Craig J. Lubitski Consulting ILC & CJLC ILC

CERTIFIED PUBLIC ACCOUNTANTS & ADVISORS

Mr. Chris LaVigne **CON & Reimbursement Department of Social Services** 55 Farmington Avenue Hartford, CT 06105

Mr. LaVigne:

This enclosed 2015 Medicaid Cost Report intentionally omits the following disallowances:

- a. Administrator and Related Party salaries
- b. Dues and Membership Fees to Professional Associations
- c. Physical or Speech Therapy salaries or fees
- d. Depreciation and/or interest expense related to capitalized items previously deemed unallowable by the Department

It is our understanding that the software utilized by the Department in the rate setting process computes the necessary disallowances for these areas and our intention is to eliminate the potential for a duplicate disallowance.

If you have any questions, please contact me at 860-610-9009.

Respectfully,

Craig J. Lubitski, CPA

Partner

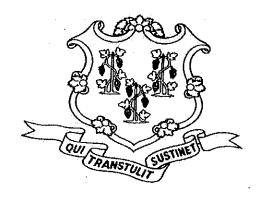


225 Pitkin Street East Hartford Connecticut 06108

860.610.9009 (t) 860.610.9030 (f)

cilc.com

State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2015

Name of Facility (as license	ed)							·
Mattatuck Health Care Faci	lity, Inc.							
Address (No. & Street, City	, State, Z	ip Code)						
9 Cliff Street, Waterbury, C	t 06710							
Type of Facility								
Chronic and Conval	escent		Rest Home wit	h Nursing				
☐ Nursing Home only			Supervision on	ly	\square	Residenti	al Ca	re Home
(CCNH)			(RHNS)					
Report for Year Beginning			Report for Yea	r Ending				
10/1/2014			9/30/2015					
License Numbers:		CCNH	RHNS	Reside	ntial Care l	Home	Me	dicare Provider
			144					075432
Medicaid Provider Number	s:	CC	CNH	RH	INS		IC	F-IID
For Department Use Only	7							
	ned and	Date	Sequence N	Tumber				
1 1 -	tarized	Received	Assign		Signed a	ınd Notari:	zed	Date Received
Assigned 140		ROCCIVCU	7 1331gH					

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Mattatuck Health Care Facility, Inc.	144 .	9/30/2015	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Mattatuck Health Care Facility, Inc. [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 1111			211	
Signed (Admitnistrator)		Date. 49/16/	Signed (Oxymer)	Date 2/9/16
Printed Name (Administrator)			Printed Name (Owner)	
Allen V. Desena			Allen V. Desena	
Subscribed and Sworn			Signed (Notary Public)	Comm. Expires
to before me:	CT	19/16	Alg	4 ,30 ,20
Address of Notary Public		.,,		
9 Cliff 87 WBy G	06710		V	

:(Notary Seal)

State of Connecticut **Department of Social Services**

25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjus	tm	ent		Page	of
				1A	37
Name of Facility		Period Cov	ered:	From	То
Mattatuck Health Care Facility, Inc.				10/1/2014	9/30/2015
Address of Facility 9 Cliff Street, Waterbury, Ct 06710					
Report Prepared By		Phone Nun	ıber	Date	
Craig J. Lubitski Consulting LLC		860-610-90	009	2/23/2016	
Item		Total	CCNH	RHNS	Residentia l Care Home
Dietary wages paid	\$	10141	CCIVII	IGINS	Home
Laundry wages paid	\$				
3. Housekeeping wages paid	\$				
4. Nursing wages paid	\$				
5. All other wages paid	\$				
6. Total Wages Paid	\$				
7. Total salaries paid	\$				
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-2 Rev. 10/2005

General Information and Questionnaire Type of Facility - Organization Structure

1	one No. of Fac		•	ar Ended		of
	3-573-9924		9/30/2015		2	37
Name of Facility (as shown on license)	,		treet, City, Sta			
Mattatuck Health Care Facility, Inc.			terbury, Ct 06 lential Care H		Madiana T	Provider No.
CCNH License Numbers:	RHNS 144	Kesia	iennai Care H		075432	rovider ino.
Type of Facility (Check appropriate box(es))						
	est Home with N pervision only			Residenti	ial Care Hon	ne
Type of Ownership (Check appropriate box)						
O Proprietorship O LLC O Partnership G	Profit Corp.	0	Non-Profit Co	р. О	Government	O Trust
If this facility opened or closed during report year provide;		Date	Opened	Date Clos	sed	
Has there been any change in ownership						
or operation during this report year?	Yes Yes	•	No	If "Yes,"	explain full	у.
		-				
Administrator						
Name of Administrator		ĺ	Nursing Ho	ome		
Allen V. Desena			Administrat	or's	000297	
	•		License l	Vo.:		
Other Operators/Owners who are assistant administrators (fu	Il or part time)	of th				
Name N/A			License 1	No.:		
						· · · · · ·

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-3 Rev. 10/2005

General Information and Questionnaire Partners/Members

Name of Facility Mattatuck Health Care Facility	/. Inc.	License No.	Report for Y 9/30/2015	ear Ended	Page of 3 37
Legal Name of Part		Business A			or Town(s) in egistered
N/A					3
Name of Partners/Members	Business Ad	Idress	7	Γitle	% Owned

New Andrews and An					
***************************************				;	

General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year E	nded	Page of
Mattatuck Health Care Facility, Inc.	144	9/30/2015		3A 37
If this facility is owned or operated as a cor	· · · · · · · · · · · · · · · · · · ·			
Legal Name of Corporation		ness Address	State(s) in Whi	ch Incorporated
Mattatuck Health Care Facility, Inc.	9 Cliff Street,	Waterbury, CT 06710	СТ	
Name of Directors, Officers	Busin	ness Address	Title	No. Shares Held by Each
Allen V. Desena	416 Beacon Hi	ll Road, Cheshire, CT	resident/Tresure	150
Karen Desena	416 Beacon Hi	ll Road, Cheshire, CT	VP/Secretary	
1.004.668.8				
Names of Stockholders Owning at Least 10% of Shares				

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-3B Rev. 10/2005

General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Mattatuck Health Care Facility, Inc.	144	9/30/2015	3B	37
If this facility is owned or operated as an individual	ual proprietorship,	provide the following informa	tion:	
O	wner(s) of Facility			
N1/A				
N/A				
•			•	
		•		
***************************************		The second secon		
			-	
		(4.4.4.4.1.4.1.1.1.1.1.1.1.1.1.1.1.1.1.1		
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-4 Rev. 10/2005

General Information and Questionnaire Related Parties*

Name of Facility Mattatuck Health Care Facility, Inc.		License No.	No. 144	Re 9/3	Report for Year Ended 9/30/2015		Page 4	of37
Are any individuals rece	Are any individuals receiving compensation from the facility	ility rel	related through	lig Tig		If "Yes," provide the Name/Address and	e Name/Add	Iress and
marriage, ability to contr	marriage, ability to control, ownership, family or business association?	ss assoc	ation?	O Yes	es O No	complete the information on Page 11 of the report.	nation on Pag	ge 11 of the report.
Are any individuals or co	Are any individuals or companies which provide goods or services,	or servic	es,					
including the rental of pr	including the rental of property or the loaning of funds to this facility,	o this fa	ility, or busines	v				
association to any of the	association to any of the owners, operators, or officials of this facility?	of this fa	or ousmos cility?	2		If "Yes," provide the following information:	e following i	information:
	And the state of t	Also	Also Provides			Indicate Where		
,	ş	Good:	Goods/Services to	<u> </u>		Costs are included		(
Name of Related Individual or Company	Business Address	Non-R	Non-Related Parties Yes No %**	* ies	Description of Goods/Services Provided	In Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
Allen V. Desena dba Tricare Unlimited	9 Cliff Street, Waterbury, CT 06710	0	· •	Re	Rental of Facility	22/9	258,500	258.500
Allen V. Desena dba Tricare Unlimited	9 Cliff Street, Waterbury, CT 06710	0	•	<u>lnt</u>	Interest on Loans	27/12d	19,017	19,017
Carriage Manor LLC	157 Hillside Ave, Waterbury, CT 06710	0	0	Lo Lo	Loans for Expenses	31/A8	204,684	204,684
Tricare LLC	9 Cliff Street, Waterbury, CT 06710	0	•	្ម	Loans for Expenses	31/A8	283,772	283,772
Allen V. Desena dba Geron	157 Hillside Ave, Waterbury, CT 06710	0	•	l.o	Loans of Funds	31/A8	338,247	338,247
Michael Mara	9 Cliff Street, Waterbury, CT 06710	0	•	Ma	Maintenance / 54 hours	16/m13	540	540
		0	•					
		0	0					,
		0	0					
* Ile additional cheets if necessary	if necessiry			_				

^{*} 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 No).	Report for Year Ended	Page	of
Mattatuck Health Care Facility, Inc.	144		9/30/2015	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.	costs
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, Aid	les and
		Attendants			
Direct Resident Care Consultants			hours of resident care provided	d by EAG	CH
			(See listing page 13)		
Maintenance and operation of plant		Square feet			
Property costs (depreciation)		Square feet			
Employee health and welfare		Gross salar			·····
Management services			e cost center involved	···.·	
All other General Administrative expenses			rect and Allocated Costs		
The preparer of this report must answer the following	owing quest	tions applic	***************************************		
1. In the preparation of this Report, were all	Yes	O No	If "No," explain fully why such	h allocat	ion was
costs allocated as required?			not made.		
0. T. 1. 4. H 0. 1. 4.					
2. Explain the allocation of related company ex	penses and	attach copy	of appropriate supporting data	•	
2 Diddi Dolle	10 11 11	1	111111111111111111111111111111111111111		
3. Did the Facility appropriately allocate and se				me cost	centers?
(e.g., Assisted Living, Home Health, Outpati	ent Services	•			
	• Yes	→ 140	If "No," explain fully why such not made.	ı allocat	ion was

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General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility	***************************************		License No.	Report for Year Ended	ear Ended	The state of the s	Page of
Mattatuck Health Care Facility, Inc.			144	9/30/2015			6 37
-	Related * to	1 * to					
	Owners,	ers,					
	Operators,	tors,				Annual	·
	Officers	ers		Date of	Term of	Amount	Amount
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	ofLease	Claimed
Great American Leasing Corp.	0	•	Copier	10/13/11	60 Months	2,106	2,106
	0	0					
	0	0					
	0	0					
	0	0				:	
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
Is a Mileage I og Book Maintained for All Leased Vehicles?	A pased	hicles	o Yes		O No	Total ***	2 106

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also. Is a Mileage Log Book Maintained for All Leased Vehicles?

Total ***

^{**} 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
Mattatuck Health Care Facility, Inc.	144	9/30/2015		7	37
The records of this facility for the pe	eriod covered by this report	were maintained on the following basis:			
Accrual O Cash O	Modified Cash				
Is the accounting basis for this					
1*	Yes	If "No," explain.			
previous period? O	No				
Independent Accounting Firm					
Name of Accounting Firm	-	Address (No. & Street, City, State, Zip Code)			
1 Craig J. Lubitski Consulting LL	C	225 Pitkin Street, East Hartford, CT 061			
2 O'Connor, Davies LLP	· ·	100 Great Meadow Road, Wethersfield, (CT 06109		
3 4					
Services Provided by This Firm (des	scribe fully)	<u></u>			
1 Medicaid Cost Report and Accounting	2 Services		\$	2,250	******************
2 Financial Statements, Tax Returns			\$	18,369	
3			\$,	
4			\$		
**************************************				r Services Pr	ovided
			\$	20,619	OTIGOG
Are These Charges Reflected in the Expend	iture Portion of This Report? If Y	es, Specify Expense Classification and Line No.	Ψ	20,017	
	Pg 15/1d				
Legal Services Information				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Name of Legal Firm or Independent	Attorney		Telephone	Number	·
1 Murtha Cullina			860-240-6	6000	
2					
3					
2 3 4 5					
Address (No. & Street, City, State, Z	(in Coda)				
l .					
1 185 Asylum St., 29th Floor, Hat 2 3 4					
3					
4					ĺ
5					
Services Provided by This Firm (des	scribe fully)				
1 Legal Services			\$	11,375	
2			\$		
3			\$		
2 3 4			\$		
5			\$		
			Charge fo	r Services Pr	ovided
			\$	11,375	
Are These Charges Reflected in the Expend	iture Portion of This Report? If Y	es, Specify Expense Classification and Line No.			
O Yes O No					
C 163					

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

Schedule of Resident Statistics

Name of Facility Mattatuck Health Care Facility, Inc.			License No.	vo. 144			Report for 9/30/2015	Report for Year Ended 9/30/2015	-5		Page 8	of 37
· · · · · · · · · · · · · · · · · · ·					<u> </u>	Period 10/1 Thru 6/30	1 Thru 6/	30		Period 7/1	Thru 9/30	0
	Total All	Total CCNH	Total RHNS	Total Residential				Residential				Residential
	Levels	Level	Level	Care Home	Totai	CCNH	RHINS	Care Home	Total	CCNH	RHINS	Care Home
 Certified Bed Capacity 							٠					
 A. On last day of PREVIOUS report period 	43		43		43		43		43		43	
B. On last day of THIS report period	43		43		43		43		43		43	•
2. Number of Residents												
A. As of midnight of PREVIOUS report period	42		42		42		42		42		42	
B. As of midnight of THIS report period	40		40		42		54		40		40	
3. Total Number of Days Care Provided During Period												
A. Medicare	155		155		122		122		33		33	-
B. Medicaid (Conn.)												
C. Medicaid (other states)					·							
D. Private Pay	917		917		733		733		184		184	
E. State SSI for RCH	13,346		13,346		9,832		9,832		3,514		3,514	
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	14,418		14,418		10,687		10,687		3,731		3,731	
Total Number of Days Not Included in Figures in 3G 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)	14,418		14,418		10,687		10,687		3,731		3,731	

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

Schedule of Resident Statistics (Cont'd)

Name of Faci	lity			Lice	nse No.				Repor	t for Year	Ended		Page	of
Mattatuck He	alth Car	e Facilit	y, Inc.		144				-	9/30/201			9	37
			in the certified b		pacity du	ring tl	ne repo	rt yea	r?	0	Yes	0	No	
II YES			llowing informa	ion:								~		
		Place of	f Change Residential		Ci	nange	in Bed	S		Ca	pacity Aft	er Change		
Date of	CONTH	RHNS	Care Home		Lost			Gaine	4					
	CCIVII	Kuns	Care Home		LOSI			James	.1	1		Residential		
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Care Home	Reason t	or Change
	(-)	(~)	(5)	(1)	(2)	(0)	(1)	(2)	(3)	COIVII	KUITO	Care Home	ICH30II I	or Change
														
			in certified bed o 90 days followin			the re	eport ye	ear (as	report	ed in item	4 above)	provide the nur	nber of	
1 . 1			Change in Re	siden	nt Days					CC	NH	RHNS	Residentia	Care Home
1st chang 2nd chan														
3rd chan														
4th chan														
		lents and	l Rates on Septe	mber	30 of Co	st Yea	ır			L				
			Medicare		Medic					Se	lf-Pay		Other Sta	te Assisted
		Γ							•					
	Item		CCNH	C	CNH	RF	INS	CC	NH	RH	NS	Residential Care Home	R.C.H.	ICF-IID
No. of Re			1	CCNH RHNS CCNH RHNS Care Home 37 2										
Per Diem														
a. One b	***************************************			125.33 175.00										
b. Two t		1					-				170.00			
c. Three		;	2424											
bed r	ins.								900 m		165.00			
		Physica	l Therapy Treat	nents						TO	ΓAL	CCNH	RHNS	Residential Care Home
			usive of Part B)		·									
		-	Treatments											
			reatments .								275		275	
C.	Other										9		9	
D,	Total P	hysical	Therapy Treatn	ents							284		284	
			Therapy Treatm	ents						0.2				
A,	Medica	re - Part	B											
В.	Moi:	ia (Exci	usive of Part B) Treatments											
			Freatments											
	Other	OILLITO I	rounions											
		peech T	herapy Treatme	nts										
			tional Therapy T		nents									
A.	Medica	re - Part	В										areas management and an areas	
			usive of Part B)					-						
			Treatments]			
		orative 7	Treatments											
	Other Total O	ccunati	onal Therapy Ti	entss	outs							,, , ,		
D.	- 04011 U	ipan	и вист иру 1 1	~111111	~****									ı I

Report of Expenditures - Salaries & Wages

Report of Ex	Ψ		T		Do	-e
Name of Facility	License No.		Report for Year	Ended	Page	of I on
Mattatuck Health Care Facility, Inc.	144		9/30/2015	***	10	37
Are time records maintained by all individuals receiving cor	npensation?	⊚	Yes	0	No	
	4		Total Cost a	nd Hours		
					Residential	
Item	CCNH	Hours	RHNS	Hours	Care Home	Hours
A. Salaries and Wages*						
Operators/Owners (Complete also Sec. I						
of Schedule A1)						
Administrator(s) (Complete also Sec. III						
of Schedule A1)			43,466	1,040		TO STATE OF THE PERSON OF THE
Assistant Administrator (Complete also Sec. IV						
of Schedule A1)	İ .					
 Other Administrative Salaries (telephone 						
operator, clerks, receptionists, etc.)		100000000000000000000000000000000000000	36,553	1,248		
5. Dietary Service						
a. Head Dietitian	 		47 077	2.254		
b. Food Service Supervisor	 	-	47,857 58,790	2,354 6,045		
c. Dietary Workers			38,790	0,043		
Housekeeping Service Head Housekeeper						
b. Other Housekeeping Workers	<u> </u>		7,870	803		<u> </u>
7. Repairs & Maintenance Services			.,0.0			
a. Engineer or Chief of Maintenance	A THORNE OF THE PARTY OF THE PA			TO SHARE THE PARTY OF THE PARTY		
b. Other Maintenance Workers	İ		45,104	2,721		
Laundry Service						
a. Supervisor						
b. Other Laundry Workers	ļ		54,736	4,789		<u> </u>
Barber and Beautician Services	<u> </u>	<u> </u>				
10. Protective Services		11579/05/07/25/07/25				
11. Accounting Services						
a. Head Accountant b. Other Accountants						
12. Professional Care of Residents		5/6/94/5/95/6/6				
a. Directors and Assistant Director of Nurses			72,202	2,630	and the second s	
b. RN			72,202	2,030		
1. Direct Care			162,785	6,758		Name and the second
2. Administrative**	1		102,100	0,100		
c. LPN						
1. Direct Care			11,618	528		
2. Administrative**				···		
d. Aides and Attendants			155,728	14,998		
c. Physical Therapists						
f. Speech Therapists		ļ				
g. Occupational Therapists			20.627	2,080		
h. Recreation Workers			39,627	2,080		
 i. Physicians 1. Medical Director 						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists	<u> </u>					
1. Podiatrists	<u> </u>	ļ .		***		
m. Social Workers/Case Management	-	ļ	9,907	520	 	-
n. Marketing						
o. Other (Specify)						
See Attached Schedule A-13. Total Salary Expenditures	1	 	746,242	46,512		
л-15, 10км отагу <u>Ехрепани</u> гез	<u> </u>	<u> </u>	170,242	-10,212	I	٨

^{*} 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	RH	INS	Residential	Care Home
Position	\$	Hours	\$	Hours	\$	Hours
		0.000.000.000	25, 30, 66,001,030	10000000000	0.40 (0.00 0.00 0.00	441-451-661-66-26-2
	15,120,161,000,100		40.00.00.00.00.00.00	18 W 15 W 18		
			6.00			
	7(1) (6) 31 (3)		35 35 35 30 30 37		20 SEC. 10 VIV. 10 VIII	file of the file
		400000000000000000000000000000000000000	65 60 60 6 60 B	u Salasa da Janas	A STATE OF STATE	30.50.50.50.50
	3.00			1.45.02.01.05.03	4 6 4 6 6	3.00
	14-31 mg (15-7) (51 1-55)	640310040400000	(S. 16) E. S. C. 1	7 (51) 451 451 51 (51)		36 G) 45 (45 S)
		62000162-24020	achterios as tago	5 0 22 100 150 2.5	015440000000000000000000000000000000000	100
	1000 150 100 100 100		450 (270 (370 (370 (370)	0.0000000000000000000000000000000000000	20 (0.03) 30 (0.0	
					12 2 20 00 00 0	50.57 (8.66.5)
	1/1505-0091-002-0021-0011	10 ASS 100 TO SEE N	1997-007-008-009-008-1	320000000000000000000000000000000000000	10 100 000 004 00 00	nta (Sulcus g) (68
			41, 531, 531, 151, 1797		50.75 (0.00)	
		5 44 5				
			00.00.00.00.00		5. 5. 19. 6. 2. 6	65 46 65 65 6
				7.67 (2.00)		
	1.60 (0.00 (0.00 (0.00))	2010/06/04	ngay tan canage naga	110000000000000000000000000000000000000	V 15 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	180700000000000000
Total	\$ -	2. 23 (a) (2. * /6. (a)	\$ -		\$ -	-

Schedule of Other Fees (Page 13)

	CC	NH	RH	INS	Residential	Care Home
Service	S	Hours	S	Hours	\$	Hours
Respiratory Therapy			\$ 1,221	Contract		
		8 48 K S S S S	2.0000000000000000000000000000000000000	100 miles (100 miles)	0.05000000	St. 250, 200, 25, 14
				0.85.55.35.00.0	Sec. 10. 10. 10. 10. 1	16 (6 (6 (6))
				161688		
	21.75.50.60	2 (2) (6) (6) (6)	(60) 262 (60) 223 (60)			(4) 150 680 681 C
			32 37 51 5			
				0.000 000 000 00		100 100 100 100 100
	100000000000000000000000000000000000000		80 80 19 18 49		0.5 6.5	30 30 38 30 S
			602000000000			
		20130 S005 C00 C00		100000000000000000000000000000000000000	dellare and agency	10.00
		(2) 284 to 2164 per est				
	5 (5 (6) (5) (6) (9)				0.00	65 65 65 65
	0.30	9 6 3 5 5 6	50363		100 55 65 65 65 6	3 3 3 3
			150 200 000		62.00	22 (21) (22 (23)
	2020 300 120 130			37/55/100	180 127 (151 281 27	
	0.000 00 00		10 6 65 65 66			
	0.000	1000 0000 000	745 12 13 12 12	40.0000.000	68 OF 68 OF 68	6 9 9 6
rotal .	\$ -	50 (AC (C) (S) <u>1</u> 57 (A	\$ 1,221	a na arang gara	\$ -	50 000 00 0 <u>0</u> 00

State of Connecticut

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

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

			Assistant	t Administra	Assistant Administrators and Other Related Parties*	Relate	d Parties	*		-
Name of Facility				License No.		Report for Year Ended	Year Ended		Page	Jo
Mattatuck Health Care Facility, Inc.	ප්		:	144		9/30/2015			11	37
	-	Salary Paid	p							-
				Fringe Benefits and/or Other		Total	Line Where		Total	
Name	CCNH	RHINS	Residential Care Home	Payments (describe fully)	Full Description of Services Rendered	Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours Worked	Compensation Received
Section I - Operators/Owners										-
				Group Insurance (15/15; Life				Carriage Manor, 157 Hillside Ave, Waterbury,		
Allen V. Desena		43,466		Insurance	Administrator	1,040	A2	CI	1,040	43,466
								-		
	·									
Section II - Other related										
parties of Operators/Owners										-
facility (EXCEPT those who										
Assistant Administrators who										
are identifica on rage 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.

State of Connecticut

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

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

Assistant Administrators and Other Related Parties*

		4	ASSISTAIL	Auminista	Assistant Auministrators and Other Related Fartles	Related	rarnes	-		
Name of Facility (as licensed)				License No.		Report for Year Ended	ar Ended		Page	of
Mattatuck Health Care Facility, Inc.	ď			144		9/30/2015	•		12	37
		Salary Paid	ď							
				Fringe Benefits and/or Other		Total	Line Where		Total	
,		C. C.	Residential	Payments	Full Description of			Name and Address of All	Hours	Compensation
Name	CCNH	KHINS	Care Home	(describe fully)	Services Rendered	Worked	Page 10	Other Employment**	Worked	Received
Section III - Administrators***							•			
								- SAMA		
Section IV - Assistant Administrators										
T AND THE STATE OF										
***************************************					***			5 5 5 5 5 5 5 5 5		
	, .			-						
** ** ** ** ** ** ** ** ** ** ** ** **	1									

*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.

Annual Report of Long-Term Care Facility

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

B. Report of E	License No.	05 110,	Report for Y		Page	of
Mattatuck Health Care Facility, Inc.	14	4	9/30/2015	cai Ended	13	37
iviatiatiek Ticatii Cate i aciity, iic.	1.		Total Cost	and Hours	1	
<u> 18 - Arthur Marian, Marian ann an Arthur Arthur Ann an Air an Air an Air an Air ann ann ann ann ann ann ann ann ann an</u>			Total Cost	litta 110tars		
					Residential	
Item	CCNH	Hours	RHNS	Hours	Care Home	Hours
*B. Direct care consultants paid on a fee						
for service basis in lieu of salary						
(For all such services complete Schedule B1)						
1. Dietitian			2,200	60		
2. Dentist			4,670	Fee for Svc		
3. Pharmacist			1,637	Fee for Svc		
4. Podiatrist						
5. Physical Therapy						
a. Resident Care			15,750	Fee for Svc		
b. Other						
6. Social Worker			1,200	12		
7. Recreation Worker					442,000,007,000,007,000	CHILD ASSESSED AND AND AND AND AND AND AND AND AND AN
8. Physicians						
 a. Medical Director (entire facility) 		VIVALORUMA, AUGUSTI SANTIA MOTOS SANTIA	4,800	48		olechenski ministrikanera
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**		PARAMETER PROSPERATION OF THE PARAMETER PARAME		nili (Alicia de la companiona de la comp		Wales of the San San San San San San San San San San
d. Administrative Services facility						
1. Infection Control Committee						
(Quarterly meetings) 2. Pharmaceutical Committee						
(Quarterly meetings)						
 Staff Development Committee 						
(Once annually)			•			
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care	ľ					
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care					<u></u>	
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***		ļ				
c. Aides						
d. Other		Water Water Andrew		Washington and the	1465 ann 2000 ann an 1	American and a second
12. Other (Specify)						
See Attached Schedule			1,221			
B-13 Total Fees Paid in Lieu of Salaries * Do not include in this section management consultants or services whi			31,478	120		

^{*} 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*

Name of Facility	License No.		Report for Y	ear Ended	Page	of
Mattatuck Health Care Facility, Inc.	144	-T	9/30/2015		14	37
Name & Address of Individual	Full Explanation of Service	Related* Operato Yes	* to Owners, ors, Officers No	Expla	nation of Re	lationship
Carolyn Hogrefe, RD, Woodbury, CT	Dietician	0	•			
Access PT, Waterbury, CT	Physical Therapist	0	•			
Counseling Associates, Waterbury, CT	Social Workers	0	0			
Charles McNair, MC, Alliance Medical Group, Waterbury, CT	Medical Director	0	0			
Health Drive	Dentist	0	0			
Kevin Czarzasty, RPH, Bunker Hill, Waterbury, CT	Pharmacy Consultant	0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
Terrorio de la companya de la companya de la companya de la companya de la companya de la companya de la compa		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
Mattatuck Health Care Facility, Inc.	144	9/30/2015		15	37
	<u> </u>				
					Residential
Item		Total	CCNH	RHNS	Care Home
Administrative and General					
a. Employee Health & Welfare Benefits					
Workmen's Compensation		\$ 28,890		28,890	
2. Disability Insurance		\$			
3. Unemployment Insurance		\$ 14,890		14,890	
4. Social Security (F.I.C.A.)		\$ 58,683		58,683	
5. Health Insurance		\$ 33,256		33,256	·
6. Life Insurance (employees only)					
(not-owners and not-operators)		\$			
7. Pensions (Non-Discriminatory)		\$ 			
(not-owners and not-operators)					
8. Uniform Allowance		\$			
9. Other (Specify)	•	\$			
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and		\$			
Profit Sharing Plans for Owners and					
Operators (Discriminatory)*					
c. Bad Debts*		\$ 			
d. Accounting and Auditing		\$ 20,619		20,619	
e. Legal (Services should be fully described	on Page 7)	\$ 11,375		11,375	
f. Insurance on Lives of Owners and		\$ 15,894	44	15,894	
Operators (Specify)*					
g. Office Supplies		\$ 1,173	M3377777777777777777777777777777777777	1,173	
 h. Telephone and Cellular Phones 					
 Telephone & Pagers 		\$ 4,685		4,685	
2. Cellular Phones		\$ 			
i. Appraisal (Specify purpose and		\$ Managara and American and Ameri			
attach copy)*					
j. Corporation Business Taxes (franchise to		\$ No. alemais ad Pennas colleges			
k. Other Taxes (Not related to property - Se	e Page 22)				
1. Income*		\$		20,333	
2. Other (<i>Specify</i>)		\$			
See Attached Schedule					
3. Resident Day User Fee		\$ 		294,639	
Subtotal		\$ 504,438		504,438	

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

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

Mattatuck Health Care Facility, Inc. 9/30/2015

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Residential Care Home
ne vage state et al se sous pare d'innancia de la company de la seguintation de la production de la company de La company de la company d			
	0.5000000000000000000000000000000000000		
	t communications		
	1000		100 00 000
			and a second second second
	Action removed the control of the co		
	MIGGINGS NO. ASSAULTINGS SEE		
	Programs as a service part of		11000
		77.7	
Total	\$ -	\$ -	\$ -

Schedule of Other Taxes

Description	CCNH	RHNS	Residential Care Home
			100000000000000000000000000000000000000
		1 (n. 2) (n. 14) (n. 16)	18 49 04 6611 3
			2.00
	10 S (10 M)		
Total	\$ -	\$ -	\$ -

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

Name of Facility	License No.		Report for	Year Ended	Page	of
Mattatuck Health Care Facility, Inc.	144		9/30/2015		16	37
		T				
						Residential
Item			Total	CCNH	RHNS	Care Home
Subtota	ls Brought Forward	l:	504,438		504,438	
1. Travel and Entertainment						
Resident Travel and Entertainment		\$				
2. Holiday Parties for Staff		\$				
3. Gifts to Staff and Residents		\$				
4. Employee Travel		\$				
Education Expenses Related to Seminars an	······································	\$	684	***************************************	684	
6. Automobile Expense (not purchase or depri		\$	1,673		1,673	
7. Other (Specify)		\$	***************************************	MATERIAL CONTROL OF THE STATE O		***************************************
See Attached Schedule						
m. Other Administrative and General Expenses						
 Advertising Help Wanted (all such expense. 		\$	543		543	
2. Advertising Telephone Directory (all such e	<u> </u>	\$				
3. Advertising Other (Specify)***		\$[610	WWW.Anness J. Frank A. Lebran N. Anness J. Est.	610	
See Attached Schedule	****					
4. Fund-Raising***		\$				
5. Medical Records		\$				
6. Barber and Beauty Supplies (if this service	1 1	\$				
directly and not by contract or fee for service		Ì				
7. Postage		\$	670		670	
* 8. Dues and Membership Fees to Professional		\$	2,066		2,066	
Associations (Specify)						
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other Non-A		\$	627		627	
9. Subscriptions		\$				
10. Contributions***		\$	250		250	
See Attached Schedule						
11. Services Provided by Contract (Specify and		\$				I. ///
Schedule C-2, Page 21 for each firm or indi						
12. Administrative Management Services**		\$			4005	
13. Other (Specify)		\$	10,069		10,069	
See Attached Schedule		_	701 (22)		501 500	
C-14 Total Administrative & General Expenditures		\$	521,629		521,629	

^{*} Do not include Subscriptions, which should go in item 9.

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	Residential Care Home
	388 JAN 1882 JAN		
	4534 (50, 68) (460	74.255 (St. 1)	65 88 88 88
	(c) (c) (c) (d)	Sall and the E	
	66.664.69.766	\$2.5650.595538.18K	000.000.000.000
	425 (AS) (AS) (AS)	Si Signapora Zanii	06708581603-009
	(860)65(465)25(2)	0.02017/80.030.030	8869 SERVICO (1988)
	(See 183 - 83) (N.)	Aces County	020-25-250-250
Total Other Travel and Entertainment	S -	s -	\$ 0.000 - 100

Schedule of Other Advertising

		Residential
CCNH	RHNS	Care Home
1921/02/2019/03/03/03	\$ 610	900 (S. 1981) - 100
SYSTEM STATES	ระหนีครัฐแก็ตัดเลื	050 (680 (680 (680))
100000000000000000000000000000000000000	Plate Park Ballic	SERVICE SECTION
\$ -	\$ 610	\$ -
		\$ 610

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
CAHCF	1859 A 1859 A 1850 A 1850 A	\$ 1,712	19850 SPS (469-1959)
Briggs	150 (St. 155 (St.	\$ 354	68 42 48 48 E
	(600.095) (500.055)	60.000.000.000.00	45. 66. 69. 69.
	100 (014) (000 (015)		55 65 56 56
	100 100 100 100	10.00 miles (20.00 miles	155 A 400 C 155 C 155 C
	000000000000000000000000000000000000000		1000
		V. S. S. V. S.	
			Calculation of the Calculation
Total Dues	\$.	\$ 2,066	S -

Schedule of Contributions

		Residential
CCNH	RHNS	Care Home
	\$ 250	
		(1)
\$	\$ 250	S
	CCNH	\$.250

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home	
Casual Labor	100 100 100 100	\$ 540	100 100 100 100	
PR Processing		\$ 5,541		
MDS Support	mic of the sign	\$ 1,512		
Bank Charges		\$ 663		
Late Fees (See Pg 28)	0.0000000000000000000000000000000000000	\$ 276		
Licenses & Permits		\$ 1,137	90 90 US	
Lions Club (See Pg 28)	100 100 20 107	\$ 400		
			5h (6) (6) (6)	
		Paris constitut		
	(25, 26, 52, 53)			
Total Other Administrative and General	S -	\$ 10,069	\$	

Schedule C-1 - Management Services*

Name of Facility Mattatuck Health Care Facility, Inc.	License No. 144	Report for Year Ended 9/30/2015	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 #

^{*} 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)

Man										
1	ne of Facility		Licen	ise	No.	Re	port for Y	ear Ended	Page	of
Mat	tatuck Health Care Facility, Inc.				144	Ì	9/30/2015	5	18	37
									Reside	ntial Care
	Item				Total		CCNH	RHNS	H	ome
2.	Dietary									
	a. In-House Preparation & Service									
	1. Raw Food			\$	95,612	20 100000000000000000000000000000000000		95,612		aqsaqaayaaqaaaayaqayayasaavaaq
	2. Non-Food Supplies			\$	6,148	†		6,148		
	3. Other (Specify)			\$						
			_							
	b. Purchased Services (by contract other			\$		8 USS 998	en en en en en en en en en en en en en e			
ĺ	than through Management Services)									
ĺ	(Complete Schedule C-2 att. Page 21)			200						
	c. Management Services**			\$		0 100000000				
	d. Other (Specify)			\$				1		
			-	88						
				200						
2E.	Total Dietary Expenditures $(2a+b+c+d)$			\$	101,759			101,759		
				Ť	·	İ			Dogidor	tial Cara
2F	Dietary Questionnaire			1	Total		CONIT	DINE	l	itial Care
				\dashv	Total	<u> </u>	CCNH	RHNS	110	ome
	Resident Meals: Total no. of meals served per					<u> </u>			<u> </u>	
H.	Is cost of employee meals included in 2E?	0	Yes		•	No)			
т	Did C	$\overline{}$	77.		-	3.7		If yes, specify		
I,	Did you receive revenue from employees?	U	Yes		•	No)	amt.		
J.	Where is the revenue received reported in the	Cos	st Repo	ort?	(Page/Line	Iten	1)			
	Is cost of meals provided to persons other				 					
	than employees or residents (i.e., Board	0	Yes		•	No	1	If yes, specify		
	Members, Guests) included in 2E?	_			_	•		cost.		
								If yes, specify		
L.	Is any revenue collected from these people?	O	Yes		•	No)	amt.		
M.	Where is the revenue received reported in the	Cos	et Reno	vrt?	(Page/Line	Iten	<u></u>			
	Is cost of food (other than meals, e.g.,	- US	e repo	/1 L f	(Fagorenie	LUCII	1)			
	snacks at monthly staff meetings, board							If you are alfe-		
INI.	meetings) provided to employees included	0	Yes		•	No	ı	If yes, specify		
	in 2E?							cost.		
	III 2L;							TC 'C		
O.	Is any revenue collected from employees?	0	Yes		•	No	ı	If yes, specify		
								amt.		
Р.	Where is the revenue received reported in the	Cos	t Reno	rt?	(Page/Line)	Item	1)			

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

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

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

Name of Fa		License		Report for Y		Page of 19 37	
Mattatuck I	Health Care Facility, Inc.		144	9/30/2015	T		
						Residential Care	
	Item	1	Total	CCNH	RHNS	Home	
3. Laund a. In-l 1.	ry House Processing* Bed linens, cubicle curtains, draperies,	Lbs.					
	gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	12,135		12,135		
2.	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. \$					
	chased Services (by contract other	\$					
	n through Management Services)						
	omplete Schedule C-2 att. Page 21)						
	nagement Services**	\$					
d. Oth	er (Specify)	\$					
3E. Total	Laundry Expenditures (3a + b + c + d)	\$	12,135		12,135	(Control (Co	
3F. Laund	ry Questionnaire						
G. Is cost	of employee laundry included in 3E? O	Yes	•	No	If yes, specify cost.		
H. Did yo	ou receive revenue from employees?	Yes	•	No	If yes, specify amt.		
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)							
Is Cos	t of laundry provided to persons other	Yes		No	If yes, specify cost.		
K. Did yo	nu receive revenue from these people?	Yes	• • • •	No	If yes, specify amt.		
L. Where	is the revenue received reported in the Cost	Report?		(Page/Line	: Item)		

^{*} Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4. All allocations should add to total recorded in 3E.

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

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

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.	Ren	ort for Year E	nded	Page	of
Mattatuck Health Care Facility, Inc.	144	""	9/30/2015		20	37
			3.50,50 10		<u> </u>	1 2
						Residential
Item			Total	CCNH	RHNS	Care Home
4. Housekeeping	Sq. Ft. Serviced			007177	XUINS	Caro Home
a. In-House Care	by Personnel					
1. Supplies - Cleaning (Mops,	Amt.	\$	7,976		7,976	
pails, brooms, etc.)		."	1,521.0		,,,,,	
b. Purchased Services (by contract other	Sq. Ft. Serviced					
than through Management Services)	by Personnel					
(Complete Schedule C-2 att.	Amt.	\$				
Page 21)		ĺ				
c. Management Services*		\$				
d. Other (Specify)		\$				
4E. Total Housekeeping Expenditures (4a +	b+c+d)	\$	7,976		7,976	
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		\$				THE PARTY OF THE P
2. Purchased from		\$				
					0.00	
b. Medicine Cabinet Drugs		\$	3,273		3,273	
c. Medical and Therapeutic Supplies		\$	22,996		22,996	
d. Ambulance/Limousine***		\$	to the said			
e. Oxygen						
 For Emergency Use 		\$				
2. Other***		\$	(1,025)		(1,025)	
f. X-rays and Related Radiological		\$[
Procedures***						
g. Dental (Not dentists who should be incl	luded under	\$	VIVI LOVI AND THE STATE OF THE		- Altragamental Control	
salaries or fees)						
h. Laboratory***		\$			96,	
i. Recreation		\$	12,108		12,108	
j. Other (Specify)****		\$	10,975		10,975	
See Attached Schedule	_					
5K. Total Resident Care Expenditures (5a - 5		\$	48,423		48,423	

^{*} 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
Part A RX (See Pg 29)		\$ 2,727	
Part A MD (See Pg 29)	100	\$ 1,877	
VA Meds (See Pg 29)		\$ 6,371	
			partition and an arrangement of the second
	nasti usay isah da mini di sat		animates especially and
			78h (1995)
	en de la companya de la companya de la companya de la companya de la companya de la companya de la companya de		
			0.00 (0.30)
		THE RESIDENCE OF THE SECOND	
Total Other Resident Care	\$ -	\$ 10,975	\$ -

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

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

Name of Facility Mattatuck Health Care Facility, Inc.	y, Inc.			License No. 144	Report for Year Ended 9/30/2015	70			Page 21	of 37
		Related ** to Owners, Operators, Officers	to Owners, Officers				Total Cost	Total Cost/Page Ref.***		
Name of Individual or Company	Address	Yes	No	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	Residential Care Home	ل 20	Line
A CONTRACTOR OF THE CONTRACTOR		0	0)	
TO THE PROPERTY OF THE PROPERT		0	0							
		0	0							
TO MAKEUM		0	0							
		0	0							
		0	0							
	- Arthur W	0	0							
		0	0							
		0	0							
		0	0							
		0	0							
And the second s		0	0							
		0	0	n de de la companya d			:			
		0	0							
* Tital 1000 1000 sections of the section of the se	A Aylar @10 000 Tlas	monacount if another in the contract	to the state of th							Ī

^{*} 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
Mattatuck Health Care Facility, Inc.	144	9/30/2015			22	37
					Resider	tial Care
Item		Total	CCNH	RHNS	Н	ome
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	27,032		27,032		
b. Heat	\$	30,772		30,772		
c. Light & Power	\$	24,924		24,924		
d. Water	\$	9,374		9,374		
e. Equipment Lease (Provide detail on p	age 6) \$	2,106		2,106		
f. Other (itemize)	\$					
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a -	6f) \$	94,207		94,207		
7. Depreciation (complete schedule page 23	*)					
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$	1,400		1,400		
d. Movable Equipment	\$	4,876		4,876		
*7e. Total Depreciation Costs $(7a + b + c + d)$	\$	6,276		6,276		
8. Amortization (Complete att. Schedule Page	ge 24*)					
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other (Specify)	\$					
*8e. Total Amortization Costs (8a + b + c + d) \$					
9. Rental payments on leased real property l	ess					
real estate taxes included in item 10b	\$	258,500		258,500		
10. Property Taxes						
a. Real estate taxes paid by owner	\$	28,165		28,165		
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	<u> \$</u>	2,526		2,526		
11. <i>Total Property Expenses</i> (7e + 8e + 9 +	10) \$	295,467		295,467		

^{*} 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
			Section 1
		0.00	(#916) (164)
	9.00		0.50
	Advantage Advantage Control of		100 S
		6.4.4.5.5.5.5.5	
The second secon			100
	almanida (dieno) ne e		
			(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)
	100000000000000000000000000000000000000		1000000
			Leading and the second
	300000 MG1	2 H 6/12 (15) (1995) (10) (1996)	
	92(5)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)		
Total Other Repairs and Maintenance	\$ -	\$ -	\$ -

State of Connecticut
Annual Report of Long-Term Care Facility
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Depreciation Schedule

				Debreci	Depreciation Schedule	neanie					
Name of Facility Mattatuck Health Care Facility, Inc.				License No. 144	_		Report for Year Ended 9/30/2015	pəpu		Page 23	of 37
				Diotorion			Accumuniated				
				Cort	1		Depression to	Mostrados			
				Exclusive of	Salvage	Cost to Be	Reginaring of	Committing	Heefin	Denreciation	
Property Item				Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
A. Land Improvements								•			
1. Acquired prior to this report period				149,113		149,133					
2. Disposals (attach schedule)		•									
3. Acquired during this report period (attach schedule)	ch schedule)										
A-4. Subtotal			155000								
B. Building and Building Improvements											
1. Acquired prior to this report period				53,324		53,324	53,324				
2. Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)	ch schedule)										
C. Non-Movable Equipment										20002	
1. Acquired prior to this report period				22,956		22,956	20,156			1,400	
2. Disposals (attach schedule)											
	ch schedule)										
											1,400
	Is a mileage										
	logbook		ğ.	Historical			Accumulated				
-	maintained?	Acquisition	ition	Cost	Less		Depreciation to	Method of			
			200	Exclusive of	Salvage Value	Cost to Be	Beginning of	Computing	Useful I ife	Depreciation for This Year	Totals
D Mexichle Benimment	I CS I NO	Monta	rear	Laur	v attro	Depreciated	1 car 3 Operations	Срисовнош	arror	JOL 11115 1 Cal	LOTAIS
and wast of each walnula)											
and year of each venture)											
b.											
Ċ											
ď											
2. Movable Equipment											
a. Acquired prior to this report period		mesi		84,451		84,451	64,440			3,941	
		7									
c. Acquired during this report period											
(attach schedule)				4,674						935	
D-3. Subtotal											4,876
E. Total Depreciation											6,276

Mattatuck Health Care Facility, Inc. 9/30/2015

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
		0.000		
220 (05/04)2 (6/20)		100000000000000000000000000000000000000		100
CONTROL OF CONTROL			100 100 100 100 100	0.000
l'otal additions for	Land Improvements	\$	ALC: 100 (201 (201 (201 (201 (201 (201 (201	\$
Deletions:				
		100 30 60	102 miles 20 2	
			5 3 3 3 3	
		0.00	8 6 8 9 8	2.0.0
		1.00 91.00 02.0		0.000,000,000,000
/AGNASA AGNASA NA ANTA	and the state of t	500219 600 000 000 0	986 100 330 350 10	100 400 20 20 00
		50.00 (Sec. 2008)	02/219/5/22/01/2/02	200000000000000000000000000000000000000
otal deletions for	Land Improvements	\$ -	0.40x.000x.000x.000x.00	\$ -

^{*}Ties to Page 23, Line A3

Schedule of Building Improvements Acquired during this report period

	ovenicates Acquired during this report period		Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:			l	T
			200	
	Programme and the second secon			
				68.020.53.000.5
				180 18 18 18
			W. S. S. S.	
otal additions for Buildir	ig Improvements	\$ 00-20-20-2	40 (0.00)	\$
Deletions;				
				(0.29) (2.10) (0.20) (0.20) (0.20)
	The state of the s			300 (300 (300 (300 (300 (300 (300 (300
1334 (334 491) (314 493 493 493 493 493 493 493 493 493 49				
			100000000000000000000000000000000000000	
Fotal deletions for Buildin	g Improvements	\$ -		s -

^{*}Ties to Page 23, Line B3

Schedule of Non-Movable Equipment Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:			1	
Angelijke gerene (angelijk		D 00 00 (5) (5)		
www.mgreeleadra.com			10.450.000.050.0000	1000 (2000)
The first Control of C				100 000 000 000 000
			1000	100 mars 100 mars 100 mars
to desprecipio programma de la compansa del compansa del compansa de la compansa		8 (CO) (CO) (CO) (CO) (CO) (CO) (CO) (CO)	940 HO 100 100 HO 10	
9 (25) 18[20] GC JANES (27) 28		77/2521(30)11/35(00)000	100 mg (100 mg	1538140337,0255,031,022
Total additions for	l r Non-Movable Equipment	\$ -	77. 171.	\$ -
Deletions;				
5 00 19 700 50 50 50		502076954800601	16/12/6/6/16	125 125 125 125 125
0.85.85.05.75.05		10/2003/03/03/03/03	100100000000000000000000000000000000000	1500000000000
4.45010000000000000000000000000000000000		202223500000000000000000000000000000000	VST 200 (4)7 (2)1 (4	1000 0000 GEO 1000 AS
Strong control logger land		and change by the second state of	# C C # C C C C C C C C C C C C C C C C	/61% 0165 / 100m (765 1105
			Street Manageria Della (P Street Manageria Della (PS)	
Tricial Discount	Non-Movable Equipment	on the second second	a composito de la composito de la composito de la composito de la composito de la composito de la composito de	6 - 10 - 10 - 10 - 10 - 10 - 10 - 10 - 1
Tarm Grichous for	ւմոր-առուռու։ Եվահաշու	\$ -	Presidente de la companya del companya de la companya del companya de la companya	\$ -

^{*}Ties to Page 23, Line C3
**Ties to Page 23, Line C2

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

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

Schedule of Movable Equipment Acquired during this report period

		Useful	
Description of Item	Cost	Life	Depreciation
NUCLE TO THE PARTY OF THE PARTY			
Couch	\$ 1,164	5	\$ 233
Refrigerator	\$ 3,510		\$ 702
			di Asir di Salahan
Movable Equipment	\$ 4,674	(c. 5) - 3(Z. (5) - 3()	\$ 935
	IF COLUMN DE AGE		
	25 25 26 6 6 6 6	2016682235009620485	090 082 300 000 000
		50 SEC 1919 SEC 1924	20 ASA (20 S2) (18
Movable Equipment	\$ -		\$ -
	Conch Refrigerator Moyable Equipment	Couch \$ 1,164 \$ 3,510	Description of Item Cost Life

^{*}Ties to Page 23, Line D2c

Schedule of Leasehold Improvements Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
				郭 美 道 医 迎
\$197,000,000,000,000,000			55 (6) (6) (6)	59 dis. 60 0 0
CERTAINS (1977) (1977) (1977)			100 (200 (200 (200 (200 (200 (200 (200 (60 (00 00 00 00
200 (50/2004) (40/2004)		337 (37 (22 (33 (33	082 (827) 639 (837) (832)	061) NG URBUNGS YERV
		45 (60 (60 (60 (60))	descripto della discolori	101000000000000000000000000000000000000
Total additions for	r Leasehold Improvement	-		\$ -
Deletions:				
NO SECURE DA SE AS		100 000 000 000 000		10.00
A CONTRACTOR OF				Valuation and make
9 20 20 30 60		100 St. 100 St. 100		
		900 (60 (60 (65 (65	26.00016.00.00	
100 March 100 Ma				
65 06 60 00 00 00		892000000000000000000000000000000000000	4 6 6 6 6 6	60 (60) (60)
Total deletions for	Leasehold Improvement	\$ -	Sp. 100-100 (19-10)	\$ -

^{*}Ties to Page 24, Line C3

^{**}Ties to Page 23, Line D2b

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

State of Connecticut

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

Amortization Schedule*

Name of Facility		License No.		Report for Year Ended	r Ended		Page	Jo
Mattatuck Health Care Facility, Inc.		144	4	9/30/2015			24	37
				Accumulated			7,7	
	Date of			Amort. to				
	Acquisition			Beginning of	Basis for			
		Length of	Cost to Be	Year's	Computing	Rate	Rate Amortization	
Item	Month Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
A. Organization Expense								
2.								
3.								
A-4. Subtotal								
B. Mortgage Expense								
1.								
2.								
3.								
B-4. Subtotal								
C. Leasehold Improvements and Other								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period								
(attach schedule)								
C-4. Subtotal								
D. Total Amortization								
		and the state of t					A CONTRACTOR OF THE CONTRACTOR	

* 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 En	ıded		Page of
Mattatuck Health Care Facility, Inc.	144	9/30/2015			25 37
II. Property Questionnaire					
Part A					
Is the property either owned by the Facilit	v				If "Yes," complete Part B.
or leased from a Related Party?*	, 0	Yes	•	NA	If "No," complete Part C.
*If any owner or operator of this facility is rel	lated by family 1	narriage ownershin ahi	lity to control or		,
business association to any person or organize					
a related party transaction.			\$21977 COM Tencopy (\$190 CO)		
Description		Total			
Date Land Purchased		28677			
2. Date Structure Completed					
3. If NOT Original Owner, Date of Purc	hase	07/06/78			
4. Date of Initial Licensure		40		6.4	
5. Total Licensed Bed Capacity		16,186			
6. Square Footage 7. Acquisition Cost		10,180			
a. Land		<u> Wasala Afrika Basala sala sala</u>			
b. Building					
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing		Tot two regage	2110 1110111345	over word Berbe	,
a. Type of Financing (e.g., fixed, var	iable)			No.	
b. Date Mortgage Obtained					
c. Interest Rate for the Cost Year					
d. Term of Mortgage (number of year	rs)				
e. Amount of Principal Borrowed					
f. Principal balance outstanding as or	f				THE AND THE PROPERTY OF THE PR
Complete if Mortgage was Refinance	ed				
During Current Cost Year					
g. Type of Financing (e.g., fixed, var	iable)				
h. Date of Refinancing					
i. New Interest Rate	·				
j. Term of Mortgage (number of year	rs)				
k. Amount of Principal Borrowed	1.066	<u> </u>			
Principal Outstanding on Note Pai					V 1400
Part C - Arms-Length Leases for Re				Term of Lease	Annual Amount of Lease
Name and Address of Lessor	- Pro	perty Leased	Date of Lease	Term of Lease	Annual Amount of Lease
					44,004
			<u> </u>		

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
Mattatuck Health Care Facility, Inc.	144		9/30/2015			26 37
						Residential Care
Item			Total	CCNH	RHNS	Home
12. Interest						
A. Building, Land Improver	nent & Non-Movabl	e				
Equipment 1. First Mortgage		\$				
Name of Lender		Rate				
		Trait				
Address of Lender						
2. Second Mortgage		\$	3600477		Erik Pelingerah Karapatan Ka	
Name of Lender		Rate				
Address of Lender						
radioss of Lender						
3. Third Mortgage		\$				
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage		\$				
Name of Lender		Rate				
Traine of Bender		Rato				
Address of Lender		1	l.			
B. CHEFA Loan Informatio	n					
1. Original Loan Amoun	t	\$	•			
2. Loan Origination Date	;					
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expe	nse					
12 B7. Total Building Interest Expe	use (M1 - M4 ± B3)	\$	10	Subtotals fo	7.	

(Carry Subtotals forward to next page)

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

Name of Facility Mattatuck Health Care Facility, Inc	se No. 144		Report for Ye 9/30/2015	ear Ended	···	Page of 27 37
Triattation House Caro Laomy, Inc						Residential
Item			Total	CCNH	RHNS	Care Home
	ubtotals Bro	ught Forward:				
12. C. Movable Equipment						
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender	1	·				
Address of Lender			-			
2. Other (Specify)		\$		1000		
A. Item	Rate	Amount				
Lender						
Address of Lender			-			
B. Item	Rate	Amount				
Lender		<u> </u>				
Address of Lender						
12. C. 3. Total Movable Equipment Ir	iterest					
Expense (C1 + 2)		\$			40.400	
12. D. Other Interest Expense (Specify)	\$	19,590		19,590	
Bank & Lease Interest						
13. Total All Interest Expense (12B7 +	1203 + 120	9) \$	19,590		19,590	
14. Insurance	1400 1 141	<i>γ</i> Ψ	17,570		.,,,,,	
a. Insurance on Property (building	s only)	\$	27,219		27,219	
b. Insurance on Automobiles		\$				
c. Insurance other than Property (a	s specified a	above)				
1. Umbrella (Blanket Coverage		\$				
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$	NISCONO PARA DE LA CONTRACTOR DE LA CONT	BANDASSET OLIVADAN SAMAAA		Hansananian Nazaranian Nazaranian
14d. Total Insurance Expenditures (14a	(a+b+c)	\$	27,219	A CONTRACTOR OF THE PROPERTY O	27,219	
15. Total All Expenditures (A-13 thru		\$			1,906,125	

D. Adjustments to Statement of Expenditures

Name	e of Fa	acility		Li	cense No.	Report for Ye	ar Ended	Page	of
Matta	atuck l	Health	Care Facility, Inc.		144	9/30/2015		28	37
					Total			1	
Item	Page	Line			Amount of			Residen	tial Care
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	Но	me
Page	10-5	alari	es and Wages						
1.			Outpatient Service Costs	\$					
2.			Salaries not related to Resident Care	\$					
3.			Occupational Therapy	\$					
4.			Other - See attached Schedule	\$	·				
Page	13 - I	rofes	sional Fees						
5.			Resident Care Physicians **	\$				1000	
6.			Occupational Therapy	\$					
7.			Other - See attached Schedule	\$					
Pages	s 15 &	16 -	Administrative and General						
8.			Discriminatory Benefits	\$					
9.			Bad Debts	\$					
10.			Accounting & Legal	\$					
11.			Telephone	\$					
12.			Cellular Telephone	\$					
13.			Life insurance premiums on the life	7					
			of Owners, Partners, Operators	\$	15,894		15,894		
14.			Gifts, flowers and coffee shops	\$	10,05				· · ·
15.			Education expenditures to colleges or	- 4		4			
			universities for tuition and related costs						
ĺ			for owners and employees	\$					
16.			Travel for purposes of attending						
10.			conferences or seminars outside the						
			continental U.S. Other out-of-state						
			travel in excess of one representative	\$					
17.			Automobile Expense (e.g. personal use)	\$					
18.			Unallowable Advertising *	\$	610		610	· · · · · · · · · · · · · · · · · · ·	
19.			Income Tax / Corporate Business Tax	\$	20,333		20,333		
20.			Fund Raising / Contributions	\$	250		250		
21.			Unallowable Management Fees	\$	2,50				
22.			Barber and Beauty	\$					
23.			Other - See attached Schedule	\$	1,303		1,303		
	18 - D		Expenditures	Ψ	1,505		1,505		
24.	<u> </u>		Meals to employees, guests and others						
			who are not residents	\$					
Page	 19 - I.		ry Expenditures	Ψ					
25.	- 		Laundry services to employees, guests						
-2.			and others who are not residents	\$					
Page	20 - H		geeping Expenditures	Ψ					
26.	- U - 11		Housekeeping services to employees, guests	_					
20.			and others who are not residents	\$			- W		
			Subtotal (Items 1 - 26)		38,390		38,390		
			Subtotal (Items 1 ~ 20)	Φ		urv Subtotal fe			

^{*} 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
					sar on said the early
din 107 (2018)	7 m m m		District Control	or all three sections	60 65 50 65 90 0
				10 10 10 10 10	3 30 65 60 35
					2.00.00.00
			(2. (30.4)) sec. (4. (4. (4. (4. (4. (4. (4. (4. (4. (4		and the second second
Total Othe	r Salaries	Adjustment	\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
				10.09	
	5 015 000 Mary				
			9.6 (0.0)	4 4 6 5 5	
				Application of the	
0.00			0.30 (0.10 (0.10		
92232 (5)033				0.000	0.0000000000000000000000000000000000000
Total Othe	r Fees Adj	ustments	\$ -	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
16	m13	Late Fees	ASSOCIATION OF THE PROPERTY OF	\$ 276	
GRANGE CONTRACTOR CONT	Accesses to the Control of the Control	Chamber of Commerce	7 1 7 7	\$ 627	50.5
SUZZANO/CONSON	ISANOSINAV/NORSIGNOSINISIS	Lions Club		\$ 400	0.000
				All the second second second	
0.00	0.000 (0.000)				
	TO THE PERSON OF				
Total Othe	r A&G Ad	justments	\$ -	\$ 1,303	\$ -

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

			D. Adjustments to Stateme					
	e of Fa			Li	cense No.	Report for `	Year Ended	Page of
Matt	atuck I	Healtl	Care Facility, Inc.		144	9/30/2015		29 37
	_	<u> </u>			Total			
1	Page				Amount of			Residential Car
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	Home
			Subtotals Brought Forward	\$	38,390		38,390	
	20 - K	Reside	nt Care Supplies***					
27.			Prescription Drugs	\$				
28.			Ambulance/Limousine	\$				
29.			X-rays, etc	\$				
30.			Laboratory	\$	96		96	
31.			Medical Supplies	\$				
32.			Oxygen (non emergency)	\$	(1,025)		(1,025)	
33.			Occupational Therapy	\$			· · · · · · · · · · · · · · · · · · ·	
34.			Other - See Attached Schedule	\$	10,975		10,975	
Page	22 - N	<i>Lainte</i>	enance and Property					
35.			Excess Movable Equipment Depreciation					
			See Attached Schedule	\$				
36.			Depreciation on Unallowable	Ì				
			Motor Vehicles	\$			W	
37.			Unallowable Property and Real	Ť				
			Estate Taxes	\$				
38.			Rental of Building Space or Rooms	\$				
39.			Other - See Attached Schedule	\$				
	27 - II			Ť				
40.			Mortgage Insurance	\$				
41.			Property Insurance	\$		·		
	- Mis			Ψ			,	
42.	1/215		Research or Experimental Activities	\$				
43.			Radio and Television Revenue	\$				
44.			Vending Machine Revenue	\$				
45.			Purchase Discounts and Allowances	\$				
46.			Duplications of functions or services	\$				
47.			Expenditures made for the protection,	φ				
'''			enhancement or promotion of the	STATE OF THE PARTY				
			providers interest	١				
48.			Interest Income on Accounts Rec	\$				
49.			Other (include personnel and other	Φ				
1771								
			costs unrelated to resident care) - See	Ţ				
Not E	on Dec		Attached Schedule	\$				
	or Pro		oviders Only					
50.			Building/Non Movable Eq. Depreciation	100				
			Unallowable Building Interest -					
	T-4:3		See Attached Schedule	\$,			
ΣΙ.	i otal z	Amou	nt of Decrease (Items 1 - 50)	\$	48,436		48,436	

^{***} 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.

Mattatuck Health Care Facility, Inc. 9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNII	RHNS	Residential Care Home
20	5j	Part A RX	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	\$ 2,727	0.0000000000000000000000000000000000000
20	5j	Part A MD		\$ 1,877	
20	5j	VA Meds	80 SS 130 SS	\$ 6,371	
24.310.002.00					
192 (1) (2)			1000 150 100 100 100	9.06 (6.06) (6.06)	
	45 (10) (10)				0.00 0.00 0.00
56 32 55					50 70 70 69 50 69
100					
160 60 200 20			10 SE SE SE NO		00 852 953 853 854 65
			0.00	9 (6) (6) (8)	
Total Othe	r Ancillary	Costs	\$ -	\$ 10,975	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
	10.00				1000 2000
100 (27 (30)	21-0-41-02-02	BEAUTION OF THE TOTAL CONTRACT OF THE TOTAL			
40 MA SELS	ra var sanda				
					8 6 0 6 6 6
			40 % (for 18)		
17 CHARLES NO.	SADAS VOST RESELLAS		100 (84 193 (81) (81)		
0.043648048			100 SE SE SE	8 6 6 6 6	67,000,000,000,000,000
Total Exce	ss Movable	e Equipment Depreciation	\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
	8 S 8 8		ing an south on		
2.00			10 00 00 00 00		
- 10/10/12/20	(0.000000000000000000000000000000000000		4 (2) (3) (5) (5)	505	
				100.000.00	
	63 (103 Ale 15)		2015.00		
	100000000000000000000000000000000000000			0.000	
Total Othe	r Property	Adjustments	\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
4. 33 45 3					1 10 75 85 50 65
	4 50 05 15				500 000 100 CE
				10 M 42 M	
			351.22 (89.72) (65.7	2.52-55 (\$455) (EE	and do do ships
	G (distance)		0.000	0.00 (0.00)	100 02 00 00 00
	G1 (67 (6) (4)			100 000 000 000	40 (0.00)
50 (0) (0)	(2) (2) (4) (5)		30 /S. 03 (Gov.)	0.05 (0.06.0)	100000000000000000000000000000000000000
3 0 0 3					
45.000				670 00 000 000 000	60.00.00.00.00
Total Othe	r Adjustme	ents	\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
.,54,626,653,67	16 18 18 18		30 32 35 53 53	50 00 00 05 0	0.020.000.000.000.000
	vio (5) (5)			-0.000000000000000000000000000000000000	
			(50) 55 (50) 161 (61)	es alcade es es	1000
20 (20)220 (6)			55 50 50 Section		100000000000000000000000000000000000000
				0.0000000000000000000000000000000000000	
			40/12/19/19/19/19		17 1940 19 19 19
		500004438 - 5000		V-0 00 00 00 00	
			147 (0), 65, 664 (0)		
	33 (300)00				0.0000000000000000000000000000000000000
Total Unal	lowable Bi	ilding Interest	\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility Mattatuck Health Care Facility, Inc. License No. 144	, 011.	Report for Y-9/30/2015	ear Ended		Page of 30 37
					Residential Care
Item		Total	CCNH	RHNS	Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (CT only)	\$	1,672,654		1,672,654	
b. Medicaid Room and Board Contractual Allowance **	\$				
2. a. Medicaid (All other states)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (all inclusive)	\$	60,249		60,249	
b. Medicare Room and Board Contractual Allowance **	\$				
4. a. Private-Pay Residents and Other	\$	207,708		207,708	
b. Private-Pay Room and Board Contractual Allowance **	\$				
II. Other Resident Revenue				###	
1. a. Prescription Drugs - Medicare	\$				
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
2. a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$				
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$				
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	€9				
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.)	\$	1,940,611		1,940,611	
IV. Other Revenue*					
Meals sold to guests, employees & others	\$	MAXIMUM DANGER PARTY OF THE PAR	DOSESSED CONTRACTOR OF THE PARTY OF THE PART		
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
Rental of Television and Cable Services	\$				
5. Interest Income (Specify)	\$				
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$,
8. Other (Specify)	\$	22,568		22,568	
V. Total Other Revenue (1 thru 8)	\$	22,568		22,568	
VI. Total All Revenue (III +V)	\$				
(A) AGINEZHI REFERINC (III · 1)	Ψ	1,963,179		1,963,179	l

^{*} 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

				Residential
Page Ref Des	scription	CCNH	RHNS	Care Home
15-200-000000000000000000000000000000000				
10 10 10 10 10 10 10 10 10 10 10 10 10 1			365 (SE SE SE SE	especially and plantage
5.6000		100 St. 60 St.	G. 183 A. 181 (8)	95.552.551.551.55
544500000			\$94,652,653,566,66 <u>\$</u>	35 (53 A) side (65
10				
Total Other R	esident Reyenue - Medicare	\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

				Residential
Page Ref	Description	CCNH	RHNS	Care Home
130 March 1986		a dia sensia asal	60 30 80 60 60	
19-10-30-10-10-10-10-10-10-10-10-10-10-10-10-10		automora aes nesset	50.00.00.00	66 85 West 15
			0.000	
55/75/1000		6 6 16 6		
		0.000 50 55 52		
		5 555 100 450 459 6	100000000000000000000000000000000000000	Action of the
Total Oth	er Resident Revenue	\$ -	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	Residential Care Home
107140007-009		6.000			
es en albert				2589 PAGE (GR. 4071) JA	000 400 000 000 000
			0.80 55 55 50 0	100 60 (6) (6) (6)	
55.657.650			6.5.5.5.5		30 50 50 50
Total Inter	rest Income		\$ -	\$	\$

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
30	Related Party Interest Income		\$ 22,568	
07900000 10000 05300000 0530				15 Day 04 July 10
		81.108.108.180.180.180.1	V (000 100 000 1000 100	de de partir
100		5 (60 AS) (65 (65))	0.0000000000000000000000000000000000000	jan (2) jakos sa es
		s and the same		
		aran da ka	45 55 76 55 0	100 (60 (8) (6)
			40.000 95.000 0	31 (1 (1 (1)
12000		es association in a market	0.000	169 269 000 2016
(68) 690 (50)		Grand and the second		VIII. 15 (1) (1) (1)
463 000 vaktor				2.00 (1.01 (2.01.0)
327 626 938	en en en en en en en en en en en en en e			
Total Othe	r Revenue	\$	\$ 22,568	\$

G. Balance Sheet

	f Facility	License No.	Report for Year Ended	Page	of
Mattatu	ck Health Care Facility, Inc.	144	9/30/2015	31	37
		Account			Amount
Assets					
	urrent Assets			m	104.075
1.			n 1 n 1 . \	\$	184,075
2.		,		\$	167,743
3.		(Excluding Owners or I	Related Parties)	\$	1.700
4	Inventories			\$	1,720
5.	Prepaid Expenses			\$	3,168
	a. Prepaid Insurance		2,722		
	b. Prepaid Taxes		446		
	с				
	d.				
6.				\$	
7.				\$	
8.	Other Current Assets (itemiz		201.601	\$	826,703
	Due from Carriage (Related Pa Due from Geron (Related Party		204,684 338,247		
	Due from Tricare (Related Par		283,772	-	
	-				
A-9. To	otal Current Assets (Lines Al	thru 8)		\$	1,183,408
B. Fi	xed Assets				
1.	Land			\$	
2.	Land Improvements	*Historical Cost		\$	
	-	Accum. Depreciation	n Net		
3.	Buildings	*Historical Cost	53,325	\$	
		Accum. Depreciation	53,325 Net		
4.	Leasehold Improvements	*Historical Cost		\$	
	•	Accum. Depreciation	n Net		
5.	Non-Movable Equipment	*Historical Cost	22,956	\$	1,400
	* *	Accum. Depreciation			
6.	Movable Equipment	*Historical Cost	89,124	\$	19,808
		Accum. Depreciation			·
7.	Motor Vehicles	*Historical Cost		\$	
		Accum. Depreciation	n Net		
8.	Minor Equipment-Not Depre			\$	
9.	Other Fixed Assets (itemize)		\$	24,939
٠,	CR vs FS Depreciation	,	6,352		,
	CON in Progress		18,587		
B-10.	Total Fixed Assets (Lines B	t thru 9)		\$	46,147

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

G. Balance Sheet (cont'd)

		f Facility	License No.	Report for Year Ended		Page of
Matt	atu	ck Health Care Facility, Inc.	144	9/30/2015		32 37
			Account			Amount
				Total Brought Forward:	\$	1,229,555
C.	Le	asehold or like property record	led for Equity Purpose	S.		·
	1.	Land			\$	
	2.	Land Improvements	*Historical Cost	149,113		
			Accum. Depreciation	n Net	\$	149,113
	3.	Buildings	*Historical Cost			
<u> </u>			Accum. Depreciation	n Net	\$	
	4.	Non-Movable Equipment	*Historical Cost			
			Accum. Depreciation	n Net	\$	
İ	5.	Movable Equipment	*Historical Cost			
			Accum. Depreciation	n Net	\$	
	6.	Motor Vehicles	*Historical Cost			
			Accum. Depreciation	Net Net	\$	
		Minor Equipment-Not Depred			\$	
C-8		tal Leasehold or Like Properti	ies (C1 thru 7)		\$	149,113
D.		vestment and Other Assets				
		Deferred Deposits			\$	
		Escrow Deposits	ATT 1 1 0		\$	
	3.	Organization Expense	*Historical Cost			
		G - 1-31 (D - 1 - 1 O 1)	Accum. Depreciation	Net Net	\$_	M-M
		Goodwill (Purchased Only)	10 (11)		\$	
	Э.	Investments Related to Reside	ent Care (<i>itemize</i>)		\$	
		Loons to Owners on Beletad D	Ponting (italian)		Φ.	
	0.	Loans to Owners or Related P Name and Address	1 	Loan Data	\$	
		Name and Address	Amount	Loan Date		
	7.	Other Assets (itemize)			\$	
		· · · · · · · · · · · · · · · · · · ·			Ψ M	
D-8.	To	tal Investments and Other Ass	ets (Lines D1 thru 7)		\$	
		tal All Assets (Lines A9 + B10			\$	1,378,668

^{*} 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 Fac	cility		License No.	Report for Year I	Ended	Page	of
Mattatuck H	ealth	Care Facility, Inc.	144	9/30/2015		33	37
			Account			Am	ount
Liabilities							
A.	Cu	rrent Liabilities					
	1.				\$		134,841
	2.	Notes Payable (itemize)			\$		
	3.	<u> </u>		1	\$		
		Name of Lender	Purpose	Amount	Date Due		
		1 A 1 D		Pt - I-I - I doug outly			21,480
	4.	Accrued Payroll (Exclusive	\$		21,460		
	5.	Accrued Payroll (Owners of		oniy)			(2.502)
	6.	Accrued Payroll Taxes Pay			\$		(2,592)
	7.	Medicare Final Settlement			\$		
	8.	Medicare Current Financia			\$		
	9.	Mortgage Payable (Curren			\$		
		. Interest Payable (Exclusive	e of Owner and/or Re	elated Parties)	\$		10.50=
		. Accrued Income Taxes*			\$		18,697
	12.	Other Current Liabilities (•		\$		629,407
		Patient Trust	21,8	390 Line of Credit	488,347		
		Security Deposits		546 Accrued User Fee Tax	75,336		
		Deferred Tax Liability	8,2	238	<u></u>		
		Accrued Property Taxes		51			001.00
A-13	. To	<i>tal Current Liabilities</i> (Lin	es A1 thru 12))	801,833

^{*} 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	License No.	Report for Year	Ended	Page	of
Mattatuck Health Care Facility, Inc.	144	9/30/2015		34	37
	Account			Amou	ınt
		Total Broug	ht Forward:		801,833
Liabilities (cont'd)					
B. Long-Term Liabilities					
 Loans Payable-Equipment 	(itemize)		\$		
Name of Lender	Purpose	Amount	Date Due		
•					
		1			
	_				
2. Mortgages Payable		<u> </u>	l do		
2. Mortgages Payable3. Loans from Owners or Rel	otod Dantina (itawiza)		\$ \$		
Name and Address of Lender		I D	***************************************		
Name and Address of Lender	Amount	Loan D	ate		
A Od T m T 1192					
4. Other Long-Term Liabilitie	es (itemize)	# 0# F	\$		12,550
Advance Acceptance		7,075			
First Lease		5,475			
P					
B-5. Total Long-Term Liabilities (1	inec R1 thru 4)		To		12.550
C. Total All Liabilities (Lines A-			\$ \$		12,550 814,383
C. Total Sandantes (Linios II.			10		014,303

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

	ne of Facility tatuck Health Care Facility, Inc.	icense No.	Report for Year Ended 9/30/2015		Page 35	of 37
iviai				nount		
Α.	Reserves	Account		\top		
	Reserve for value of leased lan	d		\$		
	Reserve for depreciation value to be amortized	of leased build	lings and appurtenances	\$		149,113
	3. Reserve for depreciation value	of leased perso	onal property (<i>Equity)</i>	\$		
	4. Reserve for leasehold real prop	erties on which	h fair rental value is based	\$		
	5. Reserve for funds set aside as o	lonor restricted	1	\$		
-	6. Total Reserves			\$		149,113
В.	Net Worth 1. Owner's Capital			\$		
	2. Capital Stock			\$		45,000
	3. Paid-in Surplus			\$		
	4. Treasury Stock			\$		(138,391)
	5. Cumulated Earnings			\$		451,511
	6. Gain or Loss for Period	10/1/2	014 thru 9/30/2015	\$		57,054
	7. Total Net Worth	<u> </u>		\$		415,173
C.	Total Reserves and Net Worth			\$		564,286
D.	Total Liabilities, Reserves, and No	et Worth		\$		1,378,670

H. Changes in Total Net Worth

Nan	ne of Facility	License No.	Report for Year	r Ended	Page	of
Mattatuck Health Care Facility, Inc.		144	9/30/2015		36	37
		Account			Am	ount
A.	Balance at End of Prior Period as s	hown on Report o	f 09/30/2014		\$	456,916
B.	Total Revenue (From Statement of Revenue Page 30)				\$	1,963,179
C.	Total Expenditures (From Statement of Expenditures Page 27)				\$	1,906,125
D.	Net Income or Deficit				\$	57,054
E.	Balance				6	513,970
F.		Additions				
	1. Additional Capital Contributed					
<u> </u>						
	2. Other (itemize)					
ĺ						
F-3.	Total Additions			9		
G.	Deductions				,	
		Drawings of Owners/Operators/Partners (Specify)			3	
	Name and Address (No., City,		Title	Amount		

	2. Other Withdrawings (Specify)					
	Purpose	Amount				
	3. Total Deductions					
Н.	H. Balance at End of Period 09/30/15					513,970

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page of				
Mattatuck Health Care Facility, Inc.	144	9/30/2015	37 37				
Check appropriate category							
Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☑ Residential Care Home					
Additional Care Facility, Inc. Check appropriate category Chronic and Convalescent Nursing Home only (CCNH) Rest Home with Nursing Supervision only (RHNS) Preparer/Reviewer Certification I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility. Signature of Preparer Title Date Signed Date Signed Printed Name of Preparer							
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							
Signature of Preparer	Title Partner		6				
Printed Name of Preparer							
Craig J. Lubitski Consulting LLC							
Address		Phone Number					
225 Pitkin Street, East Hartford, CT 06108		860-610-9009					