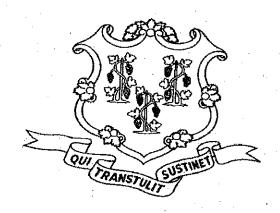
### **State of Connecticut**



### Annual Report of Long-Term Care Facility

Cost Year 2015

Name of Facility (as	licensed)							
Morning Star Reside	ntial Care Hom	e, Inc.						
Address (No. & Stre	et, City, State, 2	Zip Code)						
38 Elizabeth St, PO	Box 187, Kent,	CT 06757						
Type of Facility								
Chronic and C	Convalescent		Rest Home wi	th Nursing	2			
☐ Nursing Home	e only		Supervision or	-	•	Residential	Car	e Home
(CCNH)			(RHNS)	•				
Report for Year Begi	inning		Report for Yea	ar Ending				
10/1/2014	C		9/30/2015	-				
License Numbers:		CCNH	RHNS	Resid	dential Care Home Med 1884		licare Provider	
Medicaid Provider N	umbers:	CC	NH	RI	INS		ICF	'-IID
For Department Us	e Only						. "	
Sequence Number	Signed and	Date	Sequence N	Jumber	Cianal		1	D . D . 1
Assigned	Notarized	Received	Assign	ed	Signed an	nd Notarize	a	Date Received
			<u> </u>					
							-	

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### **General Information**

N	Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
N	Morning Star Residential Care Home, Inc.	1884	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 Morning Star Residential Care Home, 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.

Signed (Administrator)		Date	Signed (Owner)	Date
,				
Printed Name (Administrator)			Printed Name (Owner)	
,				
Brian Gulian			Brian Gulian	
Subscribed and Sworn	State of	Date	Signed (Notary Public)	Comm. Expires
to before me:	e e la companya de l	and the second of		
to before me.				
•				/ /
Address of Notary Public				

(Notary Seal)

### State of Connecticut Department of Social Services

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	tm	ent		Page	of
				1A	37
Name of Facility		Period Cov	ered:	From	То
Morning Star Residential Care Home, Inc.				10/1/2014	9/30/2015
Address of Facility 38 Elizabeth St, PO Box 187, Kent, CT 06757					
Report Prepared By		Phone Nun	nber	Date	
Davis, Mascola & Phillips, LLC		203-265-04	188		
		m . 1	GOTT	DIDIG	Residentia 1 Care
Item		Total	CCNH	RHNS	Home
1. Dietary wages paid	\$			_	
2. Laundry wages paid	\$			ļ	
3. Housekeeping wages paid	. \$				
4. Nursing wages paid	\$				
5. All other wages paid	\$				
6. Total Wages Paid	\$				
7. Total salaries paid	\$			<u> </u>	
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.** 

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

	1	e No. of Fac 027-3272	ility	Report for Ye 9/30/2015	ear Ended	Page 2	of 37
Name of Facility (as shown on license)			· e	19/30/2013 Street, City, Ste	ata Zin )	<u> </u>	31
Morning Star Residential Care Home, Inc.	3	•		PO Box 187, K		6757	
CCNH				dential Care H		***	Provider No.
License Numbers:		Idii	1001		884	TIXOUIOUIO I	1071401 110.
Type of Facility (Check appropriate box(es))							
Chronic and Convalescent Nursing Home only (CCNH)	1	Home with I rvision only		- IVI	Residenti	al Care Hon	ne
Type of Ownership (Check appropriate box)							
O Proprietorship O LLC O Partnership	0	Profit Corp.	0	Non-Profit Co	rp. O	Government	O Trust
If this facility opened or closed during report year provi	de:		Date	e Opened	Date Clos	sed	
Has there been any change in ownership							
or operation during this report year?	0	Yes	•	No	If "Yes,"	explain full	у.
	·						·
Administrator							
Name of Administrator				Nursing Ho			
Brian Gulian				Administra	l l		
	/0.11		0.1	License 1	No.:		
Other Operators/Owners who are assistant administrato	rs (full c	or part time)	ot th	•	T		
Name				License 1	NO.:		

### General Information and Questionnaire Partners/Members

Name of Facility		License No.	Report for Y	ear Ended	Page of
Morning Star Residential Care	Home, Inc.		9/30/2015		3 37
				State(s) and/o	or Town(s) in
Legal Name of Part	tnership/LLC	Business A	Address		egistered
Morning Star Residential Care		38 Elizabeth St,	PO Box	СТ	
		187, Kent, CT 0			
Name of Partners/Members	Business A	ddress		Title	% Owned
Brian Gulian	57 Brook Rd, Valley S	tream NY	Member		100
Dian Ganan	11581	or ourning 1 1 2			100
·					
<u> </u>					
		- w			
		We.			

### General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year En	ded	Page of
Morning Star Residential Care Home, Inc.	1884	9/30/2015		3A 37
If this facility is owned or operated as a corpo	oration, provide the	e following informa	tion:	
Legal Name of Corporation	Busines	s Address	State(s) in Whi	ch Incorporated
				No. Shares
Name of Directors, Officers	Busines	s Address	Title	Held by Each
				Held by Each
·				
•	·			
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		Report for Year Ended	Page	of
Morning Star Residential Care Home, Inc.	1884	9/30/2015	3B	37
If this facility is owned or operated as an individua		rovide the following informat	ion:	
	ner(s) of Facility			
	111111111111111111111111111111111111111		<u></u>	
· · · · · · · · · · · · · · · · · · ·			•	
			<u></u>	<u></u>

State of Connecticut
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### General Information and Questionnaire Related Parties\*

ŧ1.

Name of Facility Morning Star Residential Care Home, Inc.		License N	No. 1884	Report for Year Ended 9/30/2015		Page 4	of 37	
Are any individuals rece marriage, ability to contr	Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?	cility rel	gno	th © Yes O No	If "Yes," provide the Name/Address and complete the information on Page 11 of the report.	le Name/Ado	fress and ge 11 of the report.	
Are any individuals or concluding the rental of purelated through family as	Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business	or servic o this fa control,	es, ility, or business	• Ves O No	1. 1. ZAH JI			
association to any or the	association to any of the owners, operators, or otherars of this facility:	or ciris la	CHILLY :		II I es, provide the following information:	guranita a	IIIIOIIIIIIIIIII	
		Alsc	Also Provides		Indicate Where			
		Goods	Goods/Services to		Costs are Included			
Name of Related	Business	Non-R(	라	Description			Actual Cost to the	
Individual or Company	Address	Yes	No   %**	**   Provided	Page # / Line #	Reported	Related Party	
Brian Gulian	38 Elizabeth St, Kent CT 06757	0	•	Officer Loan	P 34, L b3	19,083	19,083	
Brian Gulian	38 Elizabeth St. Kent CT 06757	0	•	Real estate rental	P 22, L 9	90,000	000'06	
Brian Gulian	38 Elizabeth St, Kent CT 06757	0	•	Administrator	P 12, Sec III	52,313	52,313	
Audrey Gulian	38 Elizabeth St, Kent CT 06757	0	•	Clerical	P 11, Sec II	19,554	19,554	
	<u>-</u>	0	0					
		0	0					
		0	0					
		0	0				And the second s	
		0	0					

<sup>\*</sup> Use additional sheets if necessary.

<sup>\*\*</sup> 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		
Morning Star Residential Care Home, Inc.	1884		9/30/2015	5 37		
If the facility is licensed as CDH and/or RCH of	or provides A	IDS or TB	services with special Medic	aid rates, costs		
must be allocated to CCNH and RHNS as follo	ws:					
Item			Method of Allocation	n		
Dietary		Number of	meals served to residents			
Laundry		Number of	pounds processed			
Housekeeping		Number of	square feet serviced			
		Number of	hours of routine care provid	ed by EACH		
Nursing		employee c	lassification, i.e., Director (	or Charge Nurse),		
		Registered	Nurses, Licensed Practical N	Jurses, Aides and		
		Attendants				
Direct Resident Care Consultants		Number of	hours of resident care provide	ded by EACH		
		specialist (	See listing page 13)			
Maintenance and operation of plant		Square feet				
Property costs (depreciation)		Square feet	0 0.000			
Employee health and welfare		Gross salar	ies			
Management services			e cost center involved			
All other General Administrative expenses		Total of Di	rect and Allocated Costs			
The preparer of this report must answer the following	The preparer of this report must answer the following questions applicable to the cost information provided.					
1. In the preparation of this Report, were all  • Yes  • No  If "No," explain fully why such allocation was						
costs allocated as required? Tes O No not made.						
			11000			
2. Explain the allocation of related company ex	xpenses and	attach copy	of appropriate supporting d	ata.		
3. Did the Facility appropriately allocate and s	elf-disallow	direct and i	ndirect costs to non-nursing	home cost centers?		
(e.g., Assisted Living, Home Health, Output	tient Services	s, Adult Da	y Care Services, etc.)			
	0. 17	O N	If "No," explain fully why s	uch allocation was		
	• Yes	O No	not made.			

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### General Information and Questionnaire Leases (Excluding Real Property)

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

οĘ 37 Amount Claimed Page Annual Amount ofLease Term of Report for Year Ended Lease % O 9/30/2015 Date of Lease\*\* O Yes Description of Items Leased 1884 License No. Related \* to å Operators, 0 0 0 0 0 0 0 0 0 0 Owners, Officers Yes 0 0 0 O 0 0 0 0 0 0 Morning Star Residential Care Home, Inc. Name and Address of Lessor Name of Facility

Is a Mileage Log Book Maintained for All Leased Vehicles?

\* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

Total \*\*\*

\*\*\* Amount should agree to Page 22, Line 6e.

<sup>\*\*</sup> Attach copies of newly acquired leases.

### General Information and Questionnaire Accounting Basis

Name of Facility	License No.	Report for Year Ended		Page of
Morning Star Residential Care He		9/30/2015		7 37
The records of this facility for the	e period covered by this report	were maintained on the following basis:		
⊙ Accrual O Cash C	O Modified Cash			
Is the accounting basis for this				
14	9 Yes	If "No," explain.		
previous period?	No C			
Independent Accounting Firm			<del></del>	
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)		
1 Davis, Mascola & Phillips, L	LC	1062 Barnes Rd, Ste. 203, Wallingford, O	CT 06492	
2				
3				
4 Services Provided by This Firm (	describe fully)			•
Preparation of cost report and tax r			\$	4,950
2	otutii		\$	1,200
3	· - ## · ·		\$	
	-M	A Landerson Miles Front	\$	
4	ALCONOMICS TO THE			r Services Provided
Ara Thaga Chargas Baffaatad in the Evn	anditure Portion of This Panort? If	Yes, Specify Expense Classification and Line No.	\$	4,950
O Yes O No	P 15, L 1D	res, openiy Expense Classification and Emerico.		
Legal Services Information	1. 10,212			
Name of Legal Firm or Independ	ent Attorney		Telephon	e Number
1	·		l î	
2				
3				
4				
5		L. Market Market and the second secon	<u> </u>	
Address (No. & Street, City, State	e, Zip Code )			
3				
4				
5				
Services Provided by This Firm (	(describe fully )		-	
1			\$	
2			\$	
3			\$	
4	- Validitative tire		\$	
5			\$	
	11.00	and the standard and th	Charge fo	or Services Provided
			\$	
Are These Charges Reflected in the Exp	penditure Portion of This Report? If	Yes, Specify Expense Classification and Line No.		
O Yes O No				

State of Connecticut
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CSP-8 Rev. 9/2002

## Schedule of Resident Statistics

Name of Facility	-		License No.	ĭo.			Report fo	Report for Year Ended	þ		Page	of
Morning Star Residential Care Home, Inc.			1	1884			9/30/2015	16			∞	37
						Period 10/1 Thru 6/30	1 Thru 6/.	30		Period 7/1	Period 7/1 Thru 9/30	0,
		Total	Total	Total				:				:
	Total Ail Levels	CCNH	KHINS Level	Kesidential Care Home	Total	CCNH	RHINS	Residential Care Home	Total	CCNH	RHNS	Residential Care Home
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	18			18	18			18	.18			18
B. On last day of THIS report period	18			18	18			18	18			81
2. Number of Residents			·									
A. As of midnight of PREVIOUS report period	18			18	18			18	17			17
B. As of midnight of THIS report period	18			18	17			17	18			18
72												
A. Medicare												
B. Medicaid (Conn.)	4,929			4,929	3,641			3,641	1,288			1,288
C. Medicaid (other states)												
D. Private Pay	1,399			1,399	1,031			1,031	368			368
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	6,328			6,328	4,672			4,672	1,656			1,656
Total Number of Days Not Included in Figures in 3G 4. for Which Revenue Was Received for Reserved	ď											
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	6,328			6,328	4,672			4,672	1,656			1,656

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

Name of Faci	lity			Licer	ise No.				Report	t for Year	Ended		Page	of
Morning Star	Resider	ntial Car	e Home, Inc.	1	884			j		9/30/201	5		9	37
			in the certified b		pacity du	ring tl	he repo	rt yea	r?	0	Yes	0	No	
11 1100			f Change		Cl	าสกจะ	in Bed			Cai	nacity Afte	er Change		
		1 1000 01	Residential			шпьс	III Book				pacity 111th			
Date of	CCNH	RHNS	Care Home	1	Lost	1	(	Gaine	1			Residential		
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Care Home	Reason f	or Change
	(-)_	(2.7		(*)	(-)	(0)	(-)	(-)	(0)	001111		941011101110	1100000111	<u> </u>
winiss into														
	•	_	in certified bed o	_	_	the re	eport ye	ear (as	report	ed in item	1 4 above)	provide the nur	nber of	
			Change in R	esiden	t Days					CC	NH	RHNS	Residential	Care Home
1st chan														
2nd char														
3rd chan														
4th chan 6. Number		lante on	d Rates on Septe	mhar	30 of Co	et Va	ar .		-					,
o. Number	OI Kesi	icins an	Medicare	moor	Medi		aı			Se	elf-Pay		Other Sta	te Assisted
	Item		CCNH	C	CNH	RI	INS	cc	NH		INS	Residential Care Home	R.C.H.	ICF-MR
No. of R			5 Tresses (2001 - 2000 ) 2 William (2007 ) 5-25 - 13					E PARTICION DE MESTE				4	14	
Per Dien a. One b												02.70	00.54	
	cu m.													
												93.70	86,74	
b. Two	bed rms											93.70	86,74	-
	bed rms. or more											93.10	86,74	
b. Two c. Three bed 1  7. Total Nu A.	bed rms. or more ms. imber of	Physicare - Par								ТО	TAL	CCNH	RHNS	Residential Care Home
b. Two c. Three bed 1  7. Total Nu A.	or more ms.  umber of Medica Medica	Physicare - Par	t B lusive of Part B)							TO	TAL			
b. Two c. Three bed 1  7. Total Nu A.	or more ms.  mber of Medica Medica I. Mai	Physica re - Par aid (Excl ntenanc	t B lusive of Part B) e Treatments							ТО	TAL			
b. Two c. Three bed t  7. Total Nu A. B.	or more ms. mber of Medica Medica 1. Mai 2. Res	Physica re - Par aid (Excl ntenanc	t B lusive of Part B)							TO	TAL			
b. Two c. Three bed t  7. Total Nu A. B.	e or more or more of Medica Medica 1. Mai 2. Res	Physica re - Par rid (Exc ntenanc torative	t B lusive of Part B) e Treatments							TO	TAL			
b. Two c. Three bed t  7. Total Nu A. B.  C. D. 8. Total Nu	mber of Medica 1. Mai 2. Res Other Total I	Physical Physical Physical F Speech	t B lusive of Part B) e Treatments Treatments Therapy Treatments Therapy Treatments	nents						TO	TAL			
b. Two c. Three bed t  7. Total Nu A. B.  C. D. 8. Total Nu A.	mber of Medica 1. Mai 2. Res Other Total I	Physical recording to the following the foll	t B lusive of Part B) e Treatments Treatments Therapy Treatm Therapy Treatm t B	nents						TO	TAL			
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b. Two c. Three bed t  7. Total Nu A. B.  C. D. 8. Total Nu A.	mber of Medica 1. Mai 2. Res Other Total I mber of Medica Medica 1. Mai 1. Medica 1. Medica 1. Medica 1. Medica 1. Medica 1. Medica 1. Mai	Physical torative  Physical Speech are - Par aid (Excintenance of Speech are - Par aid (Excintenance of Physical of Speech are - Par aid (Excintenance of Physical of Speech are - Par aid (Excintenance of Par aid (Excitenance of Par	t B lusive of Part B) e Treatments Treatments Therapy Treatment Therapy Treatment t B lusive of Part B) e Treatments	nents						TO	TAL			
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b. Two c. Three bed to  7. Total Nu A. B.  C. D. 8. Total Nu A. B.  C. D. 9. Total Nu A.	mber of Medica 1. Mai 2. Res Other Medica 1. Mai 2. Res Other Total I. Mai 2. Res Other Total Sumber of Medica 1. Mai 2. Res Other Total Sumber of Medica 1. Mai 2. Res Other Total Sumber of Medica	F Physical re - Par id (Exc. ntenanc torative  Physical f Speech re - Par id (Exc. ntenanc torative  F Peech T f Occupare - Par	t B lusive of Part B) e Treatments Treatments Therapy Treatm t B lusive of Part B) e Treatments Treatments Treatments Treatments Treatments Therapy Treatm ational Therapy t B	nents nents ents Treatr						TO	TAL			
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b. Two c. Three bed to  7. Total Nu A. B.  C. D. 8. Total Nu A. B.  C. D. 9. Total Nu A. B.	mber of Medica 1. Mai 2. Res Other Total Sumber of Medica 1. Mai 2. Res Other Total Sumber of Medica 1. Mai 2. Res Other Total Sumber of Medica 1. Mai 2. Res Other Total Sumber of Medica 1. Mai 2. Res Other Oth	F Physical re - Paraid (Excintenance torative  Physical f Speech are - Paraid (Excintenance torative  F Occupation - Paraid (Excintenance torative)	t B lusive of Part B) e Treatments Treatments  Therapy Treatm t B lusive of Part B) e Treatments Treatments Treatments Therapy Treatm ational Therapy t B lusive of Part B) e Treatments	nents nents ents Treatr	ments					TO	TAL			

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

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Report of Ex	`\	- Salain	T		T	
Name of Facility	License No.		Report for Yea	r Ended	Page	of
Morning Star Residential Care Home, Inc.	1884		9/30/2015		10	37
Are time records maintained by all individuals receiving cor	mpensation?	•	Yes	0	No	
			Total Cost a	and Hours		
	3		Total Cost	1		
					Residential	
Item	CCNH	Hours	RHNS	Hours	Care Home	Hours
A. Salaries and Wages*						
Operators/Owners (Complete also Sec. I						
of Schedule A1)			No. of the last of	er engelin siyaran karan adamis		(2004 MI) 20 MA
2. Administrator(s) (Complete also Sec. III						
of Schedule A1)					52,313	2,080
Assistant Administrator (Complete also Sec. IV						
of Schedule A1)						
<ol> <li>Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)</li> </ol>					22,207	1,886
5. Dietary Service					22,201	7,000
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers					33,311	2,830
6. Housekeeping Service						
Head Housekeeper     Other Housekeeping Workers					16,655	1,415
7. Repairs & Maintenance Services				1	10,033	1,41.
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers					15,069	1,280
8. Laundry Service						
a. Supervisor		-			2000	224
b. Other Laundry Workers					3,966	331
Barber and Beautician Services     Protective Services	1				<del>                                     </del>	
11. Accounting Services						
a. Head Accountant						
b. Other Accountants				Se seminare de la companya del companya de la companya del companya de la company		
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses						
b. RN						
Direct Care     Administrative**		<del> </del>		<del>                                     </del>		
c. LPN						
1. Direct Care						
2. Administrative**						
d. Aides and Attendants				<u> </u>	53,138	4,514
e. Physical Therapists						
f. Speech Therapists g. Occupational Therapists				-		
g. Occupational Therapists h. Recreation Workers			<u> </u>		14,275	1,21
i. Physicians						
Medical Director						
- 2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists	<u> </u>					
k. Pharmacists						
1. Podiatrists						
m. Social Workers/Case Management			1			
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures				+	210,934	15,55

<sup>\*</sup> 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.

<sup>\*\*</sup> 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.

<sup>\*\*\*</sup> 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	R	HNS	Residential	Care Home
Position	\$	Hours	\$	Hours	\$	Hours
					s services controllina	
	Congress Benedition (8)					
	1 00 00 00 00 00 00 00 00 00 00 00 00 00	500000000000000000000000000000000000000				
	r de versterstersters	540 (530 Sept 1550 Sept 15			0.4051/62/05/54/03/4006	270
		50: 53: 455 (5#0655) (E				
	Para control (Extra)				8	en e
	7.8	02: 01: 007: 01: 04:02	337-1211-221-331-331-331-331-331-331-331-33			
			E-L-S			
	Leave the second					
		oreode or etcompa				
	E 12 12 12 12 13 13 13 13 13 13 13 13 13 13 13 13 13		<u> </u>			20 00 00 00 00 00 00 00 00 00 00 00 00 0
	5 5 5 5					
Total	\$ -	<b>.</b>	\$ -	j.	\$ -	

### Schedule of Other Fees (Page 13)

	CC	NH	RI	INS	Residential	Care Home
Service	\$	Hours	\$	Hours	\$	Hours
						es escale
			65 68 68 88 88 88 8	19-12-13-13-13-13		
		Service (St. Charter				
	- 0.00 mate 2 5000	Pages of Lands ()				
			2001/03/2000/03/2000/03/2000			
						5 4 5 5
(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)						
					20	
Total	\$ -		\$ -	4. 4. 60 S. 6	\$ -	

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\*

Name of Facility				License No		Renort for	Renort for Year Ended		Рас	O.P.
דימוויס טי ז מכוויול)				TATACATION TAO.		TOT TOO	TOTAL TOTAL		1 480	7
Morning Star Residential Care Home, Inc.	ome, Inc.			1884		9/30/2015			11	37
		Salary Paid	d					The state of the s		-
			Residential	Fringe Benefits and/or Other Payments	Full Description of	Total Hours	Line Where Claimed on	Name and Address of All	Total Hours	Compensation
Name	CCNH	RHINS	Care Home	(describe fully)	Services Rendered	Worked	Page 10	Other Employment**	Worked	Received
Section I - Operators/Owners										
										-
Section II - Other related parties of Operators/Owners employed in and paid by										
facility (EXCEPT those who may be the Administrator or Assistant Administrators who										
are identified on Page 12).										
Audrey Gulian			19,554			1,043				-
										·
				·						
* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required	he consider	ed unless fi	III information	n is provided. The	additional sheets if reo	nired				

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

<sup>\*\*</sup> 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\*

Name of Bacility (as licensed)		7	) Transfer	License No.	I icense No.   Report for Year Ended	Report for Year Ended	ear Ended		Page	of
Induite of I defined (as meetinged)			<u> </u>						þ	!
Morning Star Residential Care Home, Inc.	ne, Inc.			1884		9/30/2015			12	37
		Salary Paid	þ	!						
			Residential	Fringe Benefits and/or Other Payments	Full Description of	Total Hours	Line Where Claimed on	Name and Address of All	Total Hours	Compensation
Name	CCNH	RHINS	Care Home	(describe fully)	Services Rendered	Worked	Page 10	Other Employment**	Worked	Received
Section III - Administrators***										
Brian Gulian			52,313	52,313 Health insurance	Adminsitrator	2,080				
Section IV - Assistant Administrators										
*No allourne for calamae un'il he concidered unless fill information	he consider	t oal unless	1.11 informatio		is nrovided I se additional sheets if required	nired				

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

<sup>\*\*</sup> Include all other employment worked during the cost year.

<sup>\*\*\*</sup> 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

Name of Facility	License No.		Report for Y		Page	of
Morning Star Residential Care Home, Inc.	18	84	9/30/2015		13	37
			Total Cost	and Hours		
Item	CCNH	Hours	RHNS	Hours	Residential 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. Dentist				ļ		
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
<ul> <li>a. Medical Director (entire facility)</li> </ul>						The second secon
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee	-					
(Quarterly meetings)  2. Pharmaceutical Committee						
(Quarterly meetings)						
Staff Development Committee						
(Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule		SUS SUS				
B-13 Total Fees Paid in Lieu of Salaries						
1-19 Four Lees Francis Wen of Datables	l			<u> </u>	<u> </u>	<u> </u>

<sup>\*</sup> 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.

<sup>\*\*</sup> 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.

<sup>\*\*\*</sup> 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 Morning Star Residential Care Home, Inc.	License No. 1884		Report for \ 9/30/2015		Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** Operator Yes	to Owners, rs, Officers No		nation of Rela	tionship
- 14 Acceptable 1 - 1 - 1	*	0	0			
		0	0			
	· · · · · · · · · · · · · · · · · · ·	0	0	***		
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		0	0			
		0	0			

<sup>\*</sup> Use additional sheets if necessary.

<sup>\*\*</sup> 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
Morning Star Residential Care Home, Inc.	1884		9/30/2015	1007-8110-1-1-1	15	37
						Residential
Item			Total	CCNH	RHNS	Care Home
1. Administrative and General						
<ul> <li>a. Employee Health &amp; Welfare Benefits</li> </ul>						
Workmen's Compensation		\$	6,017			6,017
2. Disability Insurance		\$				
Unemployment Insurance		\$	3,923			3,923
4. Social Security (F.I.C.A.)		\$	16,196			16,196
5. Health Insurance		\$	52,971			52,971
<ol><li>Life Insurance (employees only)</li></ol>						
(not-owners and not-operators)		\$				
7. Pensions (Non-Discriminatory)		\$	14,942			14,942
(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		\$	4,950			4,950
e. Legal (Services should be fully described or	n Page 7)	\$				***
f. Insurance on Lives of Owners and		\$	7,800			7,800
Operators (Specify)*				1		
g. Office Supplies		\$	994			994
h. Telephone and Cellular Phones						
1. Telephone & Pagers		\$	2,403			2,403
2. Cellular Phones		\$				
i. Appraisal (Specify purpose and		\$				
attach copy)*						
j. Corporation Business Taxes (franchise tax	)	. \$	250			
k. Other Taxes (Not related to property - See						
1. Income*	•	\$			***************************************	
2. Other (Specify)		\$				
See Attached Schedule						
3. Resident Day User Fee		\$				
Subtotal		\$	110,446			110,446

<sup>\*</sup> Facility should self-disallow the expense on Page 28 of the Cost Report.

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

Morning Star Residential Care Home, Inc. 9/30/2015

Attachment Page 15

### **Schedule of Other Employee Benefits**

Description	CCNH	RHNS	Residential Care Home
		71.0	
Total	\$ -	\$ -	\$ -

### **Schedule of Other Taxes**

			Residential
Description	CCNH	RHNS	Care Home
			1.02.23.02.00
Total	\$ -	\$ -	\$ -

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

Name of Facility	License No.		Report for Y	Year Ended	Page	of
Morning Star Residential Care Home, Inc.	1884		9/30/2015		16	37
						Residential
Item			Total	CCNH	RHNS	Care Home
	btotals Brought Forwa	rd:	110,446			110,446
Travel and Entertainment						
Resident Travel and Entertainment		\$				
2. Holiday Parties for Staff		\$				
3. Gifts to Staff and Residents		\$	528			528
4. Employee Travel	The solution of the control of the c	\$				
5. Education Expenses Related to Semina	ars and Conventions	\$				
6. Automobile Expense (not purchase or	depreciation)	\$	976			976
7. Other (Specify)		\$				
See Attached Schedule						0.0000000000000000000000000000000000000
m. Other Administrative and General Expense	es					
1. Advertising Help Wanted (all such exp		\$	391			391
2. Advertising Telephone Directory (all s	uch expenses )***	\$	1,380			1,380
3. Advertising Other (Specify)***		\$				
See Attached Schedule						
4. Fund-Raising***		\$				
5. Medical Records		\$				
<ol><li>Barber and Beauty Supplies (if this ser</li></ol>	vice is supplied	\$	·	-		
directly and not by contract or fee for s	service)***					
7. Postage		\$	445	,		445
* 8. Dues and Membership Fees to Professi	ional	\$	500			500
Associations (Specify)						
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other N	on-Allowable Org.***	\$				
9. Subscriptions		\$				
10. Contributions***		\$				
See Attached Schedule						
11. Services Provided by Contract (Specify	and Complete	\$				
Schedule C-2, Page 21 for each firm or						
12. Administrative Management Services*	*	\$				
13. Other (Specify)		\$	6,085			6,085
See Attached Schedule						
C-14 Total Administrative & General Expendits		\$	120,751			120,751

<sup>\*</sup> Do not include Subscriptions, which should go in item 9.

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*\*</sup> Facility should self-disallow the expense on Page 28 of the Cost Report.

### Schedule of Other Travel and Entertainment

			Residential
Description	CCNH	RHNS	Care Home
		viewsky incoming as	1910,000,000
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

### Schedule of Other Advertising

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

### Schedule of Ducs

			Residential
Description	CCNH	RHNS	Care Home
Description CARCH		des one secondo e	\$ 500
			- 15-11 (15-12-13-11-15-11-15-11-15-11-15-11-15-11-15-11-15-11-15-11-15-11-15-11-15-11-15-11-15-11-15-11-15-1
		3570 FE 156 FE 156 FE	
		355 (SEC. 355 (SEC.	
		60.50.000	
			33. E. 46. 36.
			3 8 3 3
			100000000000000000000000000000000000000
Total Dues	S -	s -	\$ 500

### Schedule of Contributions

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

### Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
Payroll processing fees			\$ 1,651
Pension administration fees			\$ 3,896
Torrington Area Health Dist license			\$ 330
Republican American newspaper		100 mm (100 mm)	\$ 208
		100 300 000 1000	105145135155
	Operation with the color		
	2961966 (100 <b>9</b> 50 o.5	222 225 TSA SECR	10071150011063V3130
	96977 00 10 EF 0E	99 53 45 554	
	. December of the section	200 201 DE 2010	320 500 365 350 3
	Mary Control Conduction Control	ALCOHOLD STATE	200000000000000000000000000000000000000
Total Other Administrative and General	\$ -	\$ .	\$ 6,085

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

Name of Facility	License No.	Report for Year Ended	Page of
Morning Star Residential Care Home, Inc	1884	9/30/2015	17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
	,		

<sup>\*</sup> 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)

					rage 5	<u>'</u>				
	ne of Facility		Licen	ise l	Vo.		Report for Y		Page	of
Moi	rning Star Residential Care Home, Inc.			1	1884		9/30/2015	5	18	37
									Reside	ntial Care
	Item				Total		CCNH	RHNS	H	lome
2.	Dietary									
ļ	a. In-House Preparation & Service									
	1. Raw Food			\$	31,29	9A	200			31,290
	Non-Food Supplies			\$		18				218
<u> </u>	3. Other ( <i>Specify</i> )			\$	۷.	10				∠18
	3. Other (bpecify)		-	Φ						
<u> </u>	1 D111			d.						
	b. Purchased Services (by contract other			\$						
	than through Management Services)							1000000		
	(Complete Schedule C-2 att. Page 21)									
	c. Management Services**			\$						
	d. Other (Specify)		-	\$		(VS22110)				300
İ										
2E.	Total Dietary Expenditures $(2a + b + c + d)$			\$	31,50	80				31,508
									Reside	ntial Care
2F.	Dietary Questionnaire				Total		CCNH	RHNS	1	lome
G.	Resident Meals: Total no. of meals served per	· day	··*	+		48				48
							<u> </u>	.1	<u> </u>	40
H.	Is cost of employee meals included in 2E?	$\frac{\circ}{}$	Yes			<u>Θ</u>	No			
Ι,	Did	$\sim$				<u> </u>	Nie	If yes, specify		
J.	Did you receive revenue from employees?	U	Yes		•	•	No	amt.		
J.	Where is the revenue received reported in the	Co	st Rene	ort?	(Page/Lin	ne i	Item)			
Ë	Is cost of meals provided to persons other		оттор		(1 ugurzz		10011)			1
177	than employees or residents (i.e., Board	$\circ$	Yes			<u> </u>	No	If yes, specify		
K.		U	i es		•	<u> </u>	No	cost.		
<u> </u>	Members, Guests) included in 2E?									
L.	Is any revenue collected from these people?	O	Yes		(	•	No	If yes, specify		
	is they revenue concerns wow mass people.					_		amt.		
M.	Where is the revenue received reported in the	Co	st Repo	ort?	(Page/Lin	ne	Item)			
	Is cost of food (other than meals, e.g.,	-								
	snacks at monthly staff meetings, board	$\sim$	3.7			<u></u>	3.1	If yes, specify		
N.	meetings) provided to employees included	U	Yes		(	•	No	cost.		
	in 2E?									
						_		If yes, specify		
O.	Is any revenue collected from employees?	О	Yes		1	0	No	amt.		
<u></u>					,		<del></del>	GIIIE.		
Р.	Where is the revenue received reported in the	Co	st Rep	ort?	(Page/Li	ne	Item)			

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

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Name of Facility	License			Year Ended	Page of
Morning Star Residential Care Home, Inc.		1884	9/30/201:	5	19   37
					Residential Care
Item		Total	CCNH	RHNS	Home
<ul> <li>3. Laundry</li> <li>a. In-House Processing*</li> <li>1. Bed linens, cubicle curtains, draperies,</li> </ul>	Lbs.		-		
gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	640			640
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.	_			
b. Purchased Services (by contract other	Amt. \$	7		<u> </u>	
than through Management Services) (Complete Schedule C-2 att. Page 21)					
c. Management Services**	\$				
d. Other (Specify)	\$				
3E. Total Laundry Expenditures (3a+b+c+d)	\$	647			647
3F. Laundry Questionnaire					
	) Yes	0	No	If yes, specify cost.	
H. Did you receive revenue from employees?	) Yes	•	No	If yes, specify amt.	
I. Where is the revenue received reported in the Cos	st Report?		(Page/Lin	e Item)	
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?	) Yes	•	No	If yes, specify cost.	
K. Did you receive revenue from these people?	) Yes	•	No	If yes, specify amt.	
L. Where is the revenue received reported in the Cos	st Report?	)	(Page/Lin	e Item)	

<sup>\*</sup> 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.

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*\*</sup> 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.	Rep	ort for Year E	nded	Page	of
Morning Star Residential Care Home, Inc.	1884		9/30/2015		20	37
т.			T (1	CCNIII	DIDIG	Residential
Item			Total	CCNH	RHNS	Care Home
4. Housekeeping	Sq. Ft. Serviced	ŀ				
a. In-House Care	by Personnel	<b>.</b>	1 2 2 2			
1. Supplies - Cleaning (Mops, pails, brooms, etc.)	Amt.	\$	1,982			1,982
b. Purchased Services (by contract other	Sq. Ft. Serviced					"
than through Management Services)	by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	\$				
c. Management Services*		\$				
d. Other (Specify)		\$				
		Í		0.00		
4E. Total Housekeeping Expenditures (4a	+b+c+d	\$	1,982			1,982
5. Resident Care (Supplies)**	•		NO CONTRACTOR STATE			
a. Prescription Drugs***						
1. Own Pharmacy		\$[				
2. Purchased from		\$				
b. Medicine Cabinet Drugs		\$	114			114
c. Medical and Therapeutic Supplies		\$				
d. Ambulance/Limousine***		\$				
e. Oxygen			No.			
1. For Emergency Use		\$				
2. Other***		\$				
f. X-rays and Related Radiological		\$		NAME OF THE PARTY		
Procedures***						
g. Dental (Not dentists who should be in	icluded under	\$				
salaries or fees)						SAFERENCE AND THE
h. Laboratory***		\$				
i. Recreation		\$	3,644			3,644
j. Other (Specify)****		\$	2,048			2,048
See Attached Schedule	<b>5</b> :\					
5K. Total Resident Care Expenditures (5a -	<b>ე</b> ე)	\$	5,806			5,806

<sup>\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

<sup>\*\*\*</sup> Facility should self-disallow the expense on Page 29 of the Cost Report.

<sup>\*\*\*\*</sup> ICFMR's should provide a detailed schedule of all Day Program Costs.

### **Schedule of Other Resident Care**

Description	CCNH	RHNS		idential e Home
Cable			\$	2,048
			to Section (Section )	
			i de de la composition della c	
		The second secon		
		State Control of the	e Soverie	i di di di d
		12.1		
			L. C.	
	The second secon			
			2 5 5 5	
Total Other Resident Care	\$ -	\$ -	\$	2,048

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

Name of Facility Morning Star Residential Care Home, Inc.	Home, Inc.			License No. 1884	Report for Year Ended 9/30/2015				Page 21	of 37
		Related ** to Owners, Operators, Officers	o 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	RHINS	Residential Care Home	Po I	Line
		0	0							
		0	0							
	-	0	0							
		0	0					=		
		0	0							
	-	0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							

<sup>\*</sup> List all contracted services over \$10,000. Use additional sheets if necessary.

<sup>\*\*</sup> Refer to Page 4 for definition of related.

<sup>\*\*\*</sup> 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 Ye	ear Ended		Page of
Morning Star Residential Care Home, Inc. 1884	 9/30/2015			22   37
				Residential Care
Item	 Total	CCNH	RHNS	Home
6. Maintenance & Operation of Plant				
a. Repairs & Maintenance	\$ 17,640			17,640
b. Heat	\$ 17,916			17,916
c. Light & Power	\$ 12,144			12,144
d. Water	\$ 4,440			4,440
e. Equipment Lease (Provide detail on page 6)	\$			
f. Other (itemize)	\$ 3,949			3,949
See Attached Schedule				
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 56,089			56,089
7. Depreciation (complete schedule page 23*)				
a. Land Improvements	\$			
b. Building & Building Improvements	\$		·	
c. Non-Movable Equipment	\$			
d. Movable Equipment	\$ 558			558
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 558			558
8. Amortization (Complete att. Schedule Page 24*)				
a. Organization Expense	\$			
b. Mortgage Expense	\$			
c. Leasehold Improvements	\$ 3,450		·	3,450
d. Other (Specify)	\$			
*8e. Total Amortization Costs (8a + b + c + d)	\$ 3,450			3,450
9. Rental payments on leased real property less				
real estate taxes included in item 10b	\$ 90,000			90,000
10. Property Taxes				
a. Real estate taxes paid by owner	\$			
b. Real estate taxes paid by lessor	\$ 9,253			9,253
c. Personal property taxes	\$ 215			215
11. <i>Total Property Expenses</i> (7e + 8e + 9 + 10)	\$ 103,476			103,476

<sup>\*</sup> 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
Sewer			\$ 3,949
	mangalan ang ang ang ang ang ang ang ang ang a		1902 0 993
N Processing to the control of the c		- I	
		5	
		2	
Total Other Repairs and Maintenance	\$ -	\$ -	\$ 3,949

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

ing Star Residential Care Home, Inc.    Property Item   Historical   Cost   Cos	9		Report for Year Ended	Inded		Page	ą-C
Tach schedule)  Itach schedule)  Itah schedule)  Itach schedule)  Itah schedule)  Ita	1001			;		5	5 5
Froperty Item   Froperty Item   Cost   Cost   Salvage   Cost   Cost   Salvage   Cost	1884		9/30/2015			23	3.7
Property Item   Land Improvements	lg:		Accumulated				
Property Item   Land Improvements			Depreciation to	Method of			
Land Improvements	Salvage	Cost to Be	Beginning of	Computing	Useful	Depreciation	-
Land Improvements  1. Acquired prior to this report period  2. Disposals (attach schedule)  3. Acquired during this report period (attach schedule)  4. Disposals (attach schedule)  5. Disposals (attach schedule)  6. Acquired furior this report period  7. Disposals (attach schedule)  8. Acquired furior this report period  9. Acquired furior this report period  10. Acquired furior this report period  11. Acquired furior furior this report period  12. Acquired furior furior this report period  13. Acquired furior furior this report period  14.843  15. Acquired furior fu	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
1. Acquired prior to this report period (attach schedule) 3. Acquired during this report period (attach schedule) 3. Acquired during this report period (attach schedule) 4. Acquired during this report period (attach schedule) 5. Acquired during this report period (attach schedule) 5. Acquired during this report period (attach schedule) 6. Disposals (attach schedule) 7. Disposals (attach schedule) 8. Acquired during this report period (attach schedule) 8. Acquired during this report period (attach schedule) 9. Disposals (attach schedule) 6. Disposals (attach schedule) 7. Movable Equipment 7. Movable Equipment 8. Disposals (attach schedule) 9. Disposals (attach schedule) 6. Disposals (attach schedule) 7. Acquired during this report period (attach schedule) 8. Disposals (attach schedule) 9. Acquired during this report period (attach schedule) 9. Acquired during this report period (attach schedule)							
2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule)  Building and Building Improvements  Building and Building Improvements  Building and Building Improvements  1. Acquired prior to this report period (attach schedule)  2. Disposals (attach schedule)  3. Acquired during this report period (attach schedule)  4. Movable Equipment  5. Disposals (attach schedule)  6. Cost  7. Movable Equipment  7. Disposals (attach schedule)  8. Disposals (attach schedule)  9. Disposals (attach schedule)  6. Cost  7. Movable Equipment  9. Disposals (attach schedule)  9. Acquired during this report period (attach schedule)							
S. Acquired during this report period (attach schedule)  Building and Building Improvements  1. Acquired prior to this report period (attach schedule)  2. Disposals (attach schedule)  3. Acquired prior to this report period (attach schedule)  2. Disposals (attach schedule)  3. Acquired during this report period (attach schedule)  3. Acquired furior to this report period (attach schedule)  4. Movable Equipment  5. Movable Equipment  6. C. Acquired during this report period  7. Disposals (attach schedule)  8. Movable Equipment  9. Acquired furior to this report period  9. Disposals (attach schedule)  9. Acquired furior to this report period  9. Disposals (attach schedule)  9. Acquired during this report period  9. Disposals (attach schedule)							
Subtotal  1. Acquired prior to this report period (attach schedule) 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) 3. Acquired during this report period (attach schedule) 3. Acquired during this report period (attach schedule) 4. Disposals (attach schedule) 5. Disposals (attach schedule) 6. Disposals (attach schedule) 7. Disposals (attach schedule) 8. Acquired during this report period (attach schedule) 9. Acquisition 1. Motor Vehicles (Specify name, model and year of each vehicle) 9. Acquired prior to this report period 1. Movable Equipment 1. Movable Equipment 2. Movable Equipment 3. Acquired during this report period 4. Acquired prior to this report period 6. Disposals (attach schedule) 6. Disposals (attach schedule) 6. Disposals (attach schedule) 6. Acquired during this report period 7. Acquired during this report period 8. Acquired during this report period 8. Acquired during this repor							
Building and Building Improvements  1. Acquired prior to this report period (attach schedule)  3. Acquired during this report period (attach schedule)  3. Acquired during this report period (attach schedule)  3. Acquired during this report period (attach schedule)  4. Disposals (attach schedule)  5. Disposals (attach schedule)  7. Disposals (attach schedule)  8. Acquired during this report period (attach schedule)  9. Acquired during this report period (attach schedule)  1. Movable Equipment  1. Motor Vehicles (Specify name, model and year of each vehicle)  2. Movable Equipment  3. Acquired prior to this report period  4. Acquired during this report period (attach schedule)  5. Movable Equipment  6. C. d.  7. Movable Equipment  7. Movable Equipment  8. Acquired during this report period (attach schedule)  9. Disposals (attach schedule)  10. Acquired during this report period (attach schedule)							
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Subtotal Non-Movable Equipment  1. Acquired during this report period (attach schedule) 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) 4. Acquired during this report period (attach schedule) 5. Acquired during this report period (attach schedule) 6. Acquired during this report period (attach schedule) 7. Disposals (attach schedule) 7. Disposals (attach schedule) 8. Acquired during this report period (attach schedule) 9. 2. Movable Equipment a. Acquired during this report period (attach schedule) c. Acquired during this report period (attach schedule)							
Subtotal  1. Acquired prior to this report period (attach schedule) 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) 3. Acquired during this report period (attach schedule) 4. Acquired during this report period (attach schedule) 5. Acquired during this report period (attach schedule) 6. C. Acquired during this report period (attach schedule) 7. Acquired during this report period (attach schedule) 6. Acquired during this report period (attach schedule) 7. Acquired during this report period (attach schedule) 6. Acquired during this report period (attach schedule) 7. Acquired during this report period (attach schedule) 7. Acquired during this report period (attach schedule) 8. Acquired during this report period (attach schedule) 9. Disposals (attach schedule) 9. Acquired during this report period (attach schedule)							
Non-Movable Equipment  1. Acquired prior to this report period (attach schedule)  2. Disposals (attach schedule)  3. Acquired during this report period (attach schedule)  4. Subtotal  4. Subtotal  Acquired during this report period (attach schedule)  Acquired prior to this report period  a. 2007 Toyota Avalon XL  b. c. d.  2. Movable Equipment  a. Acquired prior to this report period  b. Disposals (attach schedule)  c. Acquired during this report period  (attach schedule)  c. Acquired during this report period  (attach schedule)  c. Acquired during this report period  (attach schedule)							
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2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) 4. Subtoral 4. Subtoral 5. Acquired during this report period (attach schedule) 6. Subtoral Movable Equipment 7. Movable Equipment 8. Z007 Toyota Avalon XL 9. Movable Equipment 9. Acquired prior to this report period 9. Disposals (attach schedule) 9. Disposals (attach schedule) 9. Disposals (attach schedule) 9. Disposals (attach schedule) 9. Acquired during this report period (attach schedule)							
4. Subtotal  4. Subtotal  4. Subtotal  1. Subtotal  1. Subtotal  1. Subtotal  1. Subtotal  1. Movable Equipment  1. Motor Vehicles (Specify name, model and year of each vehicle)  2. Movable Equipment  3. 2007 Toyota Avalon XL  4. Subtotical  1. Motor Vehicles (Specify name, model and year of each vehicle)  2. Movable Equipment  3. 2007 Toyota Avalon XL  4. Subtotical  1. Motor Vehicles (Specify name, model and year of each vehicle)  2. Movable Equipment  3. Acquired prior to this report period  4. Subtotical  4. Subtotical  5. Acquired during this report period (attach schedule)  6. C. Acquired during this report period (attach schedule)  7. Acquired during this report period (attach schedule)			**************************************				
4. Subtortal  1. Subtortal  1. Movable Equipment 1. Motor Vehicles (Specify name, model and year of each vehicle) 2. Movable Equipment 3. 2007 Toyota Avalon XL 4. Subtort beriod 1. Movable Equipment 3. 2007 Toyota Avalon XL 5. Movable Equipment 4. Subtorical 1. Movable Equipment 5. Movable Equipment 6. C. d. 6. C. d. 7. Movable Equipment 7. Movable Equipment 8. Acquired prior to this report period 9. Disposals (attach schedule) 9. Disposals (attach schedule) 9. C. Acquired during this report period (attach schedule) 9. C. Acquired during this report period (attach schedule)							
Movable Equipment  1. Motor Vehicles (Specify name, model and year of each vehicle)  2. Movable Equipment  3. Acquired prior to this report period  b. Disposals (attach schedule)  c. Acquired during this report period (attach schedule)  c. Acquired during this report period (attach schedule)							
Movable Equipment  1. Motor Vehicles (Specify name, model and year of each vehicle)  2. Movable Equipment  3. Acquired prior to this report period  4. Disposals (attach schedule)  c. Acquired during this report period (attach schedule)			Accumulated				
Movable Equipment         Yes         No         Month         Year         Exclusive of Earloage         Salvage           1. Motor Vehicles (Specify name, model and year of each vehicle)         X         9 2007         4,905         Yalue           a. 2007 Toyota Avalon XL         X         9 2007         4,905         Yalue           b.         c.         Acquired prior to this report period         Yarious various         14,843         Yarious various           c. Acquired during this report period (attach schedule)         Acquired during this report period (attach schedule)         Acquired prior to this report period (attach schedule)         Acquired prior period (attach schedule)         Acquired (attach schedul			Depreciation to	Method of			
Movable Equipment  I. Motor Vehicles (Specify name, model and year of each vehicle)  b. b. C. C. Movable Equipment a. Acquired prior to this report period b. Disposals (attach schedule) c. Acquired during this report period (attach schedule) c. Acquired during this report period (attach schedule)	Salvage	Cost to Be	Beginning of		Useful	Depreciation	
Movable Equipment       X       9 2007       4,905         a. 2007 Toyota Avalon XL       X       9 2007       4,905         b.       c.       4.905       14,843       114,843         c. Acquired prior to this report period       b. Disposals (attach schedule)       various various       14,843       11         c. Acquired during this report period (attach schedule)       c. Acquired during this report period (attach schedule)       c. Acquired thring t	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
cify name, model lon XL  X  9 2007  4,905  lon XL  this report period schedule) his report period his report period his report period							
cole							
14,843   1,905   1,000   1,905   1,9							
this report period various various various various his report period	905	4,905	4,905	SL	4		
this report period schedule) schedule) his report period							
this report period various various various various his report period							
this report period schedule) schedule) his report period							
t period various various 14,843 period							
period	,843	14,843	14,285	SL	various	558	
c. Acquired during this report period (attach schedule)							
(attach schedule)							
D-3. Subtotal							558
E. Total Depreciation							558

### Schedule of Land Improvements Acquired during this report period

	Description	G.,,	Useful	D
Acquisition Date Additions:	Description of Item	Cost	Life	Depreciation
Auditions:				
	F - 110025			
Fotal additions for	Land Improvements	\$ -	A. 180 (S. 181 (191)	\$ -
Deletions:				
			eseline Distriction and a consequence	
Fotal deletions for	Land Improvements	\$ -		\$ -

<sup>\*</sup>Ties to Page 23, Line A3

### Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				<u> </u>
SECTION OF THE RESERVE				
		8.5.0.00		50 S. S. S. S.
STORES WE SELECT				
		1.000.000		
		120 000 000		
Cotal additions for	r Building Improvements	\$ -		\$ -
Deletions:				
		35.45.00.05.00		10 ST 5 15 16
		30 (2) (4) (5)		
Fotal deletions for	Building Improvements	\$ -		\$ -

<sup>\*</sup>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:				
		VSSE(00)000000000000000000000000000000000		0.0000000000000000000000000000000000000
100,000 (20,000)		12050 (2010) (2010)	Terre 10,000 1000 14,000 1,000 10	
		AMS CONSTRUCTION AFTER		of Comments of Control Control
Total additions for	Non-Movable Equipment	S =		\$ -
Deletions:				
				50 99-50 60 60
				-85 (\$F\$5F-55) <del>(</del> 57
APP Control of the Co		1000114941145146514604		- 1-101/020 - 1900 - 101/04.
		-0.0 0.00 0.00 0.00 0.00 0.00 0.00 0.00		
		nowed-based and the Care		100-100-00-00-00-00-00-00-00-00-00-00-00
Takal daladaya fan	No. M. Salis Post Survey	00038 NSW-0 NS		¢
rotal deletions for	Non-Movable Equipment	\$		\$ -

<sup>\*</sup>Ties to Page 23, Line C3

<sup>\*\*</sup>Ties to Page 23, Line A2

<sup>\*\*</sup>Ties to Page 23, Line B2

<sup>\*\*</sup>Ties to Page 23, Line C2

### Schedule of Movable Equipment Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
				54 820 780 880 780
				Te de la constant
			100 00 00 00 00	B 96 00 00 100
And the second of the second o			A 65 / TANK & 6 4 6 6 5 7 6 6	5 (2000) (2000) (2000) (2000) 1 (2000) (2000) (2000) (2000) (2000)
				•
Fotal additions for Movable Ec	(uipment	\$ -		\$ -
Deletions:				
			100 (St. 1818)	450,000,000,000
			5.63.55.63.68	35-63-53-55-64
			7 (5) (8) (8) (8)	G 987 C180 EE
			100000000000000000000000000000000000000	
				A CONTRACTOR OF STREET
otal deletions for Movable Eq		\$ -		\$ -

<sup>\*</sup>Ties to Page 23, Line D2c

### Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
9/23/2015	Repair of dry pipe valve for sprinkler system	\$ 4,412	5	\$ -
			67.000.000.000	
		60 50 60 50 500		
\$ 10 miles			00.00.00.00.00	
20E31280 (E00E)		(8)-/40 (2) (3)(13)(13)(1	14.000 0000000	50/60-12/16/15/00
Total additions for	Leasehold Improvement	\$ 4,412		\$
Deletions:				
		5 6 6 6		0.0000000000000000000000000000000000000
		ASSIGN SO	10.00.00.00.00	
		34 (42) (5 -2)		
18 85 Content for 18 (4)		200-200-200-200-200-200-200-200-200-200		
		100 - 100 - 100 - 100 - 100 - 100	0.000	
Total deletions for	Leasehold Improvement	\$ -		\$ -

<sup>\*</sup>Ties to Page 24, Line C3

<sup>\*\*</sup>Ties to Page 23, Line D2b

<sup>\*\*</sup>Ties to Page 24, Line C2

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

## Amortization Schedule\*

Nam	Name of Facility		License No.		Report for Year Ended	r Ended	Page	- 36	fo
Mon	Morning Star Residential Care Home, Inc.		1884	34	9/30/2015		24	+	37
					Accumulated				
		Date of			Amort. to				
		Acquisition			Beginning of	Basis for			
			Length of	Cost to Be	Year's	Computing	Rate   Amortization	zation	
	Item	Month   Year	Amortization	Amortized	Operations	Amortization**	% for This Year	s Year	Totals
Ą.	Organization Expense								
	1. Oraganizational costs	8 2007	5 years	300	300 ST	ST			
	2.								
	3.								
A-4.	A-4. Subtotal								
В.	Mortgage Expense								
	1								
	2.								
	3.								
B-4.	Subtotal								
ت	Leasehold Improvements and Other								
	1. Acquired prior to this report period	various variou		40,408	27,142 SL	ST		3,450	
	2. Disposals (attach schedule)								
	3. Acquired during this report period								
	(attach schedule)			4,412					
C-4.	C-4. Subtotal								3,450
Ö.	Total Amortization								3,450
*	* Straight-line method must be used								

\* 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	ded		Page of
Morning Star Residential Care Home,	1884	9	9/30/2015			25   37
11. Property Questionnaire						
Part A						
Is the property either owned by the	ne Facility	<b>O</b> 5	Var	0	No	If "Yes," complete Part B.
or leased from a Related Party?*		•	1 03	O	140	If "No," complete Part C.
*If any owner or operator of this fa						
business association to any person	or organization from	whom b	uildings are leased, the	en it is considered		
a related party transaction.  Description			Total			
Date Land Purchased			1 0001			
2. Date Structure Completed	·					
3. If <b>NOT</b> Original Owner, Date	e of Purchase		08/01/07	6.00		
4. Date of Initial Licensure				2016 1707 B		
<ol><li>Total Licensed Bed Capacity</li></ol>			18			
6. Square Footage		25	7,200		e in Statement in the	
7. Acquisition Cost		i i	100.000			
a. Land b. Building			175,800 703,200			
Part B - Owner and Related Pa	ution		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing	rues		1st Wortgage	Ziiu iviorigage	ord Wortgage	4th Mortgage
a. Type of Financing (e.g., f	ixed. variable)	F	Fixed	Fixed		
b. Date Mortgage Obtained			08/01/07	08/01/07		
c. Interest Rate for the Cost	Year		818.00%	925.00%		
d. Term of Mortgage (numb	er of years)		20	20		
e. Amount of Principal Borr			450,000	270,000		
f. Principal balance outstand						
Complete if Mortgage was I						
During Current Cost Yo					100	
g. Type of Financing (e.g., f	ixed, variable)			********		
h. Date of Refinancing i. New Interest Rate	734 whate ***					
j. Term of Mortgage (numb	er of years)					
k. Amount of Principal Borr						
Principal Outstanding on						
Part C - Arms-Length Leas	es for Real Prop	erty In	provements Only	7		
Name and Address of Lesso	r	Prope	erty Leased	Date of Lease	Term of Lease	Annual Amount of Lease
	•					
		/				
			···			
			,,			

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

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

Name of Facility License No.		Report for Yea	ar Ended		Page of
Morning Star Residential Care Home, 1884		9/30/2015			26   37
					Residential Care
Item		Total	CCNH	RHNS	Home
12. Interest					
A. Building, Land Improvement & Non-Movable					
Equipment	<b>ሰ</b>				
First Mortgage  Name of Lender	\$ Rate				
Name of Lender	Kate				
Address of Lender					10.500.501.600.305.4
2. Second Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
3. Third Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
	Φ.				
4. Fourth Mortgage Name of Lender	Rate	The sale of the marks of the sale			
ivame of Lender	Kate				
Address of Lender					
B. CHEFA Loan Information					
1. Original Loan Amount	\$				
2. Loan Origination Date					
3. Interest Rate %					
4. Term					
5. CHEFA Interest Expense					
	\$				
12 B7. Total Building Interest Expense (A1 - A4 + B5)	Þ	I	G. 1 1	orward to n	

(Carry Subtotals forward to next page)

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

Name of Facility  Morning Star Residential Care Hor  18	No. 84		Report for Year Ended 9/30/2015			Page of 27   37
Trioning Star Residential Care Hou	UT		713012013			Residential
			Total	CCNH	RHNS	Care Home
	otals Broi	ight Forward:	10(4)	CCIVII	MINO	Care Home
12. C. Movable Equipment	Ottill Dio	agne i oi mara.				
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender	Lender					
Address of Lender						
2. Other (Specify)	\$	SOUND SHIP HOUSE STREET WE SHARE	To I be a training to the second of the second	The sign have mit to the symmetry and place and yet result in a s	Tall Specific reference in the management of the strangers of the strangers and of an expension	
A. Item	Rate	Amount				
Lender		<u>.</u>				
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Inter-	est					
Expense (C1 + 2)		\$				1.500
12. D. Other Interest Expense (Specify) Credit cards \$126/Insurance fees \$	167/100	\$ \$1200	1,593			1,593
Credit cards \$120/insurance lees \$	107/LOC	Φ1300				
13. Total All Interest Expense (12B7 + 120	C3 + 12D	) \$	1,593			1,593
14. Insurance	00 122	<u>,                                      </u>	1,000			1,000
a. Insurance on Property (buildings of	nly)	\$	11,270			11,270
b. Insurance on Automobiles		\$	2,077			2,077
c. Insurance other than Property (as s	,			,		
1. Umbrella (Blanket Coverage)						
Fire and Extended Coverage						
3. Other (Specify)		\$				
14d. Total Insurance Expenditures (14a + 1	b + c)	\$	13,347			13,347
15. Total All Expenditures (A-13 thru C-1		\$				546,133

## D. Adjustments to Statement of Expenditures

Name	e of Fa	cility		Lic	ense No.	Report for Ye	ar Ended	Page	of
Morn	ning St	ar Res	sidential Care Home, Inc.		1884	9/30/2015		28	37
					Total				
Item	Page	Line			Amount of			Resident	ial Care
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	Ho	me
Page	10 - S	alarie	es and Wages						
1.			Outpatient Service Costs	\$					
2.			Salaries not related to Resident Care	\$					
3.			Occupational Therapy	\$					
4.			Other - See attached Schedule	\$					
	_	rofes	sional Fees						
5.	1		Resident Care Physicians **	\$					
6.			Occupational Therapy	\$					
7.			Other - See attached Schedule	\$	77				
Page	s 15 &	16 -	Administrative and General						
8.	ļ		Discriminatory Benefits	\$					
9.			Bad Debts	\$					
10.	ļ		Accounting & Legal	\$					
11.			Telephone	\$	****				
12.	ļ		Cellular Telephone	\$					
13.			Life insurance premiums on the life						
			of Owners, Partners, Operators	\$					
14.	ļ		Gifts, flowers and coffee shops	\$					
15.			Education expenditures to colleges or						
			universities for tuition and related costs						
			for owners and employees	\$					
16.			Travel for purposes of attending						
			conferences or seminars outside the						
			continental U.S. Other out-of-state	_					
			travel in excess of one representative	\$					
17.	<del>-</del>		Automobile Expense (e.g. personal use)	\$	4				1.000
18.		m2	Unallowable Advertising *	\$	1,380				1,380
19.	15	1j	Income Tax / Corporate Business Tax	\$	250				250
20.	<del></del>		Fund Raising / Contributions	\$					
21.	_	<u> </u>	Unallowable Management Fees	2 (8	11/3				
22.	_					<del>\</del>			040
. 23.	1	<u> </u>	Other - See attached Schedule	. \$	. (				. 848
		Dietar <u>.</u>	y Expenditures						
24.	1		Meals to employees, guests and others	ά				SAMONAMA A	
_	10	<u> </u>	who are not residents	\$					
_		Launa T	lry Expenditures						
25.	1		Laundry services to employees, guests and others who are not residents	\$					
n	<u> </u>	YY a		\$					
		ri ouse	keeping Expenditures	·n					
26.	1		Housekeeping services to employees, guest						
<u> </u>	1		and others who are not residents  Subtotal (Items 1 - 2	\$ (6) \$	2,478		<del> </del>		2,478
<u> </u>	·····		Subtotal (Itellis 1 - 2	o) o		Tarry Subtatal t			۵,٦/٥

<sup>\*</sup> All except "Help Wanted".

<sup>(</sup>Carry Subtotal forward to next page)

<sup>\*\*</sup> 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
30 (40 00 05 00) 31 (40 00 00 00)					
	No. 10.00 and 10				
				100000000000000000000000000000000000000	
Total Othe	r Salaries	Adjustment	\$ -	\$ -	\$ -

#### Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
				2 5 6 5 5 6	
9 (g) (2 (t) (i)					
			20.20.0000		
Total Othe	er Fees Adi	ustments	\$ -	\$ -	\$ -

## Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
- 20	State Authors to select the event of	Excess cable	1		\$ 848
 Гotal Othe	r A&G Ac	ljustments	\$ -	\$ -	\$ 848

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

		1111	D. Adjustments to Stateme					Da ==	_ <b>£</b>
1	e of Fa	•		Lic	ense No.	Report for Y	ear Ended	Page	of
Morn	ung St	ar Re	sidential Care Home, Inc.		1884	9/30/2015		29	37
		l			Total			n- '-	
l I	Page				Amount of		DIDIO	1	ntial Care
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	1	ome
			Subtotals Brought Forward	\$	2 <u>,4</u> 78				2,478
	20 - I	Reside	nt Care Supplies***						
27.			Prescription Drugs	\$	<b></b>				
28.			Ambulance/Limousine	\$					
29.		ļ	X-rays, etc	\$					
30.			Laboratory	\$					
31.			Medical Supplies	\$		**********			
32.			Oxygen (non emergency)	\$					
33.			Occupational Therapy	\$					
34.			Other - See Attached Schedule	\$					
-	22 - 1	Maint	enance and Property						
35.			Excess Movable Equipment Depreciation						
			See Attached Schedule	\$					
36.			Depreciation on Unallowable						
<u></u>			Motor Vehicles	\$					
37.			Unallowable Property and Real				10.00		
			Estate Taxes	\$					
38.			Rental of Building Space or Rooms	\$					
39.			Other - See Attached Schedule	\$				material walks from the	
Page	27-1	nsura	ince						
40.			Mortgage Insurance	\$					
41.			Property Insurance	\$					
Othe	r - Mi.	scella	neous						
42.		[	Research or Experimental Activities	\$					
43.			Radio and Television Revenue	\$					
44.			Vending Machine Revenue	\$					
45.			Purchase Discounts and Allowances	\$					
46.			Duplications of functions or services	\$		A THE TAX WAS A SALE OF THE TAX A SALE OF TA		www.chaooohawachi	
47.			Expenditures made for the protection,						
			enhancement or promotion of the						
			providers interest	\$	. ,			<u> </u>	
. 48.			Interest Income on Accounts Rec	\$				<u> </u>	
49.			Other (include personnel and other						
			costs unrelated to resident care) - See						
			Attached Schedule	\$					
Not 1	For P	rofit I	roviders Only						
50.		Ţ	Building/Non Movable Eq. Depreciation						
			Unallowable Building Interest -						
			See Attached Schedule	\$					
51.	Total	Amo	unt of Decrease (Items 1 - 50)	\$	2,478			1	2,478

<sup>\*\*\*</sup> 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
	4 5 5 5		00.00 DE C. 31.		8 88 48 65 4 13 8
	250 Egussus				
	150 No. 2012		Makanah negatikan se		4 (4) (2) (4) (4)
				75-12-12-12-12-12-12-12-12-12-12-12-12-12-	
	0.8.5.8				
				0.0000000000000000000000000000000000000	
Total Othe	r Ancillary	Costs	\$ -	\$ -	\$ -

#### Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
8,48,55,853	100000				
08.0 (\$5 PELOTEO)					
	190 78 55 5				
	9-9-9-2				
Total Exce	ss Movabl	e Equipment Depreciation	\$ -	\$ -	\$ -

#### Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
I ugo Ixoz		J. Control of the con			T
	(8) S (5) S				
	ASSESSED FOR THE				
	10 51 10 10	20 SEE 35		0.0000	
					S 00-000 C 00
Section and the	Signature of the second				
	1900 - F		A 88 48 15 68 80 1	20.00.001.00.003	
	3.5h			2000	
Total Othe	r Property	Adjustments	\$ -	\$ -	\$

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
	Disk byg				
	irano de maiorio de la composición della composi				
0.0000000000000000000000000000000000000					
MINORES (1975)					
Total Otho	r Adjustm	ents	\$ -	\$ -	\$ -

#### Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
		3 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		70 A-70 -50 AF	2.00
					55.50.90.00.00.6
				5 5 5 5 5 5	
				8 8 8 8 8	1 2 2 2 3 5
774 Tribu (111 15)					22.00.000
Total Una	lowable Bu	ailding Interest	\$ -	\$ -	\$ -

## F. Statement of Revenue

F. Statement of Re	ven		P1-1		In c
Name of Facility  Morning Star Residential Care Home, Inc 1884		Report for Y 9/30/2015	Page of 30   37		
Wioring Stat Residential Care Home, IIIC 1004		7/30/2013		1	<del>                                     </del>
Item		Total	CCNH	RHNS	Residential Car Home
I. Resident Room, Board & Routine Care Revenue					2000 CO
1. a. Medicaid Residents (CT only)	\$	407,665			407,665
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)	\$				
b. Medicare Room and Board Contractual Allowance **	\$				
4. a. Private-Pay Residents and Other	\$	136,050			136,050
b. Private-Pay Room and Board Contractual Allowance **	\$				
II. Other Resident Revenue					
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	\$				
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.)	\$	543,715			543,715
IV. Other Revenue*					
Meals sold to guests, employees & others	\$		·····		1
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)	\$				
V. Total Other Revenue (1 thru 8)	\$				
VI. Total All Revenue (III +V)	\$	543,715			543,715

<sup>\*</sup> Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

<sup>\*\*</sup> Facility should report all contractual allowances and/or payer discounts.

#### Schedule of Other Resident Revenue - Medicare

#### Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
h de l'agreeme				
V 2 144 V 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			2017/2018/2019/2019/2019	29 - 20 - 25 - 25
3854382555		400 55 54 55 55	0) 100 000 000 000 000 000 000 000 000 0	.52-60-6-00-6-
				ere twente att ter
Total Oth	er Resident Revenue - Medicare	\$ -	\$ -	\$ -

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

#### Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
			4.00044400.000.0000	2500 200 200 200 200
		-v= 000000000000000000000000000000000000	500 AT 12 AT 15 AP 1 AP 1 A	
Total Oth	er Resident Revenue	\$ -	\$	\$ -

#### **Interest Income**

#### Account

					Residential
Page Ref	Account	Balance	CCNH	RHNS	Care Home
363000000000000000000000000000000000000					
- Pro-Einstein					
	110				0000002549000000000 Ecologic Student (EC
Augustania (		all officers of the second			
Total Inte	rest Income		\$	\$ -	\$

#### Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
. 0				
		88 S. E. E. E.	2000 5000 600	
100000000000000000000000000000000000000		0.000 660 000 000 000		
	10 (20 (20 (20 (20 (20 (20 (20 (20 (20 (2			
Total Oth	er Revenue	\$ 3 2 3 - 3	\$ -	\$ -

## G. Balance Sheet

Name	of	f Facility	License No.	Report for Year Ended		Page	of
Morn	ing	Star Residential Care Home,	, I 1884	9/30/2015		31	37
			Account			Am	ount
Asset	S	111111 H-11					
A.	Cu	rrent Assets					
	1.	Cash (on hand and in banks	)		\$		(11,328)
	2.	Resident Accounts Receival	ole (Less Allowance f	for Bad Debts)	\$		22,415
	3,	Other Accounts Receivable	(Excluding Owners o	r Related Parties)	\$		
	4	Inventories			\$		1,080
	5.	Prepaid Expenses			\$		9,758
		a. Prepaid oil		691			
		b. Prepaid insurance		9,067			
		c					
		d.					
		Interest Receivable			\$		
	7.	Medicare Final Settlement R	teceivable		\$		
	8.	Other Current Assets (itemiz	re)		\$		
		tal Current Assets (Lines A1	thru 8)		\$		21,925
		ked Assets					
		Land			\$		•
	2.	Land Improvements	*Historical Cost		\$		
			Accum. Depreciati	ion Net			
	3.	Buildings	*Historical Cost		\$		
			Accum. Depreciat				
	4.	Leasehold Improvements	*Historical Cost	44,820	\$		14,228
			Accum. Depreciati	ion 30,592 Net			
	5.	Non-Movable Equipment	*Historical Cost		\$		
			Accum. Depreciati		<b>.</b>		
	6.	Movable Equipment	*Historical Cost	14,843	\$		
			Accum. Depreciat				
	7.	Motor Vehicles	*Historical Cost	4,905	\$		
			Accum, Depreciat	ion 4,905 Net	ф		
	8.	Minor Equipment-Not Depre	eciable	ı	\$		
	9.	Other Fixed Assets (itemize	)		\$		
		`	•	•			
B-10.	1	Total Fixed Assets (Lines E	31 thru 9)		\$		14,228

<sup>\*</sup> 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 Ended	Page	of
Morning Star Residential Care Home	e, Ii 1884	9/30/2015	32	37
	Account		I	Amount
		Total Brought Forward	1: \$	36,153
C. Leasehold or like property reco	rded for Equity Purpo	ses.		"
1. Land			\$	:
2. Land Improvements	*Historical Cost			
	Accum. Depreciati	ion Net	\$	
3. Buildings	*Historical Cost			
	Accum. Depreciati	ion Net	\$	
4. Non-Movable Equipment	*Historical Cost			
	Accum, Depreciati	ion Net	\$	
5. Movable Equipment	*Historical Cost			
	Accum. Depreciati	ion Net	\$	
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciati	ion Net	\$	
7. Minor Equipment-Not Dep			\$	
C-8 Total Leasehold or Like Prope	erties (C1 thru 7)		\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	1,238
2. Escrow Deposits			\$	
3. Organization Expense	*Historical Cost	300		
	Accum. Depreciati	ion 300 Net	\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Res	ident Care (itemize)		\$	
6. Loans to Owners or Related	l Parties (itemize)		\$	NAME OF THE PARTY
Name and Address	Amount	Loan Date		
			######################################	
7. Other Assets (itemize)			\$	
	W 18 1 W 1 C 1	· · · · · · · · · · · · · · · · · · ·		
	/ /T! Did	<b>~</b> `		1.000
D-8. Total Investments and Other	· · · · · · · · · · · · · · · · · · ·	7)	\$	1,238
D-9. Total All Assets (Lines A9 + E	310 + C8 + D8)	·	\$	37,391

<sup>\*</sup> 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
Morning Sta	ır Res	idential Care Home, Inc.	1884	9/30/2015		33	37
			Account			Am	ount
Liabilities							
A.	Cu	rrent Liabilities			1.		
	1.	Trade Accounts Payable			\\$		4,958
	2.	Notes Payable (itemize)			3		
				····			
			-				
		Loans Payable for Equipm	ont (Campont nontion	a) (itamiga)		,	
	٥.	Name of Lender	Purpose	Amount	Date Due	)	
	*****	Name of Lender	1 thpose	Amount	Date Due		
	4.	Accrued Payroll (Exclusive					4,165
	5.	Accrued Payroll (Owners		only)	\$		527
	6.	Accrued Payroll Taxes Pay		DESCRIPTION OF THE PROPERTY OF	\$		
	<u>7.</u>	Medicare Final Settlement					
	8.	Medicare Current Financia			\$		
	9.	Mortgage Payable (Curren					
		. Interest Payable (Exclusive	e of Owner and/or R	elated Parties)	\$		250
		. Accrued Income Taxes*					250
	12	. Other Current Liabilities (	•		\$	)	32,731
		Pension payable		941			
	· (·	Webster LOC		790	<u> </u>		
	_	The second secon					
A-13	To	tal Current Liabilities (Lin	es A1 thru 12)		<u> </u>	3	42,631
A-13	,, 10	an Carrent Masumes (Dill	war und 127		. [4	,	14,001

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

(Carry Total forward to next page)

# G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year	Ended	Page	of
Morning Star Residential Care Home, Inc.	1884	9/30/2015		34	37
	Account			Amo	
		Total Broug	ht Forward:		42,631
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment		1	\$		
Name of Lender	Purpose	Amount	Date Due		
			r in		
2. Mortgages Payable			\$		
3. Loans from Owners or Rel	ated Parties (itemize)		\$		19,083
Name and Address of Lender	Amount	Loan D	management of the second secon		
Brian Gulian	19,083	open			
		1			
•					
4. Other Long-Term Liabilitie	es (itemize)	<u> </u>	\$		
,. other bong to michaeline	( )				
···					
B-5. Total Long-Term Liabilities (	Lines B1 thru 4)		\$		19,083
C. Total All Liabilities (Lines A-	13 + B-5)		\$		61,714

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

•	·	License No.	Report for Year Ended	Pa	-
Mor	ning Star Residential Care Home,	1884 Account	9/30/2015	35	5   37 Amount
A.	Reserves	Account			Amount
	1. Reserve for value of leased la	ınd		\$	
ν,	Reserve for depreciation value to be amortized	e of leased build	lings and appurtenances	\$	
	3. Reserve for depreciation valu	e of leased perso	onal property (Equity)	\$	
	4. Reserve for leasehold real pro	perties on which	h fair rental value is based	\$	
•••	5. Reserve for funds set aside as	donor restricted	l	\$	
	6. Total Reserves			\$	
В.	Net Worth				
	1. Owner's Capital			\$	
	2. Capital Stock			\$	
	3. Paid-in Surplus			\$	5,000
	4. Treasury Stock	<b>****</b>		\$	
	5. Cumulated Earnings			\$	(26,905
	6. Gain or Loss for Period	10/1/2	014 thru 9/30/2015	\$	(2,418
	7. Total Net Worth		· · · · · · · · · · · · · · · · · · ·	\$	(24,323
C.	Total Reserves and Net Worth			\$	(24,323
D.	Total Liabilities, Reserves, and I	Net Worth		\$	37,391

# H. Changes in Total Net Worth

Name of Facility		License No.	Report for Year	r Ended	Page	of
Mori	ning Star Residential Care Home, In	1884	9/30/2015		36	37
		Account	count			mount
A. Balance at End of Prior Period as shown on Report of 09/30/2014						(21,905)
В.	Total Revenue (From Statement of				\$	543,715
C.	Total Expenditures (From Stateme	nt of Expenditures I	Page 27)		\$	546,133
D.	Net Income or Deficit				\$	(2,418)
E.	Balance				\$	(24,323)
F.	Additions  1. Additional Capital Contributed  2. Other (itemize)	(itemize)				
	F-3. Total Additions					
G.	Deductions 1. Drawings of Owners/Operators	Dortners (Spacify)			\$	
<u> </u>	Name and Address ( <i>No., City,</i>	<u>, , , , , , , , , , , , , , , , , , , </u>	Title	Amount	Ψ	
		State, Zip j	Title	Amount	\$	
	2. Other Withdrawings (Specify)					X X X X X X X X X X X X X X X X X X X
	Purpose	Amount		ount		
	3. Total Deductions				\$	
H.	Balance at End of Period	09/30/	15		\$	(24,323)

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

Name of Facility	License No.	Report for Year Ended	Page	of					
Morning Star Residential Care Home, Inc.	1884	9/30/2015 37 37		37					
Check appropriate category									
Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)	☑ Residential Care Home							
Preparer/Reviewer Certification									
I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.									
Signature of Preparer	Title	Date Signed							
Printed Name of Preparer									
Davis, Mascola & Phillips, LLC									
Addres Address		Phone Number							
1062 Barnes Rd, Ste. 203, Wallingford, CT 0	203-265-0488								