь			Treatments											
			Freatments						-					
C	Other								•					
			Therapy Treatn											
			Therapy Treatm	ents					,		n each			
	Medica								<u>.</u>	Market Service	Village and the second	Value because the overselve providence A		
В			usive of Part B) Treatments											
····			Freatments											
C	Other	oraci vo	Treatments											
		veech T	herapy Treatme	nts										
9. Total N	umber of	Occupa	tional Therapy T		ents				•• •					
A.	Medica	re - Part	В											
, В.			usive of Part B)											
<u> </u>			Treatments	····			-		···					
	2. Rest	orative 1	reatments .											
		ccupatio	onal Therapy Ti	eatm	ente					<u>.</u>				
	Tour U	cenpun	mus incrupy II	cu(III)	-itto									

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Report of Ex		- Salati				
Name of Facility	License No.		Report for Yea	r Ended	Page	of
APRIL TIME RESIDENTIAL CARE HOME, LLC	1885		09/30/15		10	37
Are time records maintained by all individuals receiving co	mmanasti					
L	•		Yes		No	
	Ž.	,	Total Cost a	nd Hours		
					Residential	
Item	CCNH	Hours	RHNS	Hours	Care Home	Hours
A. Salaries and Wages*	The state of the s	100000		8 0 0		
Operators/Owners (Complete also Sec. I			100			
of Schedule A1)	Management (1/2/2/2)	E GRANGISTICS CHONOCONO.	STATE OF STREET OF STREET	THE RESERVE THE PROPERTY OF	24,868	1,059
2. Administrator(s) (Complete also Sec. III	1000	10 mg 100 mg	134 PM 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	P. S. P. S. P. S. P.		
of Schedule A1)				A STATE OF THE PARTY OF THE PAR	61,370	2,175
3. Assistant Administrator (Complete also Sec. IV		0.000				2,11
of Schedule A1)		4 servenesse na productio	A STATE OF THE STA		77.5.4.6.6.4.6.6.6.6.6.6.6.6.6.6.6.6.6.6.6	
4. Other Administrative Salaries (telephone	-			100 mg		100000000000000000000000000000000000000
operator, clerks, receptionists, etc.)		CONTROL CONTROL CONTROL			13,076	1,020
5. Dietary Service	CONTROL OF THE PROPERTY OF THE				15,070	1,020
a. Head Dietitian	VERTERAL MENTAL PROPERTY AND PARTY A	TEACHERSIA SANISAN		DISTRIBUTE DE L'ANDRE		
b. Food Service Supervisor	<u> </u>	<u> </u>	1			
c. Dietary Workers	1			 	36,727	3,390
Housekeeping Service		Particular States	end to the			
a. Head Housekeeper	110000000000000000000000000000000000000	***************************************	THE THE PARTY OF T	INSTITUTE STATES STATES OF THE	100000000000000000000000000000000000000	
b. Other Housekeeping Workers			~~~		38,990	3,763
7. Repairs & Maintenance Services	1.75 67 65	10.70	Sugar Baran			
a. Engineer or Chief of Maintenance			The state of the s		COLD INCOME THE STREET, SALL	AND THE PROPERTY OF THE PARTY O
b. Other Maintenance Workers					32,317	2,064
8. Laundry Service	A Part of the	FEBRUARY				
a. Supervisor						
b. Other Laundry Workers	ļ				27,916	2,229
9. Barber and Beautician Services	ļ					
10. Protective Services	Service Constitution (Service)	servalekorun Jankako	Charles I and Labour 2007 annual area	HORSE (MARK) AT REAL PROPERTY.		
11. Accounting Services	Maria Lina de la Compania del Compania de la Compania del Compania de la Compania				ere karan	
a. Head Accountant b. Other Accountants						
12. Professional Care of Residents	Bearing and August	167.05% N.C.2 (10.074)		AND THE PERSON NAMED IN	CONTRACTOR OF THE PARTY OF THE	TOTAL CONTRACTOR MAN
1						
a. Directors and Assistant Director of Nurses	\$2000.000000000000000000000000000000000	Fill (selection) (selection)		CONTRACTOR OF CONTRACTOR		
b. RN						
1. Direct Care 2. Administrative**		ļ				
c. LPN	Barrana Casanana		10050011515002110001101100	Market Side (market)	TO COLUMN TO PRODUCE AND	De la constanta
1. Direct Care						
2. Administrative**						
d. Aides and Attendants	 				114 021	0.031
e. Physical Therapists					114,031	9,031
f. Speech Therapists	 					
g. Occupational Therapists	1					
h. Recreation Workers		-			12,824	997
i. Physicians		a leaster.	MARKET BEEF			991
Medical Director	- THE REAL PROPERTY OF THE	THE PROPERTY OF THE PROPERTY OF THE PARTY OF	TO THE PROPERTY OF THE PARTY OF	CONTRACTOR OF THE STATE OF THE		
Utilization Review						
3. Resident Care***						
4. Other (Specify)				Y 17 17 18 18 18 18 18 18 18 18 18 18 18 18 18		
						-ar-arearanto-pententill
j. Dentists						
k. Pharmacists						
I. Podiatrists						
m. Social Workers/Case Management						
n. Marketing		771				
o. Other (Specify)						
See Attached Schedule						
A-13. Total Salary Expenditures	<u> </u>				362,119	25,728

^{*} 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)

	_	CC	NH	F	HNS	Residential	Care Home
Position		\$	Hours	\$	Hours	S	Hours
					`		
		V					
						<u> </u>	<u> </u>
						<u> </u>	
		 -					-
		· ·				ļ	
	··-					· :	
	<u></u>				· ·		
					1 1		
	:						
Cotal		5 -	-	\$ -		\$ -	

Schedule of Other Fees (Page 13)

	cc	NH	RI	HNS	Residential	Care Home
Service	\$	Hours	S	Hours	\$	Hours
				· · · · · · · · · · · · · · · · · · ·		
						-
			1: 1			
	1.					

			5.	14.4		
						
•				 		
			··			<u> </u>
	-				200	
Total	\$ -		\$		\$ -	

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

Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties*

			Assistan	t Administra	Assistant Administrators and Other Related Parties*	. Kelate	d Parties	*		
Name of Facility				License No.		Report for	Report for Year Ended		Page	Jo
APRIL TIME RESIDENTIAL CARE HOME, LLC	JRE HOM	E, LLC		1885		21/05/60			11	37
		Salary Paid	id					The state of the s		
Name	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
Section I - Operators/Owners										
Kuldip Bhogal			Per 24,868 ins	Pension & Group General Office & ins	General Office & Facility	1,059	A1	High Chase	2,170	61,370
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*

		7	ASSISTAIL	t Administra	Assistant Administrators and Other Related Parties*	Kelated	Parties*			
Name of Facility (as licensed)				License No.		Report for Year Ended	sar Ended		Page	of
APRIL TIME RESIDENTIAL CARE HOME, LLC	RE HOM	E, LLC		1885		51/08/60			12	37
		Salary Paid	id							
Name	CCNH	RHINS	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	Total Hours	Compensation
Section III - Administrators***							ò	area Cardina vano	TO WOOD	TYPE I A
Jaswinder Bhogal			Pen 61,370 ins	Pension & Group ins	Administrator	2,175 A2		High Chase	1,038	24.868
Section IV - Assistant Administrators										
			. `							

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

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

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

Annual Report of Long-Term Care Facility

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B. Report of Expenditures - Professional Fees

Mamo of Facility		CS - 1 1 O			I 5	C
Name of Facility	License No.	0.5	Report for Y	ear Ended	Page	of
APRIL TIME RESIDENTIAL CARE HOME, LLC	18	85	09/30/15		13	37
	- Syr	T	Total Cost	and Hours	·	1
T.	COM		DIRIG		Residential	
Item	CCNH	Hours	RHNS	Hours	Care Home	Hours
*B. Direct care consultants paid on a fee						
for service basis in lieu of salary			10 m (201	0.00		
(For all such services complete Schedule B1)	-					
1. Dietitian	ļ <u></u>					
2. Dentist	ļ					
3. Pharmacist						
4. Podiatrist			ON SAME OF THE SAM	MATTAGA SAMBAN MASAMATAN MERAN	STEEL PEREITS STRUCTURE	Seni de su de sus compressos de compressos de su compresso de su compres
5. Physical Therapy						
a. Resident Care	 					
b. Other						
6. Social Worker						
7. Recreation Worker		SOMEON DE CONTRA	Managada an ang ang ang ang ang ang ang ang ang	LY Mark VA Vinta Amerikan Amerika	u saboli saa sulkaskus saas	mysteric or the social planetum
8. Physicians						
a. Medical Director (entire facility)	MATCHEMENT AND BETTER WEEKS	#UP-Strayer en consentence son	TOO BY BUILD CONTRACTOR OF THE	ACCIONAL (CONTINUE DE ACCIONAL DE CONTINUE DE CONTINUE DE CONTINUE DE CONTINUE DE CONTINUE DE CONTINUE DE CONTI		
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**	Manual Company of the	C. C				
d. Administrative Services facility						
Infection Control Committee (Quarterly meetings)						
2 Pharmaceutical Committee						
(Quarterly meetings)						
 Staff Development Committee 						
(Once annually)						
e. Other (Specify)						
9. Speech Therapist	100					
a. Resident Care	Passin is some process which	OAGREGA ESCORATA				
b. Other						
10. Occupational Therapist			K COLUMN			
a. Resident Care	PROPERTY AND	AND THE PERSON NAMED IN COLUMN	enter de la companya	er in the second second second		
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	NEWTONIA ZORDA GARAGO	s and the second se	roundessalidation (EXIII)	AND PARTY OF THE P		
2. Administrative***						
b. LPN						
1. Direct Care	ELIMONE ESTABLISME			WANTE METALOGICA		MALINE MARKET
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)		77-25-1-27-2-1-1-17		LCAUS (AS CENT).		
See Attached Schedule			Telle Men (
B-13 Total Fees Paid in Lieu of Salaries						
* Do not include in this section management consultants or services which	must be reported or	n Page 16 item M	12 and supported by	. no quine d'in Er	D16	

^{*} 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.

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

e of Facility RIL TIME RESIDENTIAL CARE HO	ME, LLC	License No. 1885		Report for Yes 09/30/15	ar Ended	Page 14	of 37
Name & Address of Individual	Full Exp	planation of Service	Related** Operator Yes	to Owners, rs, Officers	Expla	nation of Re	lationship
and the second s			0	0		<u></u>	
			0	0	***		
			0	0			
		, , , , , , , , , , , , , , , , , , , ,	0	0			
			0	0			
			0	0			
			0	0			
			0	0		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
			0	0		77-78-1	
			0	0			10000
			0	0			
			0	0			
			0	0	,		, -
			0	0			
			0	0			
			0	0		***	
			0	0			
			0	0			
			0	0			
			0	0			
			0	0			
			0	0			

^{*} Use additional sheets if necessary.

^{**} Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Y	ear Ended	Page	of
APRIL TIME RESIDENTIAL CARE HOME, L	1885	09/30/15	om Emuou	15	37
, ,	1000			1 13] <u> </u>
				•	Residential
Item		Total	CCNH	RHNS	Care Home
1. Administrative and General				10.11	
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	S	20,096			20,096
2. Disability Insurance	(B			20,000
3. Unemployment Insurance		10,089			10,089
4. Social Security (F.I.C.A.)	S	27,605			27,605
5. Health Insurance	9	73,516			73,516
6. Life Insurance (employees only)			12000		E de Campana
(not-owners and not-operators)		S		TOWNS TO SHARE STORY	THE PERSON NAMED IN COLUMN TWO
7. Pensions (Non-Discriminatory)	4	13,739			13,739
(not-owners and not-operators)					
8. Uniform Allowance					200000000000000000000000000000000000000
9. Other (Specify)	\$	S			
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and	\$	3			The state of the s
Profit Sharing Plans for Owners and					
Operators (Discriminatory)*					
c. Bad Debts*	\$				
d. Accounting and Auditing	\$	14,705			14,705
e. Legal (Services should be fully described of		·			
f. Insurance on Lives of Owners and	\$	Payar Saltawaran (sa Kila			
Operators (Specify)*					
g. Office Supplies	\$	1,650			1,650
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$				1,685
2. Cellular Phones	\$	2,486			2,486
i. Appraisal (Specify purpose and	\$	Spocked United States and Spocked United States	TOPES ASSOCIATION WITH THE PROPERTY OF THE PRO		
attach copy)*					
: Compliant To the state of the					
j. Corporation Business Taxes (franchise tax		250	604110		250
k. Other Taxes (Not related to property - See	_ ,				
1. Income*	\$	5,393			5,393
2. Other (Specify)	\$	ments in the process of the	Parametric Property and Company	III Iraa waxaa ka k	
See Attached Schedule					
3. Resident Day User Fee Subtotal	\$				
* Pagility should gelf disallow the annual D. CO. Co.	\$	171,214			171,214

^{*} Facility should self-disallow the expense on Page 28 of the Cost Report.

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

APRIL TIME RESIDENTIAL CARE HOME, LLC 09/30/15

Attachment Page 15

Schedule of Other Employee Benefits

Description	C	CNH	RHNS	Residential Care Home
			·	
			2	
			5	
otal	\$	- \$	-	\$ -

Schedule of Other Taxes

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

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

Name of Facility	License No.		Report for	Year Ended	Page	of
APRIL TIME RESIDENTIAL CARE HOME, LLC	1885		09/30/15		16	37
			-			Residential
Item			Total	CCNH	RHNS	Care Home
	ls Brought Forwa	ırd:	171,214			171,214
1. Travel and Entertainment						
Resident Travel and Entertainment		\$				
2. Holiday Parties for Staff		\$				
3. Gifts to Staff and Residents		\$				
4. Employee Travel		\$	397			397
5. Education Expenses Related to Seminars ar		\$				
6. Automobile Expense (not purchase or depr	eciation)	\$	1,294			1,294
7. Other (Specify)		\$		***************************************		
See Attached Schedule						
m. Other Administrative and General Expenses						
1. Advertising Help Wanted (all such expense	 	\$				
2. Advertising Telephone Directory (all such	expenses)***	\$				
3. Advertising Other (Specify)***		\$				
See Attached Schedule						
4. Fund-Raising***		\$				
5. Medical Records		\$				
6. Barber and Beauty Supplies (if this service	is supplied	\$				
directly and not by contract or fee for service	ce)***					
7. Postage		\$	197		·	197
* 8. Dues and Membership Fees to Professional		\$	235			235
Associations (Specify)						
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other Non-A	.llowable Org.***	\$				
9. Subscriptions		\$				
10. Contributions***		\$	75			75
See Attached Schedule						
11. Services Provided by Contract (Specify and	Complete	\$				
Schedule C-2, Page 21 for each firm or ind	ividual)					
12. Administrative Management Services**		\$				
13. Other (Specify)		\$	4,039			4,039
See Attached Schedule						
C-14 Total Administrative & General Expenditures		\$	177,451			177,451

^{*} 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	cc	NH	R	HNS	Resid Care	
					1	
			1			
					1	
					1	
			 		1	
			1		 	
			 	••••		
Total Other Travel and Entertainment	\$		\$		\$	<u>-</u>

Schedule of Other Advertising

Description	c	RH	ls.	Residential Care Home		
Total Other Advertising	\$	-	\$		\$	

Schedule of Dues

Description	CCNH	RHNS	Care	e Home			
CARCH		}	\$	75			
BJ's Wholesale			\$	50			
Costco			\$	110			
	·						
Total Dues	\$ -	\$ -	\$	235			

Schedule of Contributions

Description	CCNH R	HNS	 dential Home
PPSNE			\$ 25
Manchester Police			\$ 50
Total Contributions	\$ - \$		\$ 75

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home		
Staff Education program reimbursement			\$	(3,712)	
Payroll Processing			\$	2,799	
Pension Admin			\$	3,683	
Licenses			\$	120	
Rent - Parking			s	1,149	
			<u> </u>		
		ļ	ļ		
Total Other Administrative and General	\$ -	\$ -	s	4,039	

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
APRIL TIME RESIDENTIAL CARE HO	1885	09/30/15	17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
N/A			

^{*} 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

		1			n Page 5)				
	ne of Facility		Lice	nse	e No.	Report for Y	Page	of	
AP	RIL TIME RESIDENTIAL CARE HOME, LI	C	<u> </u>		1885	09/30/1:	5	18	37
		-						Residen	tial Care
	Item				Total	CCNH	RHNS	Но	me
2.	Dietary				1.0				
	a. In-House Preparation & Service								
	1. Raw Food			_\$					54,350
<u> </u>	2. Non-Food Supplies			\$	3,043				3,043
	3. Other (Specify)		_	\$	1. Order 2001 of State of Stat	D. MATERICA STRUMENTON WALLAND IN	is i atherity to the same constraint type and the		
-	h Durchard Court (1								
	b. Purchased Services (by contract other			\$	Green and Anna Company	. Michael and Company	o opical organizacioù potembrou suma senva	d seessa veriores arressos	SID SAGOT OF PROVIDENCE AS INC.
	than through Management Services)								
	(Complete Schedule C-2 att. Page 21) c. Management Services**								
-	d. Other (Specify)			\$		ļ		ļ	
	u. Other (specify)		-	\$	THE COUNTY WAS TRACK	7/24/2012/00/2012/00/2012	WATER WELFT WATER	EDMINITER SHOWS	Makorkos eness
2E.	Total Dietary Expenditures (2a + b + c + d)			\$	67.202				
	· · · · · · · · · · · · · · · · · · ·		<u> </u>	Ф	57,393				57,393
ap.	Di tamana di di							Resident	ial Care
	Dietary Questionnaire				Total	CCNH	RHNS	Hor	ne
G.	Resident Meals: Total no. of meals served pe	r da	y:*		99				99
H.	Is cost of employee meals included in 2E?	0	Yes		•	No			
I.	Did you receive revenue from employees?	0	Yes		•	No	If yes, specify amt.		
J.	Where is the revenue received reported in the	Co	st Rep	ort	? (Page/Line)	Item)	alit.		
	Is cost of meals provided to persons other		······································						
K.	than employees or residents (i.e., Board	0	Yes		•	No	If yes, specify		
	Members, Guests) included in 2E?					_,_	cost.		
L.		_					If yes, specify		
L/.	Is any revenue collected from these people?	O	Yes		•	No	amt.		
M.	Where is the revenue received reported in the	Co	st Ren	ort	? (Page/Line)	(tem)			
	Is cost of food (other than meals, e.g.,		р		(- 1.80/1.110)				
λī	snacks at monthly staff meetings, board	_			_		If yes, specify		
N.	meetings) provided to employees included	О	Yes		•	No	cost.		
	in 2E?						vogt,		
^	To						If yes, specify		
O.	Is any revenue collected from employees?	O	Yes		•	No	amt.		:
P.	Where is the revenue received reported in the	Cor	of Dan	ort'	Dogo/fine Y	tom)			
- •	There is the revenue received reported in the	CU	n web	on	(Lage/Line I	iem)			

^{*} 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)

	me of Facility	Licens		Report for	Year Ended	Page	of
Al	RIL TIME RESIDENTIAL CARE HOME, LLC		1885	09/30/1	5	19	37
	Item	"	Total	CCNH	RHNS	4	ntial Care ome
3.	Laundry a. In-House Processing*					1	
	1. Bed linens, cubicle curtains, draperies,	Lbs.					
	gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$					
	 Employee items including uniforms, gowns, etc. washed, ironed and/or 	Lbs.					
	processed.***	Amt. \$					
	3. Personal clothing of residents	Lbs.					
	washed, ironed, and/or processed.***	Amt. \$					
	4. Repair and/or purchase of linens.***	Lbs.					
		Amt. \$					
	b. Purchased Services (by contract other	\$	Management				
	than through Management Services)			()			
	(Complete Schedule C-2 att. Page 21)						
	c. Management Services**	\$				THE STATE OF THE S	en romania en
	d. Other (Specify)	\$	964				964
	Supplies						
3E.	Total Laundry Expenditures $(3a+b+c+d)$	\$	964				964
3F.	Laundry Questionnaire						70-
G.	Is cost of employee laundry included in 3E? O	Yes	•	No	If yes, specify cost.		
Η.	Did you receive revenue from employees?	Yes	•	No	If yes, specify amt.		
· · · · · · · · · · · · · · · · · · ·	Where is the revenue received reported in the Cost	Report?		(Page/Line			
١.	Is Cost of laundry provided to persons other	Yes		No	If yes, specify cost.		
ζ.	Did you receive revenue from these people? O	Yes	•	No	If yes, specify amt.	<u> </u>	
J.	Where is the revenue received reported in the Cost	Report?		(Page/Line			

^{*} 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.

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

	ne of Facility	License No.	Rep	ort for Year E	Ended	Page	of
APR	IL TIME RESIDENTIAL CARE HOME,	1885		09/30/15		20	37
	Item			Total	CCNH	RHNS	Residential Care Home
4.	Housekeeping	Sq. Ft. Serviced					
	a. In-House Care	by Personnel					
	1. Supplies - Cleaning (Mops,	Amt.	\$	9,846			9,846
	pails, brooms, etc.)						
	b. Purchased Services (by contract other	Sq. Ft. Serviced					
	than through Management Services)	by Personnel					
	(Complete Schedule C-2 att.	Amt.	\$				
	Page 21)						
	c. Management Services*		\$				
	d. Other (Specify)		\$	danas sallis kontranti sistem teknin	tions constitutive and marrow markets a	UNICODE A PRESE CONTRACTOR OF THE PROPERTY	
4E.	Total Housekeeping Expenditures (4a +	b+c+d)	\$	9,846			9,846
5.	Resident Care (Supplies)**					the state of	are all and the first
	a. Prescription Drugs***						
	1. Own Pharmacy		\$				
	2. Purchased from		\$	SOCIAL VIOLET CONTROL CONTROL VIOLENCE	sicki oblikarovni stanarenim more.	GANGASANA (USANGPANAHANDAY M	Chia na mantala manana di uni transco
	b. Medicine Cabinet Drugs		\$				
	c. Medical and Therapeutic Supplies		\$				
	d. Ambulance/Limousine***		\$				
	e. Oxygen						
	1. For Emergency Use		\$:			
	2. Other***		\$				
	f. X-rays and Related Radiological		\$	Paris armining a 22 and	THE DESCRIPTION OF THE PERSON		SOUTH POST TO SERVE AND
	Procedures***						
	g. Dental (Not dentists who should be inc	luded under	\$	isiaoderaksaksiksiinaaksek	wokesto de pro-	DE MOTA CIRCO CONTINUE DE	<i>Vertaninan</i> elioniator
	salaries or fees)	,	\$				
h. Laboratory***				:			
	i. Recreation		\$	1,370			1,370
	j. Other (Specify)****		\$	**************************************			ATTENDED TO THE THE OWNER.
#T 5	See Attached Schedule	1					
5K.	Total Resident Care Expenditures (5a - 5	J)	\$	1,370			1,370

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	Residential Care Home
·	CCIVII	Kiiris	Care Home
			·
			.".
·			
Total Other Resident Care	<u> </u>		d's .
Total Other Resident Care	\$ -	\$ -	\$ -

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

of 37		Line			[
Page 21		Pg											-			
	Total Cost/Page Ref.***	Residential Care Home														
	Total Cost	RHINS														
ġ		CCNH														
Report for Year Ended 09/30/15		Full Explanation of Service Provided*														
License No. 1885		Explanation of Relationship														
	o Owners, Officers	oN o	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Related ** to Owners, Operators, Officers	Yes	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CARE HOME, LLC		Address				1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1										
Name of Facility APRIL TIME RESIDENTIAL CARE HOME, LLC		Name of Individual or Company														

^{*} 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 Y	ear Ended		Page of
APRIL TIME RESIDENTIAL CARE HOME 1885		09/30/15			22 37
_					Residential Care
Item		Total	CCNH	RHNS	Home
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$	19,029			19,029
b. Heat	\$	11,632			11,632
c. Light & Power	\$	14,154			14,154
d. Water	\$	8,544			8,544
e. Equipment Lease (Provide detail on page 6)	\$				
f. Other (itemize)	\$				
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)	\$	53,359			53,359
7. Depreciation (complete schedule page 23*)					
a. Land Improvements	\$	1,830			1,830
b. Building & Building Improvements	\$				
c. Non-Movable Equipment	\$	18,250			18,250
d. Movable Equipment	\$	8,874	·		8,874
*7e. Total Depreciation Costs (7a + b + c + d)	\$	28,954			28,954
8. Amortization (Complete att. Schedule Page 24*)					
a. Organization Expense	\$	5,667			5,667
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$	4,615			4,615
d. Other (Specify)	\$,
*8e. Total Amortization Costs (8a + b + c + d)	\$	10,282			10,282
9. Rental payments on leased real property less					
real estate taxes included in item 10b	\$	91,000			91,000
10. Property Taxes					, , , , , , , , , , , , , , , , , , , ,
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$	18,856	-,,,		18,856
c. Personal property taxes	\$	5,094		····	5,094
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	154,186			154,186

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

Schedule of Other Repairs and Maintenance

Description		CCNH	RHNS	Residential Care Home
			* .	
				·
Total Other Repairs and Maintenance	.:	\$ -	\$ -	\$ -

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

Depreciation Schedule

NT)			,			
Name of Facility	;		License No.	e No.			Report for Year Ended	Suded		Page	Jo
AFKUL LIME KESIDENTIAL CAKE HOME, LLC	IE, LLC			1885			09/30/15			23	37
			Hist	Historical			Accumulated				
			చ —	Cost	Less		Depreciation to	Method of			
1			Exclu	Exclusive of	Salvage	Cost to Be	Beginning of	Computing	Useful	Depreciation	
Property Item			La	Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
A. Land Improvements											
 Acquired prior to this report period 				9,150		9,150	534	SL	52	1.830	
2. Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)	ch schedule)	-									
A-4. Subtotal											1.830
B. Building and Building Improvements											O COCY
1. Acquired prior to this report period										(CAP Pacy	
2. Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)	ch schedule)										
B-4. Subtotal											
C. Non-Movable Equipment		-				The same of the sa	į.				
 Acquired prior to this report period 				129.869		129 869	84 476	15	5.7.75	18 250	
2. Disposals (attach schedule)						200	21.6		316	16,20	
3. Acquired during this report period (attach schedule)	ch schedule)		-								
C-4. Subtotal				No.							10.250
	Is a mileage										000,01
	logbook	Date of	王	rical	,		Accumulated				_
	ואומוווומווובחי	Acquismon	T		Less	•	Depreciation to	Method of		•	
	Yes	Month	Year Exclusive	Jo s	Salvage Value	Cost to Be	Beginning of	Computing	Useful I :fa	Depreciation	T
D. Movable Equipment		10000					Total S of bendungs	Tompicordon	2117	IOI LIIIS LEGI	LUCAIS
1. Motor Vehicles (Specify name, model											
and year of each vehicle)											
•	×	12 201	2	40,901		40.901	14315	15	5	8 181	
ъ,						20.60		22	,	10,10	
c.				-							
ф.											
2. Movable Equipment											
a. Acquired prior to this report period			13	130,965		130,965	128,655		5-7 VT	693	
b. Disposals (attach schedule)											
c. Acquired during this report period											
(attach schedule)									National Section 1		
D-3. Subtotal											8,874
E. Total Depreciation											28.954
							ATTACAMENT AND	A CONTRACTOR OF THE PROPERTY O	The second secon	AND CONTRACTOR OF THE PROPERTY	

Schedule of Land Improvements Acquired during this report period

A annifolding Date		_	Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
				1
Total additions for Land Improvem-	ou to			
	E1118	\$		\$ -
Deletions:				
			Ī	
İ				
			•	
Cotal deletions for To-d Y				
Cotal deletions for Land Improveme	nts	\$.]	\$ -

^{*}Ties to Page 23, Line A3

Schedule of Building Improvements Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				1
			· · · · · · · · · · · · · · · · · · ·	
		<u> </u>		
Total additions for Building Imp	rovements	\$ -		\$ -
Ocletions:			·-·	
			*.	
				ļ
· · · · · · · · · · · · · · · · · · ·				ļ
	<u> </u>			
Cotal deletions for Building Imp	ovements	\$ -		\$ -

^{*}Ties to Page 23, Line B3

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:			17.1.00	
				1
				1
Total additions for Non-Movab	le Equipment	\$ -		\$ -
Deletions:				

				1
Total deletions for Non-Moyabl	e Equipment	\$ -		\$ -

^{*}Ties to Page 23, Line C3

^{**}Ties to Page 23, Line A2

^{**}Ties to Page 23, Line B2

^{**}Ties to Page 23, Line C2

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
		·		
Fotal additions for Movable Equip	nent	\$ -		\$ -
Deletions:				
Total deletions for Movable Equipa	nent	\$ -		\$ -

Schedule of Leasehold Improvements Acquired during this report period

		Uscful	
Description of Item	Cost	Life	Depreciation
		I	1
	711111111111111111111111111111111111111	1	
			
		-	
provement	[\$ -		\$ -
			-1.1.1
			1.
		<u></u>	
provement	\$		\$
	Description of Item provement provement	aprovement \$ -	provement \$ -

^{*}Ties to Page 24, Line C3

^{**}Ties to Page 24, Line C2

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

Amortization Schedule*

Name of Facility		License No.		Report for Year Ended	r Ended		Page	of
APRIL TIME RESIDENTIAL CARE HOME, LLC	E, LLC	18	1885	09/30/15			24	37
				Accumulated				
	Date of			Amort. to				
	Acquisition			Beginning of	Basis for			
		Length of	Cost to Be	Year's	Computing	Rate 4	Amortization	
Item	Month Year	r Amortization	Amortized	Operations	Amortization**	¥ %	for This Year	Totals
A. Organization Expense						_	11999	
1. Organization Expense	10 2007	7 5	2,133	2,133 SL	SL	20		
2. Goodwill	10 2007	7 15	85,000	39,666 ST	SL	9	5.667	
3.							2000	
A-4. Subtotal								5 667
B. Mortgage Expense				The state of the s				2,001
1.								
2.								
3.								
B-4. Subtotal								
C. Leasehold Improvements and Other								
1. Acquired prior to this report period			90,227	24,637 SI		Varion	4.615	
2. Disposals (attach schedule)			,					
3. Acquired during this report period								
(attach schedule)								
C-4. Subtotal						4		4,615
D. Total Amortization								10 282
	and the second s	Actual and the second and second	a Parameter (1995) year and a second control of the second control	The second secon	PARTICIPATION OF THE PROPERTY OF THE PARTICIPATION	100 march 200 ma		1024601

* 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 E	nded		Page of
APRIL TIME RESIDENTIAL CARE	1885	09/30/15			25 37
11. Property Questionnaire					
Part A		*****			
Is the property either owned by the	ne Facility				If "Yes," complete Part B.
or leased from a Related Party?*	•) Yes	0	No	If "No," complete Part B. If "No," complete Part C.
*If any owner or operator of this fa	cility is related by family,	marriage, ownership, ab	ility to control or		II Ivo, complete t are c.
business association to any person	or organization from whor	n buildings are leased, th	hen it is considered	ı	
a related party transaction.			Language Control of the Control of t		
Description	-	Total			
Date Land Purchased Date Structure Completed		_			
Date Structure Completed If NOT Original Owner, Date	of Durchage	10/05/05			
4. Date of Initial Licensure	OI Purchase	10/05/07			
5. Total Licensed Bed Capacity		10/05/07			
6. Square Footage		34			
7. Acquisition Cost					
a. Land		NOT THE OUT TO PERSON AND ADDRESS OF			
b. Building		**			
Part B - Owner and Related Pa	rties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing			A P. Coll McCord Proc. (Different St.) Materials Street Proceed Proceed Proc.	Jid Wortgage	THE PARTY OF THE P
a. Type of Financing (e.g., fi	xed, variable)	CHECKEL COMMENTS OF STREET			
b. Date Mortgage Obtained				-	
c. Interest Rate for the Cost					
d. Term of Mortgage (number					
e. Amount of Principal Borro					
f. Principal balance outstand					
Complete if Mortgage was F					
During Current Cost Yes					
g. Type of Financing (e.g., fi	xed, variable)				
h. Date of Refinancing i. New Interest Rate			<u> </u>	ļ	
j. Term of Mortgage (numbe	f				
k. Amount of Principal Borro		 	 		
I. Principal Outstanding on N					
Part C - Arms-Length Lease		Improvements Only		<u> </u>	
Name and Address of Lessor		perty Leased		Tarm of Lagge	Annual Amount of Lease
THE STATE OF THE PARTIES OF THE PARTIES		perty Leased	Date of Lase	Term of Tease	Annual Amount of Lease
				i	
			Ì		

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 Ye	ar Ended		Page of
APRIL TIME RESIDENTIAL CARE 1885		09/30/15			26 37
					Residential Care
Item		Total	CCNH	RHNS	Home
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment	9				
1. First Mortgage	\$				
Name of Lender	Rate				
Address of Lender	 				
2. Second Mortgage	, \$	ari nasarinakal malikasibili s	DATAMINAN MENTANDAN MENTANDAN	Names on Land Anna Valoria Advances	b Wandaya Wan reduser process Mars. For addition
Name of Lender	Rate				
Address of Lender	<u> </u>				
Address of Bender					
3. Third Mortgage	\$				
Name of Lender	Rate				
Address of Lender					a trait
A. Pourd, Mark					
4. Fourth Mortgage Name of Lender	Rate				
Name of Lenger	Rate				
Address of Lender	1				
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)	\$			orward to n	

(Carry Subtotals forward to next page)

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

Name of Facility License	No		Report for Y	ear Ended		Page of
· .	885		09/30/15	cai Effect		Page of 27 37
		······································	07/30/13			Residential
Item			Total	CCNH	RHNS	Care Home
	totals Brou	ight Forward:	10(41	CCIVII	KIINS	Care riome
12. C. Movable Equipment		Birriorian				
1. Automotive Equipment		\$	903			903
A. Item	Rate	Amount				703
2013 CADILLAC SRX6	3.89%	18,917				
Lender				Salary Salary		
Chase Auto Finance						100
Address of Lender						
PO Box 78068Phoenix, AZ 85060-8068						
2. Other (Specify)		\$		The second secon	ancarast a political participation	and sentitive representations are reserved.
A. Item	Rate	Amount				
Lender						
Address of Lender						
	,					
B. Item	Rate	Amount				
Y d						
Lender						
Address of Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Inte						
Expense (C1 + 2)	rest	ds.	002			225
12. D. Other Interest Expense (Specify)		<u>\$</u>	903			903
Working Capital		ð	2,041			2,041
Working Cupitur						200400
13. Total All Interest Expense (12B7 + 12	C3 + 12D	\$	2,944			2.044
14. Insurance	122)	Ψ,	4,777		· · · · · · · · · · · · · · · · · · ·	2,944
a. Insurance on Property (buildings of	nly)	\$	8,986			8,986
b. Insurance on Automobiles		\$	1,406			1,406
c. Insurance other than Property (as s	specified at		2,100			1,400
1. Umbrella (Blanket Coverage)	•	, , I				
2. Fire and Extended Coverage		\$ \$	6,978			6,978
3. Other (Specify)		\$				-,2,0
14d. Total Insurance Expenditures (14a +		\$	17,370			17,370
15. Total All Expenditures (A-13 thru C-1	(4)	\$	837,002			837,002

D. Adjustments to Statement of Expenditures

	e of Fa			Lie	cense No.	Report for Ye	ar Ended	Page	(of
APR	IL TIN	Æ RI	ESIDENTIAL CARE HOME, LLC		1885	09/30/15		28	3	7
					Total					
Item	Page				Amount of			Reside	ntial (Care
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	F	Iome	
Page	10 - 5	Salari	es and Wages	·						
1.			Outpatient Service Costs	\$						
2.			Salaries not related to Resident Care	\$						
3.			Occupational Therapy	\$					••	
4.			Other - See attached Schedule	\$						
Page	13 - 1	rofes	sional Fees							
5.			Resident Care Physicians **	\$						
6.			Occupational Therapy	\$						
7.			Other - See attached Schedule	\$						
Page	s 15 &	16 -	Administrative and General			1000	Selfger Heits			40
8.			Discriminatory Benefits	\$,					,
9.			Bad Debts	\$						
10.			Accounting & Legal	\$,	
11.			Telephone	\$			-			
12.	15	1h2	Cellular Telephone	\$	1,766				1,7	766
13.			Life insurance premiums on the life			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	i di garantan			
			of Owners, Partners, Operators	\$	AND THE PERSON WELL AND THE PERSON A	**************************************	SERVICE SERVIC	COMMUNICATION OF THE PARTY OF T	ACTIVISH IVAN	X DY II KO
14.			Gifts, flowers and coffee shops	\$	·					
15.			Education expenditures to colleges or		100				A STATE	
			universities for tuition and related costs							
			for owners and employees	\$		1244141616141414141414141414141414141414	Manufalan Manufa			iena e
16.			Travel for purposes of attending							
			conferences or seminars outside the				ALC: NO SECURITION			
			continental U.S. Other out-of-state							
			travel in excess of one representative	\$				essant home		
17.	see lin	23	Automobile Expense (e.g. personal use)	\$						
18.			Unallowable Advertising *	\$						
19.	15	k1	Income Tax / Corporate Business Tax	\$	5,393				5.3	393
20.	16		Fund Raising / Contributions	\$	75		-		,,,	75
21.			Unallowable Management Fees	\$						
22.			Barber and Beauty	\$						
23.			Other - See attached Schedule	\$	3,961			<u>.</u>	3,9	961
	18 - I)ietar	y Expenditures				HEAV WILLIAM		With Boom and Armed	
24.			Meals to employees, guests and others	-						
			who are not residents	\$						Me Me
Page	19 _ Y	aund	ry Expenditures	Ψ						
25.	-/-1		Laundry services to employees, guests							
40.			and others who are not residents	\$						
$p_{\alpha\alpha\rho}$	20 - F	Inusa	keeping Expenditures	Ψ					V (AM)	30
26.	20 - 1.	. UHSE.	Housekeeping services to employees, guests							
۷0,			and others who are not residents	\$						
			Subtotal (Items 1 - 26)	<u> </u>	11,195				11,1	05
· · · · · · · · · · · · · · · · · · ·			Buototal (Itelis 1 - 20)	ψ	<u> </u>	arry Subtotal fo			11,1	193

^{*} 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
					
			 	-	-
otal Othe	r Salaries 2	Adjustment	s -	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
	7.1			-	
•					
Total Othe	r Fees Adj	istments	 \$ -	\$ -	s -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
16	L6	Auto Expense			\$ 404
22	10c	Auto Taxes			\$ 204
22	14b	Auto Insurance			\$ 439
22	7d	Auto Depreciation			\$ 2,554
27	12¢1	Auto Interest			\$ 360
Total Othe	r A&G Ad	justments	\$	\$ -	\$ 3,961

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

Nom	e of Fa		D. Adjustments to Stateme					r <u></u>	
				Li	cense No.	Report for	Year Ended	Page	of
APR	IT 111V	AE KI	ESIDENTIAL CARE HOME, LLC		1885	09/30/15		29	37
Y4.	, i	T .			Total]			
	Page				Amount of				ntial Car
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	I	lome
	40 F		Subtotals Brought Forward	\$	11,195				11,195
	20 - K		nt Care Supplies***						
27.			Prescription Drugs	. \$					
28.			Ambulance/Limousine	\$					
29.			X-rays, etc	\$					
30.			Laboratory	\$		L			
31.			Medical Supplies	\$					
32.			Oxygen (non emergency)	\$					
33.			Occupational Therapy	\$					
34.			Other - See Attached Schedule	\$					
	22 - N	1ainte	nance and Property			1000			
35.		İ	Excess Movable Equipment Depreciation						
			See Attached Schedule	\$				4	
36.			Depreciation on Unallowable			Marie San Carlo		8 18 16	
			Motor Vehicles	\$	Less of conference on a property of the property of	to receive de reduce to the Name of	WITESON KING SANDERSON CO.	men Cratina and	onatora decorrera
37.			Unallowable Property and Real				7/12/11/14		
[Estate Taxes	\$	······································	G CONCANTRON	2012/19/19/09 18/02/19/19/19	Tari William San	
38.			Rental of Building Space or Rooms	\$					
39.			Other - See Attached Schedule	\$	5,667				5,667
Page	27 - II	nsura	nce						
40.			Mortgage Insurance	\$	te mention in the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con	120 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College March 1864 Million College M	1981 Value Brought Brought Brought	COMMENSATION OF THE PERSONS ASSESSMENTS	45. FEZIN 12 FEZ (1971)
41.			Property Insurance	\$					
Other	- Mis			-7				11.0	
42.			Research or Experimental Activities	\$	SATE OF THE RESIDENCE PROPERTY.	Transport Control Control	CELE A BASTON AND CHRONICATES		
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,	*		- W			
			enhancement or promotion of the			ip.			
ļ	l		providers interest	\$	er andre en en en en en en en en en en en en en	WALLEY OF STATE STATE			
48.			Interest Income on Accounts Rec	\$					
49.			Other (include personnel and other	Ť					
	1		costs unrelated to resident care) - See						
			Attached Schedule	\$					
Not F	or Pro		oviders Only	Ψ					C 45 0 5 1
50	T		Building/Non Movable Eq. Depreciation					e e e e e e e e e e e e e e e e e e e	
- 5'			Unallowable Building Interest -	i i					
1			See Attached Schedule	\$					
- 1									

^{***} 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.

Schedule of Other Ancillary Costs

Page Ref Line	Ref Description		CCNH	RHNS	Residential Care Home
				-	
		 - ""			
		 ·····	· ·		
otal Other Anci	llary Costs	 	\$ -	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description			C	CNH	R	HNS	Resider Care H	
		•		-						
							1			
			77772						-	

				***************************************						***********
Total Exce	ss Movable	Equipment Depreciation			\$		\$		\$	

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description		CCNH	RHNS	Residential Care Home
22	8a	Amortization				\$ 5,667
						
					·	
· ·					· · · · · · · · · · · · · · · · · · ·	
		9437 HF				
Total Othe	r Property	Adjustments		\$ -	\$ -	\$ 5,667

Page Ref	Line Ref	Description			 CCNH	RHNS	Reside Care H	
			 		 1.			
								- :
·					 			
				•				
Fotal Othe	r Adjustme	ents			\$ -	\$ -	\$	-

Schedule of Unallowable Building Interest

Page Ref Line Ref Description	CCNH	RHNS	Residential Care Home
		1	1
		· .	110
Total Unallowable Building Interest	\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility License No. APRIL TIME RESIDENTIAL CARE HC 1885		Report for Y 09/30/15		Page 30	of 37	
Item		Total	CCMU	DIDIC	l l	ntial Care
I. Resident Room, Board & Routine Care Revenue		1 Utal	CCNH	RHNS	17	ome
1. a. Medicaid Residents (CT only)	ø	(0) 000				
b. Medicaid Room and Board Contractual Allowance **	- \$	+	 	<u> </u>	<u> </u>	696,063
2. a. Medicaid (All other states)	\$				<u> </u>	
b. Other States Room and Board Contractual Allowance **	\$			<u> </u>	ļ	
3. a. Medicare Residents (all inclusive)	<u>\$</u>					
b. Medicare Room and Board Contractual Allowance **					-	
4. a. Private-Pay Residents and Other	\$	T				105.000
b. Private-Pay Room and Board Contractual Allowance **	\$					187,280
II. Other Resident Revenue	\$	2.1 CO 1 SPOT 1 VID 201	100000000000000000000000000000000000000	K. 200 C. 140		
· · · · · · · · · · · · · · · · · · ·	_					
1. a. Prescription Drugs - Medicare	\$			<u> </u>	<u> </u>	
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$	† ****				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$	 				
a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$					
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$					
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
Speech Therapy - Medicare	\$					
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$					
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$					
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$					
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				-	
6. a. Other (Specify) - Medicare	\$					
b. Other (Specify) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)	\$	883,343			~	883,343
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$	ADERCEASES PROPRIO DEL	PARAMETER PROGRAMMENT	THE PROPERTY OF THE PARTY OF TH	ucrastica con	
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
Rental of Television and Cable Services	\$					
5. Interest Income (Specify)	\$	8				8
6. Private Duty Nurses' Fees	\$	3		-		0
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (Specify)	\$					
V. Total Other Revenue (1 thru 8)	\$	8				o
						8
VI. Total All Revenue (III +V)	\$	883,351				883,351

^{*} 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	CC	CNH	RHN	S	Residenti Care Hor	ial me
						_
						_
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

Account

Page Ref	Ассоият	Balance	CCNH	RHNS	Residentia Care Hore	
31/A1	Cash - Savings	100,031			\$	8
			•			
Total Inte	rest Income		\$ -	\$ -	\$	-8

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
			1.	
				.21
Fotal Othe	r Revenue	\$ -	\$ -	\$ -

G. Balance Sheet

		f Facility	License No.	Report for Year Ended	Pag	
APKII	L,	TIME RESIDENTIAL CARE		09/30/15	31	37
			Account			Amount
Assets		rought Assets			İ	
4. (Cu 1	rrent Assets			φ.	140.04
	<u>1.</u> 2.	Cash (on hand and in banks		D - 1 D -1.4-)	\$	140,04
					\$	63,50
	<u>3.</u> 4	Other Accounts Receivable Inventories	(Excluding Owners o	r Related Parties)	\$	
		Prepaid Expenses			\$ \$	14.00
•	٥.	a. Real Estate Taxes		A 700	2	14,08
		b. Personal Property Tax		4,782		
		c. Payroll Taxes		1,635 7,326	_	
		d. Insurance - Auto		341		
	6.	Interest Receivable	<u></u>	J41	\$	
		Medicare Final Settlement F	Receivable		\$	
		Other Current Assets (itemiz			\$	
`	٠.	omer carrent russes (nemiz	<i>(,)</i>		Ψ.	
				·	—	
-9, 7	To.	tal Current Assets (Lines A1	thru 8)		\$	217,63
		ked Assets			Ψ	217,03
1	i.	Land			\$	
2	2.	Land Improvements	*Historical Cost	9,150	\$	6,78
		•	Accum. Depreciati			-,
3	3.	Buildings	*Historical Cost	,	\$	
		J	Accum. Depreciati	on Net		
4	1.	Leasehold Improvements	*Historical Cost	90,227	\$	60,97
		•	Accum, Depreciation			,
5	5.	Non-Movable Equipment	*Historical Cost	129,869	\$	27,19
			Accum. Depreciation	on 102,676 Net		·
6	5.	Movable Equipment	*Historical Cost	130,965	\$	1,61
			Accum, Depreciation	on 129,348 Net		·
7	7,	Motor Vehicles	*Historical Cost	40,901	\$	18,40
			Accum. Depreciation	on 22,496 Net		
8	3.	Minor Equipment-Not Depre	eciable		\$	
9)	Other Fixed Assets (itemize))		\$	
-10.		Total Fixed Assets (Lines B	1 thru 9)		\$	114,97

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

G. Balance Sheet (cont'd)

1		f Facility	License No.	Report for Year Ended	 Page		of
APk	ЛГ.	TIME RESIDENTIAL CARE	H 1885	09/30/15	32		37
·			Account		Am	ount	
				Total Brought Forward:	\$ 	33	2,613
C.		easehold or like property recor	ded for Equity Purposes	S.			
		Land			\$ 		
	. 2.	Land Improvements	*Historical Cost				
			Accum. Depreciation	Net 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	\$		
		Minor Equipment-Not Depre	eciable	·	\$		
C-8	To	tal Leasehold or Like Proper	ties (C1 thru 7)		\$		
Đ.	Inv	vestment and Other Assets					
<u> </u>	1.	Deferred Deposits			\$		
	2.	Escrow Deposits			\$		
	3.	Organization Expense	*Historical Cost	87,133			
			Accum. Depreciation	47,466 Net	\$	3	9,667
	4,	Goodwill (Purchased Only)			\$ 		
	5.	Investments Related to Resid	lent Care (itemize)		\$ 		
	6.	Loans to Owners or Related	Parties (itemize)		\$ WO WASHINGTON TO WASHINGTON TO	MINNEY PARTERING	(NEW EST CASE IN PRO-
		Name and Address	Amount	Loan Date			
	7.	Other Assets (itemize)			\$ SO IN THURS OF THE REAL PROPERTY.	y para department	
				· · · · · · · · · · · · · · · · · · ·			
			<u> </u>				
D-8.	To	tal Investments and Other As	sets (Lines D1 thru 7)		\$ Marsy running water in		9,667
		tal All Assets (Lines A9 + B1			\$ 		2,280

^{*} 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			License No.	Report for Year Er	nded	Page	of
APRIL TIM	E RE	SIDENTIAL CARE HOME	1885	09/30/15		33	37
			Account			Am	ount
Liabilities							
A.	Cu	rrent Liabilities					
	1.	Trade Accounts Payable			\$		14,275
	2.	Notes Payable (itemize)			\$	TO MARKET HET BERKE MARKET SON	The College William Town 1882 on 1
				· · · · · · · · · · · · · · · · · · ·			
		T D 11 C D 1		/th			10.500
	3.	Loans Payable for Equipm	·, ···································	——————————————————————————————————————	\$	ISTRITUTE TO THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STA	12,536
		Name of Lender	Purpose	Amount	Date Due		
		Chase Auto	2012 Cadillac	9 704	09/30/16		
		Chase Auto	2012 Cadillac	8,794	09/30/10		
		Huebsh Financial	Laundry Equip	3,742	09/30/16		
		114COSH I HIGHORI	Edulary Equip	5,742	02/30/10		
ļ						1.0	
•							
	4.	Accrued Payroll (Exclusive	e of Owners and/or Sto	ockholders only)	\$	on construction and an experience	8,126
	5.	Accrued Payroll (Owners of	and/or Stockholders or	ıly)	\$		2,593
	6.	Accrued Payroll Taxes Pay	/able		\$	··-·	
	7.	Medicare Final Settlement	Payable		\$		
	8.	Medicare Current Financin	ig Payable		\$		
	9.	Mortgage Payable (Curren	t Portion)		\$		
	10.	Interest Payable (Exclusive	of Owner and/or Rela	ited Parties)	\$		
	11.	Accrued Income Taxes*			\$		5,633
	12.	Other Current Liabilities (i	temize)		\$		42,708
		Deposits	28,970)			
		Pension	13,738		Ž.		
					N.		
				,	M.		
A-13.	To	tal Current Liabilities (Line	es A1 thru 12)		\$		85,871

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

G. Balance Sheet (cont'd)

Name of Facility	, <u>, , , , , , , , , , , , , , , , , , </u>			Page	of	
APRIL TIME RESIDENTIAL CARE HON		09/30/15		34		
	Account	T. 15 1		Amount		
Liabilities (cont'd)		Total Brough	it Forward:		85,871	
B. Long-Term Liabilities						
1. Loans Payable-Equipment	(itemize)			\$	18,917	
Name of Lender	Purpose	Amount	Date Due	*	10,717	
				T		
Chase Auto	2012 Cadillac	10,123	12/1/17			
Huebsh Financial	Laundry Equip	8,794	9/30/19		a property and	
Tracosii i manerai	Laundry Equip	0,794	9/30/19/8			
2. Mortgages Payable	<u> </u>		9	B		
Loans from Owners or Rel	ated Parties (itemize)		\$	B	139,843	
Name and Address of Lender	Amount	Loan Da	ate			
J & K Bhogal Realty	80,741	open				
J & K Bhogal	59,102	open				
4. Other Long-Term Liabilitie	es (itemize)	<u></u>	\$	A CONTRACTOR OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF TH		
	-					
D.C. W. I.Y. W. Y. Y. Y. Y. Y. Y. Y. Y. Y. Y. Y. Y. Y.	** ** ** * * * * * * *					
B-5. Total Long-Term Liabilities (1 C. Total All Liabilities (Lines A-	Lines B1 thru 4)		\$		158,760	
C. Ioui Au Liubinites (Lilles A-	(כ-ם דו כו		\$) 	244,631	

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

Name of Facility		License No.	Report for Y	ear Ended	Page	of
APRIL TIME R	ESIDENTIAL CARE		09/30/15		35	37
A. Reserves		Account				Amount
	e for value of leased la	and			\$	
	e for depreciation valu	ue of leased build	ings and appurte	nances	\$	
3. Reserv	e for depreciation valu	ie of leased perso	nal property (Eq	uity)	\$	
4. Reserv	e for leasehold real pr	operties on which	fair rental value	e is based	\$	
5. Reserv	e for funds set aside as	s donor restricted			\$	
6. Total F	Leserves				\$	
B. Net Wortl 1. Owner					\$	37,353
2. Capital	Stock			*,	\$	
3. Paid-in	Surplus				\$	
4. Treasu	y Stock				\$	
5. Cumul	ated Earnings				\$	43,947
6. Gain o	Loss for Period	10/01/	14 thru	09/30/15	\$	46,349
7. Total N	let Worth				\$	127,649
C. Total Rese	rves and Net Worth				\$	127,649
D. Total Liab	ilities, Reserves, and l	Vet Worth			\$	372,280

H. Changes in Total Net Worth

1	License No.	Report for Year	Ended	Page	of
APRIL TIME RESIDENTIAL CARE H	1885	09/30/15		36	37
	Account			A	mount
A. Balance at End of Prior Period as sh	own on Report of	f 09/30/2014		\$	76,383
B. Total Revenue (From Statement of I	Revenue Page 30)		\$	883,351
C. Total Expenditures (From Statemen	t of Expenditures	Page 27)		\$	837,002
D. Net Income or Deficit	· · · · · · · · · · · · · · · · · · ·			\$	46,349
E. Balance			<u> </u>	\$	122,732
F. Additions 1. Additional Capital Contributed (itemize)				
2. Other (itemize)					
Auto useage Adj - 09/30/15		3,961			
Prior year adj	·	956			
F-3. Total Additions				\$	4,917
G. Deductions					
1. Drawings of Owners/Operators/I				\$	
Name and Address (No., City, S	itate, Zip)	Title	Amount		
2. Other Withdrawings (Specify)	· · · · · · · · · · · · · · · · · · ·	. ,		\$	A STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PERSON NAMED IN COLUMN TO STATE OF THE PER
Purpose		Amo	unt		
3. Total Deductions	00100			\$	
H. Balance at End of Period	09/30/	15		\$	127,649

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page of
APRIL TIME RESIDENTIAL CARE	1885	09/30/15	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	ation	
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	
Thelle	CRA	1/13/16	
Printed Name of Preparer			
Thomas W. Daniele CPA			
Addres Address		Phone Number	
66 Cedar St., Newington, CT. 06111		860-666-5942	

Item

Level

State of Connecticut Long-Term Care Facility RATE COMPUTATION REPORT Based on 10/01/2014 through 09/30/2015

DRAFT

April Time Residential Care Center

Facility: 188 Page: 22

Date: 01/19/2016

Page - Lic. Type - Rate Yr 3-Res. Care Home	Error Message Physician Hourly Limit Cost Year Variable is 0, hourly limits cannot be checked
3-Res. Care Home	Dietician Hourly Limit Cost Year Variable is 0, hourly limits cannot be checked
4-Res. Care Home	Physician Hourly Limit Cost Year Variable is 0, hourly limits cannot be checked
4-Res. Care Home	Dietician Hourly Limit Cost Year Variable is 0, hourly limits cannot be checked
17	Administrator's salary needs to be entered
19	(73,564), Total Cash is Greater than Monthly Expenses
19	Investments and Other Assets - Organization expense does not equal 0
RC-Res. Care Home	No Self Pay rates entered