State of Connecticut



Annual Report of Long-Term Care FacilityCost Year 2016

Name of Facility (as	licensed)							
Morning Star Resider	ntial Care Home	e, Inc.						
Address (No. & Stree	et, City, State, Z	Zip Code)						
38 Elizabeth St, PO I	Box 187, Kent,	CT 06757						
Type of Facility								
Chronic and C	Convalescent		Rest Home wit	th Nursing				
☐ Nursing Home	e only		Supervision or	ıly	V	Residenti	al Ca	re Home
(CCNH)			(RHNS)					
Report for Year Begi	nning		Report for Yea	r Ending				
10/1/2015			9/30/2016					
License Numbers:		CCNH	RHNS	Reside	ntial Care l	Home	Me	dicare Provider
					1884			
				·				
Medicaid Provider N	umbers:	CC	CNH	RH	INS		IC.	F-IID
For Department Us	e Only							
Sequence Number	Signed and	Date	Sequence N	Number	Signed o	nd Notari	zad	Date Received
Assigned	Notarized	Received	Assign	ed	Signed a	III NOTALI	zeu	Date Received

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Morning Star Residential Care Home, Inc.	1884	9/30/2016	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, 2015 and ending September 30, 2016, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

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

(Notary Seal)

State of Connecticut **Department of Social Services**

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	tm	ent		Page	of
				1A	37
Name of Facility		Period Cov	ered:	From	То
Morning Star Residential Care Home, Inc.				10/1/2015	9/30/2016
Address of Facility					
38 Elizabeth St, PO Box 187, Kent, CT 06757		,			
Report Prepared By		Phone Nun		Date	
Davis, Mascola & Phillips, LLC		203-265-04	88		
					Residentia 1 Care
Item		Total	CCNH	RHNS	Home
1. Dietary wages paid	\$				
2. Laundry wages paid	\$				
3. Housekeeping wages paid	\$				
4. Nursing wages paid	\$				
5. All other wages paid	\$				
6. Total Wages Paid	\$				
7. Total salaries paid	\$				
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire Type of Facility - Organization Structure

			ne No. of Fac -927-3272	cility	Report for Ye 9/30/2016	ar Ended	Page 2	o 3'	
Name of Facility (as shown on license)		800		2 & 9	Street, City, Sta	ata Zin)			
Morning Star Residential Care Home, Inc.			1 '		PO Box 187, K)6757		
Trieffining Star Teoriasina Sare Home, mer	CCNH		RHNS	_	dential Care H		Medicare I	rovide	r No.
License Numbers:	001,111		202210	11001		884		101100	
Type of Facility (Check appropriate box(es	3))			-					
Chronic and Convalescent Nursing Home only (CCNH)			t Home with i		- 1/1	Residenti	ial Care Hon	ne	
Type of Ownership (Check appropriate box	r)								
O Proprietorship	Partnership	0	Profit Corp.	0	Non-Profit Cor	rp. O	Government	0 1	Γrust
If this facility opened or closed during repo	ort year provid	e:		Date	Opened	Date Clo	sed		
Has there been any change in ownership				-					
or operation during this report year?		0	Yes	•	No	If "Yes,"	explain full	y.	
Administrator									
Name of Administrator					Nursing Ho	ome			
Brian Gulian					Administrat	or's			
					License N	No.:			
Other Operators/Owners who are assistant	administrators	(ful	or part time)	of th					
Name					License N	No.:			

General Information and Questionnaire Partners/Members

Name of Facility		License No.	Report for Y	Year Ended	Page of
Morning Star Residential Care	Home, Inc.	1884	9/30/2016		3 37
Legal Name of Part		Business A	Address		or Town(s) in egistered
Morning Star Residential Care		38 Elizabeth St, 187, Kent, CT 0		СТ	
Name of Partners/Members	Business Ac	ldress		Title	% Owned
Brian Gulian	57 Brook Rd, Valley S 11581	tream, NY	Member		100

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	9/30/2016		3A	37
If this facility is owned or operated as a corpo	oration, provide the	e following informat	tion:		
Legal Name of Corporation	Busines	s Address	State(s) in Whi	ch Incorp	orated
Name of Directors, Officers	Busines	s Address	Title	No. Si Held by	
Names of Stockholders Owning at Least 10% of Shares					

General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page of
Morning Star Residential Care Home, Inc.	1884	9/30/2016	3B 37
If this facility is owned or operated as an individua	l proprietorship, p	rovide the following informat	ion:
	ner(s) of Facility		
	1		

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General Information and Questionnaire Related Parties*

Name of Facility Morning Star Residential Care Home, Inc.	ıl Care Home, İnc.	License No.	No. 1884		Report for Year Ended 9/30/2016		Page 4	of 37
Are any individuals rece	Are any individuals receiving compensation from the facility related through	icility re	ated thre	qgnc		If "Yes," provide the Name/Address and	le Name/Add	lress and
marriage, ability to cont	marriage, ability to control, ownership, family or business association?	ess assoc	iation?	0	Yes O No	complete the information on Page 11 of the report.	nation on Pa	ge 11 of the report.
A ** Claribinitation	above objects doiling actions		6					
including the rental of p	Are any manyiduals of companies which provide goods of services, including the rental of property of the loaning of funds to this facility.	or servi to this fa	cility.					
related through family a	related through family association, common ownership, control, or business	control	or busin	ıess	O Yes O No			
association to any of the	association to any of the owners, operators, or officials of this facility?	of this fa	cility?			If "Yes," provide the following information:	e following	information:
		Also J	Also Provides Goods/Services to	S S S		Indicate Where		
Name of Related	Business	Non-R	Non-Related Parties	arties	Description of Goods/Services	in Annual Report	Cost	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	0		Officer Loan	P 34, L B3	27,652	27,652
Brian Gulian	38 Elizabeth St, Kent, CT 06757	0	•		Real estate rental	P 22, L 9	90,000	000,006
Brian Gulian	38 Elizabeth St, Kent, CT 06757	0	•		Administrator	P 12, Sec III	51,259	51,259
Audrey Gulian	38 Elizabeth St, Kent, CT 06757	0	•		Clerical	P 11, Sec II	19,619	19,619
		0	0					
		0	0					
		0	0					
		0	0					
		0	0					
* I To additional charte if necessary	if nooocour.							

^{*} 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
Morning Star Residential Care Home, Inc.	1884		9/30/2016	5	37
If the facility is licensed as CDH and/or RCH o	r provides A	AIDS or TB	I services with special Medicaio	d rates,	costs
must be allocated to CCNH and RHNS as follow	ws:				
Item			Method of Allocation		
Dietary		Number of	meals served to residents		
Laundry		Number of	pounds processed		
Housekeeping		Number of	square feet serviced		
		Number of	hours of routine care provided	by EAC	CH
Nursing		employee o	classification, i.e., Director (or	Charge :	Nurse),
		Registered	Nurses, Licensed Practical Nur	rses, Ai	des and
		Attendants			
Direct Resident Care Consultants		Number of	hours of resident care provided	l by EA	.CH
		specialist ((See listing page 13)		
Maintenance and operation of plant		Square feet			
Property costs (depreciation)		Square feet	i.		
Employee health and welfare		Gross salar	ies		
Management services		Appropriat	e cost center involved		
All other General Administrative expenses		Total of Di	rect and Allocated Costs		
The preparer of this report must answer the foll	owing ques	tions applic	able to the cost information pro	vided.	
1. In the preparation of this Report, were all	O 17	O N	If "No," explain fully why sucl	h alloca	tion was
costs allocated as required?	O Yes	O No	not made.		
•					
2. Explain the allocation of related company ex	penses and	attach copy	of appropriate supporting data	•	
	•				
3. Did the Facility appropriately allocate and se	elf-disallow	direct and i	indirect costs to non-nursing ho	me cos	t centers?
(e.g., Assisted Living, Home Health, Outpati			-		
(8-,			If "No," explain fully why such	h allaan	tion was
	O Yes	O No	not made.	n anoca	lion was
			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.

should not be included in these amounts.				3	,		
Name of Facility			License No.	Report for Year Ended	ear Ended		Page of
Morning Star Residential Care Home, Inc.			1884	9/30/2016			6 37
	Related * to	d * to					
	Owners,	ers,					
	Operators,	itors,				Annual	
	Officers	cers		Date of	Term of	Amount	Amount
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	of Lease	Claimed
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					

Is a Mileage Log Book Maintained for All Leased Vehicles?

Total ***

o No

O Yes

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

** Attach copies of newly acquired leases.

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

General Information and Questionnaire Accounting Basis

Name of Facility	License No.	Report for Year Ended		Page of
Morning Star Residential Care Hor	1884	9/30/2016		7 37
	·	were maintained on the following basis:		
	Modified Cash			
Is the accounting basis for this				
I*	Yes	If "No," explain.		
previous period?	No			
Independent Accounting Firm				
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)		
1 Davis, Mascola & Phillips, LL	C	1062 Barnes Rd, Ste. 203, Wallingford, C	CT 06492	
2				
3				
4				
Services Provided by This Firm (de	escribe fully)			
1 Preparation of cost report, tax return	and assistance with 2011 audit		\$	7,500
2			\$	
3			\$	
4			\$	
			Charge for Se	rvices Provided
			\$	7,500
Are These Charges Reflected in the Expen	diture Portion of This Report? If Y	es, Specify Expense Classification and Line No.		.,
⊙ Yes O No	P 15, L 1d			
Legal Services Information				
Name of Legal Firm or Independen	t Attorney		Telephone Nu	ımber
1				
2				
3				
4				
5				
Address (No. & Street, City, State,	Zip Code)			
1				
2				
3				
4				
5 Services Provided by This Firm (de	escribe fully)			
1	,		\$	
			\$	
2				
3			\$	
4			\$	
I a			\$	
5			1	
5			1	rvices Provided
	diture Portion of This Report? If Y	es, Specify Expense Classification and Line No.	Charge for Se	rvices Provided
	diture Portion of This Report? If Y	es, Specify Expense Classification and Line No.	Charge for Se	rvices Provided

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Schedule of Resident Statistics

Name of Facility			License No.	70.			Report for	Report for Year Ended	7		Page	fo
Morning Star Residential Care Home, Inc.				1884			9/30/2016	,			∞	37
						Period 10/1 Thru 6/30	1 Thru 6/	30		Period 7/1 Thru 9/30	1 Thru 9/2	0
	Total All	Total CCNH	Total RHNS	Total Residential				Residential				Residential
	Levels	Level	Level	Care Home	Total	CCNH	RHNS	Care Home	Total	CCNH	RHNS	Care Home
1. Certified Bed Capacity	,			:	,							
A. On last day of PREVIOUS report period	18			18	18			28	18			18
B. On last day of THIS report period	18			18	18			18	18			18
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	15			15	16			16	15			15
3. Total Number of Days Care Provided During Period												
A. Medicare												
B. Medicaid (Conn.)	4,746			4,746	3,642			3,642	1,104			1,104
C. Medicaid (other states)												
D. Private Pay	1,430			1,430	1,092			1,092	338			338
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	6,176			6,176	4,734			4,734	1,442			1,442
Total Number of Days Not Included in Figures in 3G 4 for Which Revenue Was Received for Reserved	rD											
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	6,176			6,176	4,734			4,734	1,442			1,442

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Schedule of Resident Statistics (Cont'd)

Name of Facil	lity			Licer	ise No.				Report	for Year	Ended		Page	of
Morning Star	Residen	tial Car	e Home, Inc.] 1	1884					9/30/201	6		9	37
	-	_	in the certified b		pacity du	ring tl	пе геро	rt yea	r?	0	Yes	0	No	
II IES			Change	lion.	Ch		in Dad			Con	nagity A ft	or Changa		
		Place of	Residential	<u> </u>	Cr	lange	in Bed	S		Ca	pacity Afte	r Change		
Date of	CCNH	RHNS	Care Home		Lost		(Gaine	d					
					Boot							Residential		
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Care Home	Reason fo	or Change
			,	Ť		Ť								
			in certified bed o 90 days followir			the re	eport ye	ear (as	report	ed in item	4 above)	provide the nur	nber of	
104 -1			Change in Ro	esiden	nt Days					CC	NH	RHNS	Residential	Care Home
1st change 2nd char									_					
3rd chan									_					
4th chan														
		dents an	d Rates on Septe	mber	30 of Co	st Ye	ar							
			Medicare		Medi	caid				Se	lf-Pay		Other Star	e Assisted
	Item		CCNH	C	CNH	Ri	HNS	CC	CNH	RF	INS	Residential Care Home	R.C.H.	ICF-MR
No. of R			001111	Ť	01111							3	12	
Per Dien					1 2 5 1	File		Bill	15.81		100	74	E UNI	
a. One b	ed rm.											93.70	86.90	
b. Two	bed rms.			_										
c. Three		e												
bed r	ms.													
		-	al Therapy Treat	ments	S					то	TAL	CCNH	RHNS	Residential Care Home
		re - Par												
В.			lusive of Part B) e Treatments											
			Treatments			_								
C.	Other	torative	Troumonts											
		Physical	Therapy Treatm	nents										
8. Total Nu	ımber of	f Speech	Therapy Treatn	nents						18 - 1				Attack to
		re - Par												
B.			lusive of Part B)							III-III		Harden Sell		
			e Treatments											
		torative	Treatments											
	Other	Snaach 7	Therapy Treatm	ante										
			ational Therapy		ments							NOTE OF		
		re - Par		ricau							Disco III			
			lusive of Part B)									or Action and	R.D. B.	
			e Treatments											
	2. Res		Treatments											
	Other													
D.	Total C	ecupati)	ional Therapy T	reatn	ients									

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.		Report for Yea		Page	of
Morning Star Residential Care Home, Inc.	1884		9/30/2016		10	37
Are time records maintained by all individuals receiving co	mpensation?	•	Yes	0	No	
			Total Cost a	and Hours		
	CON III		DADA		Residential	**
Item	CCNH	Hours	RHNS	Hours	Care Home	Hours
Salaries and Wages* Operators/Owners (Complete also Sec. I of Schedule A1)			THE SHALL			
2. Administrator(s) (Complete also Sec. III					53.100	2.000
of Schedule A1) 3. Assistant Administrator (Complete also Sec. IV					53,109	2,080
of Schedule A1)						
4. Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)					22,381	1,853
Dietary Service a. Head Dietitian						
b. Food Service Supervisor	1		1	<u> </u>	t	
c. Dietary Workers					33,571	2,779
6. Housekeeping Service			D. 3.1.1.			E 3 194
a. Head Housekeeper						
b. Other Housekeeping Workers					16,785	1,389
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	1				15 107	1.057
b. Other Maintenance Workers 8. Laundry Service					15,187	1,257
a. Supervisor						
b. Other Laundry Workers					3,996	331
Barber and Beautician Services						
10. Protective Services						
11. Accounting Services		W-0				
a. Head Accountant						
b. Other Accountants 12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses b. RN						
1. Direct Care			- 11	The second second		
2. Administrative**						
c. LPN						
1. Direct Care						
2. Administrative**						
d. Aides and Attendants					53,554	4,433
e. Physical Therapists f. Speech Therapists						
g. Occupational Therapists	1	-				
h. Recreation Workers					14,388	1,191
i. Physicians			Bisquest, no			
Medical Director						
Utilization Review						
3. Resident Care***						
4. Other (Specify)		No. 200 A			E TO TOTAL	- 1 6 - 1
j. Dentists						
k. Pharmacists						
1. Podiatrists	1				-	
m. Social Workers/Case Management n. Marketing	1				-	
o. Other (Specify)				20,320		
See Attached Schedule						
A-13. Total Salary Expenditures					212,971	15,313

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

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

^{***} This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

Schedule of Other Salaries and Wages (Page 10)

	(CCNH	R	HNS	Residentia	Care Home
Position	\$	Hours	\$	Hours	\$	Hours
		-				1
						+
			+			
Total	\$ -		\$ -		\$ -	
1 0(8)	\$ -	<u> </u>	- \$	<u> </u>		-

Schedule of Other Fees (Page 13)

		CNH	R	HNS	Residentia	l Care Home
Service	\$	Hours	\$	Hours	\$	Hours
			1			
				1		
						1
Total	\$ -	-	\$ -		\$ -	-

......

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

Assistant Administrators and Other Related Parties*

Name of Facility			Assistan	r Administr	Assistant Administrators and Other Related Parties*	Relate	Kelated Parties	4	Родо	40
Ivalle of Facility				LICCING INO.		neport for	I cal Ellucu		rage	ĭ
Morning Star Residential Care Home, Inc.	me, Inc.			1884		9/30/2016			11	37
		Salary Paid	q							
			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	RHNS	Care Home	9	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			19,619	19,619 Pension	Clerical, aid and recreation	1,040	1,040 A-4, 12d, 12l			
* No allowance for salaries will be considered unless full information is movided. Itse additional sheets if required	he consider	ed unless fi	Il information	n is mosnidad He	podditional chapte if rea	horin				

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

^{**} Include all employment worked during the cost year.

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

Assistant Administrators and Other Related Parties*

Nome of Equility (on lines and)			T TOOLOGIC T	***	Administrators and Carlot resulted a district	Denort for Veer Foded	L W. L. C.		Рада	30
name of racility (as incensed)				LICCIISC INO.		Nepoli 101 1	במו דווחבת		1 age	10
Morning Star Residential Care Home, Inc.	me, Inc.			1884		9/30/2016			12	37
		Salary Paid	p							
			:	Fringe Benefits and/or Other		Total			Total	
Name	CCNH	RHNS	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	Compensation Received
Section III - Administrators***										
Brian Gulian			53,109	53,109 health insurance	Administration	2,080				
Section IV - Assistant Administrators										
*No office of the solution of	he concide	toolan boo	11 informatio		bariman fi standa lancitible as I Labinoma si	minod				

^{*}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

,	License No.		Report for Y		Page	of
Morning Star Residential Care Home, Inc.	188	34	9/30/2016	1 77	13	37
			Total Cost	and Hours	т т	
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
*B. Direct care consultants paid on a fee						
for service basis in lieu of salary			100000	The same in	3-18-17	
(For all such services complete Schedule B1)				T. F. L.		
1. Dietitian						
2. Dentist						
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians			3.10-6	35 34		
a. Medical Director (entire facility)						
b. Utilization Review		اغراضا	196 - 19	N. 15		4111
(Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility	أالنس الملاآ					PRO
Infection Control Committee						
(Quarterly meetings) 2. Pharmaceutical Committee			-			
(Quarterly meetings)						
3. Staff Development Committee						
(Once annually)						
e. Other (Specify)					Part Spill	
9. Speech Therapist				1 2 3 1		- 0 - 1
a. Resident Care						
b. Other						
10. Occupational Therapist			LER SUS	45 1 - 2		المات الم
a. Resident Care						
b. Other						
11. Nurses and aides and attendants	- 12	I STATE OF		The state of		BULL
a. RN				11 - 2		
1. Direct Care						
2. Administrative***						
b. LPN		The Party	ST PRE	and the		
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						_
12. Other (Specify)						11/21/19
See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries			1			

^{*} 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 Morning Star Residential Care Home, Inc.	License No. 1884		Report for Y 9/30/2016	ear Ended	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Operato	* to Owners, rs, Officers	Expla	nation of Relat	ionship
		Yes	No			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
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		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			

^{*} Use additional sheets if necessary.

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility Lices	nse No.	Report for Ye	ar Ended	Page	of
Morning Star Residential Care Home, Inc.	1884	9/30/2016		15	37
					Residential
Item		Total	CCNH	RHNS	Care Home
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	6,399			6,399
2. Disability Insurance	\$	187			187
3. Unemployment Insurance	\$	4,392			4,392
4. Social Security (F.I.C.A.)	\$	16,122			16,122
5. Health Insurance	\$	58,529			58,529
6. Life Insurance (employees only)					
(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		1-517 - 1-1	3110,000	STATE OF	THE WASTER
b. Personal Retirement Plans, Pensions, and	\$				
Profit Sharing Plans for Owners and		N 2 - 1		100 to 11	The state of the s
Operators (Discriminatory)*		13-1-1			100
c. Bad Debts*	\$				DV TREE
d. Accounting and Auditing	\$	7,500			7,500
e. Legal (Services should be fully described on P		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
f. Insurance on Lives of Owners and	\$	7,800			7,800
Operators (Specify)*	7				Carlo and the same
g. Office Supplies	\$	857			857
h. Telephone and Cellular Phones				Te English	Se lieue
1. Telephone & Pagers	\$	2,430			2,430
2. Cellular Phones	\$,			
i. Appraisal (Specify purpose and	\$				
attach copy)*		La sea l'ille	AL PAUL SIN		Land St
		The State of			
j. Corporation Business Taxes (franchise tax)	\$				
k. Other Taxes (Not related to property - See Pag	ge 22)				The second
1. Income*	\$				
2. Other (Specify)	\$				
See Attached Schedule			Tracki (Ti		
3. Resident Day User Fee	\$				
Subtotal	\$	119,158			119,158

^{*} 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. 9/30/2016

Attachment Page 15

Schedule of Other Employee Benefits

		-	Residential
Description	CCNH	RHNS	Care Home
			+
		_	4
	Wallington and the same of the	_	
		1	
		1	1
Total	\$ -	\$ -	\$ -

Schedule of Other Taxes

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

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

Name of Facility	License No.	Ī	Report for Y	ear Ended	Page	of
Morning Star Residential Care Home, Inc.	1884		9/30/2016		16	37
Item			Total	CCNH	RHNS	Residential Care Home
Sui	btotals Brought Forwar	rd:	119,158			119,158
Travel and Entertainment	g				Transfer VST	
Resident Travel and Entertainment		\$				
2. Holiday Parties for Staff		\$				
3. Gifts to Staff and Residents		\$	283			283
4. Employee Travel		\$				
5. Education Expenses Related to Semina	ars and Conventions	\$				
6. Automobile Expense (not purchase or		\$	962			962
7. Other (Specify)		\$				
See Attached Schedule					30 1 37	
m. Other Administrative and General Expense	es			T Yang		
1. Advertising Help Wanted (all such exp		\$				
2. Advertising Telephone Directory (all s	such expenses)***	\$	1,267			1,267
3. Advertising Other (Specify)***		\$				
See Attached Schedule			Market St.	ARE STATE	1000	T- 373 174
4. Fund-Raising***		\$				
5. Medical Records		\$				
6. Barber and Beauty Supplies (if this ser	vice is supplied	\$				
directly and not by contract or fee for s			100 Lat 1	Charles St.	11/11/11	
7. Postage	•	\$	418			418
* 8. Dues and Membership Fees to Profess:	ional	\$	500			500
Associations (Specify)		- 1	2000	134 F	The Land	20 7 11 15
See Attached Schedule						125,1510
8a. Dues to Chamber of Commerce & Other N	Ion-Allowable Org.***	\$				
9. Subscriptions		\$	208			208
10. Contributions***		\$				
See Attached Schedule			ATTER Y	Part of		F 25
11. Services Provided by Contract (Specify	v and Complete	\$				
Schedule C-2, Page 21 for each firm or	r individual)		K TYTE			THE PARTY OF
12. Administrative Management Services*		\$				
13. Other (Specify)		\$	3,673			3,673
See Attached Schedule				PART		
C-14 Total Administrative & General Expendit	ures	\$	126,469			126,469

^{*} 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	C	CNH	R	HNS		dential Home
					-	_
			+		-	
	_		+-		-	-
Total Other Travel and Entertainment	\$		\$		\$	

Schedule of Other Advertising

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

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home		
ARCH			\$	500	
			-		
			-		
			1	44-	
Total Dues	s -	\$ -	\$	500	

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home		
Payroll processing fee			\$	1,593	
Pension administration fees			\$	1,084	
Treasurer, State of CT			\$	646	
Torrington Area health			\$	350	
				12101	
			-		
Total Other Administrative and General	\$ -	s -	s	3,673	

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page	of
Morning Star Residential Care Home, Inc		9/30/2016	17	37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Whare Included Report Page	in Annual
Company Supprying Service	Bel vice	Tiovided	Report Lago	J III LINE II

^{*} 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)

	ne of Facility ning Star Residential Care Home, Inc.		Licen		No. 1884	Report for Y 9/30/2010		Page of 18 37
IVIOI	Item				Total	CCNH	RHNS	Residential Care Home
2.	Dietary a. In-House Preparation & Service			•		CCIVII	King	
	 Raw Food Non-Food Supplies Other (Specify) 			\$ \$ \$	33,717			33,717
	3. Other (Specify)			٩				W. W. D.
	b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)			\$				
	c. Management Services** d. Other (Specify)		4	\$				
2E.	Total Dietary Expenditures $(2a+b+c+d)$			\$	33,717			33,717
2F.	Dietary Questionnaire				Total	CCNH	RHNS	Residential Care Home
G.	Resident Meals: Total no. of meals served per	r da	y:*		48			48
H.	Is cost of employee meals included in 2E?	0	Yes		•	No		
I.	Did you receive revenue from employees?	0	Yes		•	No	If yes, specify amt.	
J.	Where is the revenue received reported in the	Co	st Rep	ort	? (Page/Line	Item)		
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	0	Yes		•	No	If yes, specify cost.	
L.	Is any revenue collected from these people?	0	Yes		0	No	If yes, specify amt.	
M.	Where is the revenue received reported in the	Co	st Rep	ort	? (Page/Line	Item)		
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	0	Yes		•	No	If yes, specify cost.	
O.	Is any revenue collected from employees?	0	Yes		•	No	If yes, specify amt.	
P.	Where is the revenue received reported in the	Co	st Rep	ort	? (Page/Line	Item)		

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

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

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

	of Facility	License		1 -	Year Ended	Page	of
Morni	ing Star Residential Care Home, Inc.		1884	9/30/2016		19	37
	T.		77 1	COMIT	DIDIG	ı	ential Care
	Item	r	Total	CCNH	RHNS	1	Iome
	Laundry I. In-House Processing* 1. Bed linens, cubicle curtains, draperies,	Lbs.					
	gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	472				472
	Employee items including uniforms, gowns, etc. washed, ironed and/or	Lbs.					
	processed.***	Amt. \$					
	3. Personal clothing of residents	Lbs.					
	washed, ironed, and/or processed.***	Amt. \$					
	4. Repair and/or purchase of linens.***	Lbs.				-	
		Amt. \$					
b	o. Purchased Services (by contract other	\$					
	than through Management Services)						VI III
	(Complete Schedule C-2 att. Page 21)				171.49		
	. Management Services**	\$					
d	l. Other (Specify)	\$			10 70 10	3003	\$50 BY
	Total Laundry Expenditures (3a + b + c + d)	\$	472				472
3F. I	Laundry Questionnaire						
G. Is	s cost of employee laundry included in 3E? O	Yes	•	No	If yes, specify cost.		
H. D	Oid you receive revenue from employees?	Yes	•	No	If yes, specify amt.		
I. V	Where is the revenue received reported in the Cost	Report?		(Page/Line	e Item)		
, Is	s Cost of laundry provided to persons other	Yes		No	If yes, specify cost.		
K. I	Oid you receive revenue from these people?	Yes	•	No	If yes, specify amt.		
L. V	Where is the revenue received reported in the Cost	Report?		(Page/Line	e 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)

Nan	ne of Facility	License No.	Rep	ort for Year E	nded	Page	of
Moı	ming Star Residential Care Home, Inc.	1884		9/30/2016	-	20	37
	Item			Total	CCNH	RHNS	Residential Care Home
4.	Housekeeping	Sq. Ft. Serviced					
	a. In-House Care	by Personnel					
	1. Supplies - Cleaning (<i>Mops</i> , pails, brooms, etc.)	Amt.	\$	1,228			1,228
	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)		\$	The Designation	entirolbe ki		
4E.	Total Housekeeping Expenditures (4a +	b+c+d)	\$	1,228			1,228
5.	Resident Care (Supplies)**						
	a. Prescription Drugs***						
	1. Own Pharmacy		\$				
	2. Purchased from		\$				
	b. Medicine Cabinet Drugs	=	\$				
	c. Medical and Therapeutic Supplies		\$				
	d. Ambulance/Limousine***		\$				
	e. Oxygen		_				
	1. For Emergency Use		\$				
	Other*** f. X-rays and Related Radiological		\$ \$				
	Procedures***		Ĭ,	INTERIOR STATE	9 A 7 B	HE - GE	
	g. Dental (Not dentists who should be inc	luded under	\$	lette utpel			
	salaries or fees)		\$				
	h. Laboratory*** i. Recreation		\$	2 722			2 722
	i. Recreation j. Other (Specify)****		\$	3,722 1,747			3,722 1,747
	See Attached Schedule		Φ	1,/4/			1,/4/
5K.	Total Resident Care Expenditures (5a - 5		\$	5,469			5,469

^{*} 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		idential e Home
Cable			\$	1,747
			1	_
			1	
			-	
			1.1	
			3 - 6	
			1	
			+	
Total Other Resident Care	\$ -	\$ -	\$	1,747

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

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 9/30/2016	75			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	Ño	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHINS	Residential Care Home	Pg 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							
,										

^{*} 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 Ye	ear Ended		Page	of
Morning Star Residential Care Home, Inc. 18	84	9/30/2016			22	37
					Residen	tial Care
Item		Total	CCNH	RHNS	Но	me
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	17,647				17,647
b. Heat	\$	11,621				11,621
c. Light & Power	\$	11,165				11,165
d. Water	\$	8,279				8,279
e. Equipment Lease (Provide detail on page 6)	\$					
f. Other (itemize)	\$					
See Attached Schedule			South 1			
6g. Total Maint. & Operating Expense (6a - 6f)	\$	48,712				48,712
7. Depreciation (complete schedule page 23*)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$	771				771
*7e. Total Depreciation Costs (7a + b + c + d)	\$	771				771
8. Amortization (Complete att. Schedule Page 24*)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$	4,595				4,595
d. Other (Specify)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$	4,595				4,595
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	\$	9,598				9,598
c. Personal property taxes	\$	150				150
11. Total Property Expenses $(7e + 8e + 9 + 10)$	\$	105,114				105,114

^{*} 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

	COM	DING	Residential
Description	CCNH	RHNS	Care Home
		+	
		-	
			-
Total Other Repairs and Maintenance	\$ -	\$ -	\$ -

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

Namon of Pacility Namo				and and	Dept celation Dencault	TIME					
Figure Property Team	Name of Facility Morning Star Residential Care Home. Inc.			License No.	4		Report for Year E 9/30/2016	papu		Page 23	of 37
Land Improvements Property Item Land Improvements Land Improvements	6										
Land Improvements Property Item				Historical Cost	Less		Accumulated Depreciation to	Method of			
Land Improvements Property Item				Exclusive of	Salvage	Cost to Be	Beginning of	Computing	Useful	Depreciation	
Land Improvements Land	Property Item			Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
1. Acquired prior bits report period (statch subchle) 2. Dispossible (states) schedule) 3. Acquired prior by this report period (statch subchle) 4. Subchle 5. Subchle 5. Subchle 6. Subchle 8. Subchle 9. Acquired during this report period (statch subchle) 1. Acquired prior to this report period (statch subchle) 1. Acquired prior to this report period (statch subchle) 1. Acquired during this report period (statch subchle) 1. Acquired during this report period (statch subchle) 1. Acquired during this report period (statch subchle) 2. Acquired during this report period (statch subchle) 3. Acquired during this report period (statch subchle) 4. Subchle 5. Subchle 6. Subchle 6. Subchle 8. Subchle 9. Subchle 1. Subchle 1. Subchle 1. Subchle 1. Subchle 1. Subchle 2. Movable Equipment 3. Acquired furing this report period (statch subchle) 4. Subchle 6. Acquired furing this report period (statch subchle) 8. Subchle 9. Subchle 1. Subchle 1. Subchle 1. Subchle 1. Subchle 2. Movable Equipment 3. Acquired furing this report period (statch subchle) 6. Acquired furing this report period (statch subchle) 9. Subchle 1. Subchle 1. Subchle 1. Subchle 1. Subchle 2. Movable Equipment 1. Subchle 1. Subchle 1. Subchle 1. Subchle 1. Subchle 2. Movable Equipment 3. Acquired subchle 4. Subchle 5. Subchle 6. Acquired subchle 6. Acquired subchle 6. Acquired subchle 6. Acquired subchle 8. Subchle 9. Subchle 9. Subchle 1. Subchle											
2. Disposals (statuch schedule) 4. Subroral 4. Subroral 4. Subroral 4. Subroral 5. Acquired during this report period (statuch schedule) 5. Acquired during this report period (attach schedule) 5. Acquired during this report period (attach schedule) 6. Acquired during this report period (attach schedule) 7. Acquired during this report period (attach schedule) 8. Acquired during this report period (attach schedule) 9. Acquired during this report period (attach schedule) 1. Acquired during this report period (attach schedule) 1. Acquired during this report period (attach schedule) 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) 4. Sahroral 1. Move Vehicles (Specify name, model and any vehicle) 4. Sahroral 2. Movable Equipment 3. Acquired prior to this report period 4. Sahroral 4. Acquired prior to this report period 5. Acquired during this report period 6. Acquired prior to this report period 6. Acquired prior to this report period 6. Acquired prior to this report period 7. Acquired prior to this report period 6. Acquired prior to this report period 7. Acquired prior to this report period 6. Acquired prior to this report period 6. Acquired prior to this report period 7. Acquired prior to this report period 6. Acquired prior to this report period 6. Acquired prior to this report period 6. Acquired during this report period 6. Acquired prior to this report period 7. Acquired prior to this report period 6. Acquired during this report period 7. Acquired prior to this report period 6. Acquired during this report period 7. Acquired prior to this rep	 Acquired prior to this report period 										
3. Acquired during this report period (attach schedule) Building and Building Improvements Careginate and Building Improv	2. Disposals (attach schedule)										
Subtotal Building Improvements	3. Acquired during this report period (attac	ch schedule)									
Building and Building Improvements	A-4. Subtotal								3		
1. Acquired prior to this report period (attach schedule) 2. Disposals (attach schedule) 3. Acquired through this report period (attach schedule) 4. Subtotal 3. Acquired through this report period (attach schedule) 3. Acquired through this report period (attach schedule) 3. Acquired through this report period (attach schedule) 4. Subtotal 2. Disposals (attach schedule) 3. Acquired attach schedule) 4. Subtotal 4. Subtotal 4. Subtotal 5. Acquired attach schedule) 5. Acquired attach schedule) 5. Acquired attach schedule) 6. Acquired attach schedule) 7. Subtotal 8. Subtotal 9. Acquired attach schedule) 1. Motor Varieles (Specify name, model and year of each vehicle) 8. Subtotal 1. Acquired attach schedule) 1. Motor Varieles (Specify name, model and year of each vehicle) 2. Movable Equipment 3. Acquired attach schedule) 4. Subtotal 9. Acquired attach schedule) 1. Acquired attach schedule) 1. Acquired attach schedule) 2. Movable Equipment 3. Acquired attach schedule) 4. Subtotal 6. Computing for the for This Year attach schedule) 6. Acquired attach schedule) 7. Acquired attach schedule) 8. Subtotal 9. Acquired attach schedule) 1. Acquired attach schedule) 1. Acquired attach schedule) 1. Acquired attach schedule) 1. Acquired attach schedule) 2. Acquired attach schedule) 3. Subtotal 4. Subtotal 5. Acquired attach schedule) 6. Acquired attach schedule) 7. Acquired attach schedule) 8. Subtotal 9. Acquired attach schedule) 1. Acquired attach											
2. Disposals (attach schedule) Non-Movable Equipment 1. Acquired during this report period (attach schedule) 3. Acquired during this report period (attach schedule) 4. Subotal 3. Acquired during this report period (attach schedule) 4. Subotal 4. Subotal 5. Acquired during this report period (attach schedule) 6. Subotal 7. Subotal 8. Subotal 9. Movable Equipment 1. Motor Vehicles (Specify name, model and year of each vehicle) 2. Acquired prior to this report period 4. Subotal 9. Acquired prior to this report period 1. Acquired prior to this report period 2. Acquired prior to this report period 3. Acquired prior to this report period 4. Acquired prior to this report period 4. Acquired prior to this report period 6. Acquired prior to this report period 9. Acquired prior to this report period 1. Acquired prior to this report period 2. Acquired prior to this report perior 3. Acquired prior to this report perior 4. Acquired prior to this report perior 5. Acquired prior to this report perior 6. Acquired prior to this	 Acquired prior to this report period 										
3. Acquired during this report period (attach schedule) S. Suboral Accumulated prior to this report period (attach schedule) B. Suboral Accumulated prior to this report period (attach schedule) B. Suboral Accumulated prior to this report period (attach schedule) B. Suboral Accumulated prior to this report period (attach schedule) B. Suboral Accumulated prior to this report period (attach schedule) B. Suboral	2. Disposals (attach schedule)										
4. Subtotal 1. Acquired during this report period (attach schedule) 2. Disposals (attach schedule) Is a mileage (prior) Table (attach schedule) Table (attach schedule) Table (attach schedule) Accumulated (attach schedule) Accu	3. Acquired during this report period (attac.	ch schedule)									
Non-Movable Equipment Acquired factor period (attach schedule) Acquired factor to this report period (attach schedule) Acquired factor to this report period (attach schedule) Acquired factor to this report period (attach schedule) Acquired factor schedule) Acquired fa	B-4. Subtotal										
1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) 4. Subtoral B. Subtoral Inaintained? Acquired during this report period (attach schedule) 4. Subtoral Inaintained? Acquired during this report period (attach schedule) 5. Acquired during this report period (attach schedule) 6. Disposals (attach schedule) 7. Subtoral Inaintained? Acquired during this report period (attach schedule) 8. Subtoral Inaintained? Acquired during this report period (attach schedule) 9. Disposals (attach schedule) 9. Disposals (attach schedule) 9. Subtoral Inaintained? Acquired during this report period (attach schedule) 9. Disposals (attach schedule) 9. Subtoral Inaintained? Acquired during this report period (attach schedule) 9. Subtoral Inaintained? Acquired during this report period Acquired bear acquired during this report period Acquired acquired during this report period Acquired Ac											
2. Disposals (attach schedule) 4. Subtotal Acquired during this report period (attach schedule) In anileage (attach schedule) Acquisition (attach schedule) Historical (attach schedule) Accommission (attach schedule) Accommission (attach schedule) Accommission (attach schedule) In anileage (attach schedule) Accommission (attach schedule) Accommission (attach schedule) Accommission (attach schedule) Accommission (attach schedule) Accounties (attach schedule)	 Acquired prior to this report period 										
3. Acquired during this report period (attach schedule) 4. Subtotal Acquired during this report period (attach schedule) Is anileage (and and year of each vehicle) Tistorical (attach schedule) Historical (attach schedule) Historical (attach schedule) Historical (attach schedule) Historical (attach schedule) Accompanies	2. Disposals (attach schedule)										
1. Subtotal	3. Acquired during this report period (attac	ch schedule)									
Inaminatine Page	C-4. Subtotal					THE STATE	1 1 1 3 W			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
Movable Equipment Yes No Movable Equipment Yes No Movable Equipment		Is a mileage logbook	Date of	Historical			Accumulated	4			
Movable Equipment Yes No Mount Year Land Value Depreciation of Equipment Computing of Equipment Computing Operations Depreciation of Equipment Life A,625		maintained?	Acquisition	Cost	ress		Depreciation to	Method of			
Movable Equipment A control co				Exclusive of Land	Salvage Value	Cost to Be Depreciated	Beginning of Year's Operations	Computing Depreciation	Useful Life	Depreciation for This Year	Totals
r Vehicles (Specify name, model ear of each vehicle) X											
rear of each vehicle) X 4 16 4,625 4,625 SL 3 771 906 Scion X 4 16 4,625 SL 3 771 able Equipment var var var 14,843 14,843 SL various sisposals (attach schedule) cquired during this report period trach schedule) Area (attach schedule) Area	1. Motor Vehicles (Specify name, model			7		The same				The Assessment	
ble Equipment the Eq	th vehicle)		4 10	4 000	The same	4 (20		1	•		
tach Equipment squired prior to this report period cquired during this report period trach schedule) cquired during this report period trach schedule) spreciation	2000 301011	<	t I	4,022		4,022		J.C.	n	1///	
able Equipment var var 14,843 14,843 I.4,843 SL various siposals (attach schedule) cquired during this report period trach schedule) cquired during this report period	3										
able Equipment var var 14,843 14,843 SL various signosals (attach schedule) sequired during this report period trach schedule) trach schedule) trach schedule) trach schedule)	d,										
cquired prior to this report period isposals (attach schedule) var 14,843 SL various isposals (attach schedule) cquired during this report period trach schedule) trach schedule) trach schedule) trach schedule)	2. Movable Equipment			- S-10-							
isposals (attach schedule) cquired during this report period ttach schedule) trach schedule)	a. Acquired prior to this report period			14,843		14,843	14,843		various		
equired during this report period trach schedule)	b. Disposals (attach schedule)										
ttach schedule) trach schedule)	c. Acquired during this report period								To State of	Section 1	
preciation	(attach schedule)	3									
Total Depreciation	D-3. Subtotal							- Annual -			771
				THE REAL PROPERTY.	1000		a car				771

Morning Star Residential Care Home, Inc. 9/30/2016

Schedule of Land Improvements Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
otal additions for Land Improv	ements	\$ -		\$ -
Deletions:				
Total deletions for Land Improve	ements	\$ -		\$ -

^{*}Ties to Page 23, Line A3

Schedule of Building Improvements Acquired during this report period

	ents required during this report period		Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
				+
Fotal additions for Building Im	provoments	\$ -		\$ -
	provenients	3 -		Φ -
Deletions:				
Total deletions for Building Imp	provomente	\$ -		\$ -
total deletions for Dunding Imp	or ovenients	φ -		Ψ

^{*}Ties to Page 23, Line B3

Schedule of Non-Movable Equipment Acquired during this report period

. 7750			Useful		
Acquisition Date	Description of Item	Cost	Life	Depreciatio	n_
Additions:					
					_
				18	
Total additions for Non-N	Movable Equipment	\$ -		\$ -	_ *
Deletions:					
Total deletions for Non-N	Iovable Equipment	\$ -		\$ -	*

^{*}Ties to Page 23, Line C3

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

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

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

Schedule of Movable Equipment Acquired during this report period

Cost	Life	Depreciatio
	10.1	_
S -	74.10	\$ -
4		_
	19/10	
	_	
		\$ -
		S -

^{*}Ties to Page 23, Line D2c

Schedule of Leasehold Improvements Acquired during this report period

AI-141 TD-4	Description of House		Cont	Useful	D	
Acquisition Date Additions:	Description of Item		Cost	Life	Depre	eciation
	repalce front steps & railings	S	2,696	5	\$	180
9/1/2016	replace kitchen sink	\$	4,959	5	\$	83
				W.A.		
Total additions for	Leasehold Improvement	S	7,655		\$	263
Deletions:				48.5		
Total deletions for	Leasehold Improvement	\$			\$	-

^{*}Ties to Page 24, Line C3

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

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

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

Amortization Schedule*

Name of Facility			License No.		Report for Year Ended	r Ended		Page	Jo
Morning Star Residential Care Home, Inc.			1884		9/30/2016			24	37
					Accumulated				
	<u>й</u>	Date of			Amort. to				
	Acq	Acquisition			Beginning of	Basis for			
			Length of	Cost to Be	Year's	Computing	Rate	Rate Amortization	
Item	Month	h Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
A. Organization Expense									
1. Organization Expense		8 2007	5	300	300	SL			
2.									THE PARTY OF
3,	12 2								
A-4. Subtotal					1000				
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other	ır								
1. Acquired prior to this report period	d var	var	var	44,820	30,591			4,332	The second
2. Disposals (attach schedule)									The State of the S
3. Acquired during this report period									
(attach schedule)				7,655				263	
C-4. Subtotal									4,595
D. Total Amortization		J.					E.		4,595
* 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 Ended					Page	of
Morning Star Residential Care Home,	1884	9/30/2016			25	37
11. Property Questionnaire						
Part A						
Is the property either owned by the l	Facility				If "Yes," complet	e Dort R
or leased from a Related Party?*	O	Yes	•	No	If "No," complete	
· ·			lite. to comtact on		ii ivo, compica	Tart C.
*If any owner or operator of this facility business association to any person or of						
a related party transaction.	organization from whom	ountaings are reason, an	011 10 10 00110100100			
Description		Total				
Date Land Purchased						
Date Structure Completed						
If NOT Original Owner, Date or	f Purchase	08/01/07				
4. Date of Initial Licensure						
5. Total Licensed Bed Capacity		18				- 200
6. Square Footage		7,200				
7. Acquisition Cost						
a. Land		175,800				Section.
b. Building		703,200				
Part B - Owner and Related Parti	ies.	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortga	age
1. Financing						
a. Type of Financing (e.g., fixe	ed, variable)	Fixed	Fixed			
 b. Date Mortgage Obtained 		08/01/07	08/01/07			
c. Interest Rate for the Cost Ye	ear	8.18%	9.25%			
d. Term of Mortgage (number of	of years)	20	20			
e. Amount of Principal Borrow		450,000	270,000			
f. Principal balance outstanding	g as of					
Complete if Mortgage was Re						100
During Current Cost Year						
g. Type of Financing (e.g., fixe	ed, variable)					
h. Date of Refinancing						
i. New Interest Rate						
j. Term of Mortgage (number of						
k. Amount of Principal Borrow						
Principal Outstanding on No						
Part C - Arms-Length Leases						
Name and Address of Lessor	Prop	erty Leased	Date of Lease	Term of Lease	Annual Amount	of Lease
			ĺ			

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 L	icense No.		Report for Ye	ar Ended		Page of
Morning Star Residential Care Home,	1884		9/30/2016			26 37
						Residential Care
Item			Total	CCNH	RHNS	Home
12. Interest	. 0 37 36 11					
A. Building, Land Improveme	nt & Non-Movabl	e				
Equipment 1. First Mortgage		\$				
Name of Lender		Rate				W. C. Bart
Address of Lender						
2. Second Mortgage		\$				
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage		\$				REMARKS MINERAL STREET
Name of Lender		Rate				
Address of Lender				The state of		
4. Fourth Mortgage		\$		0,111	1130,1113	
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount		\$				
2. Loan Origination Date			0			
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expens	se					
12 B7. Total Building Interest Expens	se (A1 - A4 + B5)	\$				

(Carry Subtotals forward to next page)

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

Name of Facility Morning Star Residential Care Hor	se No. 1884		Report for Y 9/30/2016	ear Ended		Page of 27 37
						Residential
Item			Total	CCNH	RHNS	Care Home
S	ubtotals Bro	ught Forward:				
12. C. Movable Equipment						
Automotive Equipment		\$				
A. Item	Rate	Amount	MALE			
Lender						
Address of Lender						
2. Other (Specify)		\$		1000		A Shire Shi
A. Item	Rate	Amount				
Lender		I.				
Address of Lender					13.3	
B. Item	Rate	Amount			4	1917
	Rate	Amount			THE P	
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment In	nterest					
Expense $(C1 + 2)$	`	\$				
12. D. Other Interest Expense (Specify		\$	555			555
Interest on insurance \$139/LOC	\$410			1 Harry (m)		
13. Total All Interest Expense (12B7 +	12C3 + 12D) \$	555			555
14. Insurance						
a. Insurance on Property (building	s only)	\$	11,885			11,885
b. Insurance on Automobiles		\$	2,090			2,090
c. Insurance other than Property (a	as specified a	ibove)				
1. Umbrella (Blanket Coverage		\$				
2. Fire and Extended Coverage		\$				
3. Other (<i>Specify</i>)		\$			Replan	
14d. Total Insurance Expenditures (14a	1 + h + c)	\$	13,975			13,975
15. Total All Expenditures (A-13 thru		\$	548,682			548,682
13. Ioun An Expenditures (A-13 inru	U-14)	Φ	340,002		L	340,082

D. Adjustments to Statement of Expenditures

Name	e of Fa	cility		Lic	ense No.	Report for Ye	ar Ended	Page of
Morn	ing St	ar Re	sidential Care Home, Inc.		1884	9/30/2016		28 37
					Total			
	Page				Amount of			Residential Care
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	Home
Page	10 - S	alari	es and Wages				311 1	
1.			Outpatient Service Costs	\$				
2.			Salaries not related to Resident Care	\$				
3.			Occupational Therapy	\$				
4.			Other - See attached Schedule	\$				
Page	13 - I	Profes	sional Fees					
5.			Resident Care Physicians **	\$				
6.			Occupational Therapy	\$				
7.			Other - See attached Schedule	\$				
Page	s 15 &	16 -	Administrative and General			CALL PROPERTY		
8.			Discriminatory Benefits	\$				
9.			Bad Debts	\$				
10.			Accounting & Legal	\$				
11.			Telephone	\$				
12.			Cellular Telephone	-\$				1
13.			Life insurance premiums on the life	Ψ				
15.			of Owners, Partners, Operators	\$				
14.			Gifts, flowers and coffee shops	-\$				
15.			Education expenditures to colleges or	1				
13.			universities for tuition and related costs			11000	- P1	
				d.		A CONTRACTOR		
1.0			for owners and employees	\$				
16.			Travel for purposes of attending		The Late of the La			
			conferences or seminars outside the					2000
			continental U.S. Other out-of-state			100		
			travel in excess of one representative	\$				
17.			Automobile Expense (e.g. personal use)	\$				1
18.	16	m 2	Unallowable Advertising *	\$	1,266			1,266
19.			Income Tax / Corporate Business Tax	\$				
20.			Fund Raising / Contributions	\$				
21.			Unallowable Management Fees	\$				
22.			Barber and Beauty	\$				
23.			Other - See attached Schedule	\$				
Page	18 - 1	Dietar	y Expenditures					
24.			Meals to employees, guests and others			BETTER IN	Man Ailt	
			who are not residents	\$				
Page	19 - 1	aund	ry Expenditures				XX TOTAL	
25.			Laundry services to employees, guests			HER WALL	IVE TABLE	
40.		1	and others who are not residents	\$				
43.			and others who are not residents	4				
		House	keeping Expenditures		Town Tark			
		House	keeping Expenditures					
Page		Touse		\$				

^{*} All except "Help Wanted".

(Carry Subtotal forward to next page)

^{**} Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

Schedule of Other Salaries Adjustment

Page Ref	Line Ref Description	CCNH	RHNS	Residential Care Home
otal Othe	r Salaries Adjustment	\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
				+	
THE STATE OF					
Total Othe	r Fees Adj	istments	\$ -	- \$	-

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Othe	r A&G Ad	justments	\$ -	\$ -	\$ -

.....

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

Name	e of Fa	cility	D. Adjustments to Stateme		ense No.	Report for Y		Page	of
		-	sidential Care Home, Inc.		1884	9/30/2016		29	37
					Total	3/30/2010		27	
Item	Page	Line			Amount of			Residen	tial Care
No.			Item Description		Decrease	CCNH	RHNS	Ho	
	2.101	2101	Subtotals Brought Forward	\$	1,266	COLVII	Idito	110	1,266
Page	20 - K	eside	nt Care Supplies***	Ψ	1,200			En e.)	1,200
27.			Prescription Drugs	\$					
28.			Ambulance/Limousine	\$					
29.			X-rays, etc	\$					
30.			Laboratory	\$					
31.			Medical Supplies	\$					
32.			Oxygen (non emergency)	\$				<u> </u>	
33.			Occupational Therapy	\$					
34.			Other - See Attached Schedule	\$	547				547
Page	22 - N	<i>Tainte</i>	enance and Property	Ť				11 12 12	
35.			Excess Movable Equipment Depreciation					120 00	
			See Attached Schedule	\$	7				
36.			Depreciation on Unallowable		2 1 1 2 - 1			14.00	
			Motor Vehicles	\$					
37.			Unallowable Property and Real				TRIBE,	NID III	
			Estate Taxes	\$					
38.			Rental of Building Space or Rooms	\$					
39.			Other - See Attached Schedule	\$					
Page	27 - I	nsura	nce						- 18 3
40.			Mortgage Insurance	\$					
41.			Property Insurance	\$					
Other	r - Mis	cellar	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	\$					
47.			Expenditures made for the protection,	П	Till con		11122		
			enhancement or promotion of the						
			providers interest	\$					
48.		_	Interest Income on Accounts Rec	\$					
49.			Other (include personnel and other		A THE REAL PROPERTY.				
			costs unrelated to resident care) - See			FW MILE		HE HILL	
			Attached Schedule	\$					
	or Pro		roviders Only		A STATE				
50.			Building/Non Movable Eq. Depreciation					E ESI	
			Unallowable Building Interest -					V BALL	
			See Attached Schedule	\$					
51.	Total .	Amou	int of Decrease (Items 1 - 50)	\$	1,813				1,813

^{***} 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.

 $\begin{tabular}{ll} Morning Star Residential Care Home, Inc. \\ 9/30/2016 \end{tabular}$

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS		idential e Home
20	5j	Excess cable expense			\$	547
					-	
					-	
Total Othe	r Ancillar	Costs	\$	- \$ -	\$	547

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCN	H I	RHNS	Residential Care Home
Total Exce	ss Movable	Equipment Depreciation	\$	- \$		- \$

Schedule of Other Property Adjustments

Page Ref	Line Ref De	escription		 CC	NH	RHNS	Residen Care He	
				4				
				 -	-			
					77			
				-				
Total Othe	r Property Ad	ljustments		\$		\$	- \$	-

Page Ref	Line Ref	Description	ССПН	RHNS	Residential Care Home
Total Othe	r Adjustme	ents	\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Unal	llowable Bu	ilding Interest	\$ -	\$ -	\$ -

F. Statement of Revenue

r. Statement of Re-	V CH				
Name of Facility License No.		Report for Ye	Page of		
Morning Star Residential Care Home, Inc 1884		9/30/2016		T	30 37
Item		Total	CCNH	RHNS	Residential Car Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (CT only)	\$	411,135			411,13
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	\$	141,000			141,00
b. Private-Pay Room and Board Contractual Allowance **	\$				
I. Other Resident Revenue		850 mm		100	
1. a. Prescription Drugs - Medicare	\$				
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$				
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$				-
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				1
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	\$	550 105			
II. Total Resident Revenue (Section I. thru Section II.)	30	552,135			552,13
V. Other Revenue*					100
1. Meals sold to guests, employees & others					
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)	\$	1,216			1,21
7. Total Other Revenue (1 thru 8)	\$	1,216			1,21
VI. Total All Revenue (III+V)	\$	553,351			553,35

^{*} 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 Description	CCNH	RHNS	Care Home
	The second		
Total Other Resident Revenue - Medicare	\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	cc	NH RHN	Residential Care Home
Total Othe	r Resident Revenue	\$	- \$	- \$ -

Interest Income

Account

Page Ref Account	Balance	CCNH	RHNS	Residential Care Home
				The second
Total Interest Income		\$.	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS		idential e Home
	Gain on disposal of asset (trade in given for old vehicle)			\$	300
	MAT education reimbursement			\$	916
			100 870		
			19		
				1	
Total Oth	er Revenue	\$ -	\$ -	\$	1,216

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Morning Star Residential Care Home	e, I 1884	9/30/2016	31	37
	Account			Amount
Assets				
A. Current Assets				
1. Cash (on hand and in bank			\$	(4,376
2. Resident Accounts Receiva			\$	15,543
3. Other Accounts Receivable	(Excluding Owners	or Related Parties)	\$	
4 Inventories			\$	1,080
5. Prepaid Expenses			\$	9,777
a. Prepaid oil		808		
b. Prepaid insurance		8,969	100	
c			N	
d.				
6. Interest Receivable			\$	
7. Medicare Final Settlement	Receivable		\$	
8. Other Current Assets (item)	ize)		\$	
(
1			1 3 3 4	
A-9. Total Current Assets (Lines A	1 thru 8)		\$	22,024
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost		\$	
	Accum. Deprecia	ation Net		
3. Buildings	*Historical Cost		\$	
	Accum. Deprecia	ntion Net		
4. Leasehold Improvements	*Historical Cost	52,475	\$	17,289
	Accum. Deprecia	ation 35,186 Net		
5. Non-Movable Equipment	*Historical Cost		\$	
	Accum. Deprecia	ntion Net		
6. Movable Equipment	*Historical Cost	14,843	\$	
	Accum. Deprecia	ation 14,843 Net		
7. Motor Vehicles	*Historical Cost	4,625	\$	3,854
	Accum. Deprecia	ation 771 Net		
8. Minor Equipment-Not Dep			\$	
9. Other Fixed Assets (itemize	•)		\$	
7. Ono 1 1300 115500 (nem2e	·)		l ^w	
B-10. Total Fixed Assets (Lines)	B1 thru 9)		\$	21,143

^{*} 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	P	age of
Morning Star Residential Care He	ome, I 1884	9/30/2016	3	32 37
	Account			Amount
		Total Brought Forward:	\$	43,167
C. Leasehold or like property i	ecorded for Equity Purpos	es.		
1. Land			\$	
2. Land Improvements	*Historical Cost			
	Accum. Depreciation	on Net	\$	
3. Buildings	*Historical Cost			
	Accum. Depreciation	on Net	\$	
4. Non-Movable Equipme	nt *Historical Cost			
	Accum. Depreciation	on Net	\$	
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation	on Net	\$	
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation	on Net	\$	
7. Minor Equipment-Not I			\$	
C-8 Total Leasehold or Like Pr			\$	
D. Investment and Other Asset	S			
Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense	*Historical Cost	300		
	Accum. Depreciation	on 300 Net	\$	
4. Goodwill (Purchased O			\$	
5. Investments Related to	Resident Care (itemize)		\$	
	170 (1)			Relative to the same
6. Loans to Owners or Rel			\$	
Name and Addre	ess Amount	Loan Date		
			199	
7. Other Assets (<i>itemize</i>)			\$	1,188
Section 444 deposit		1,188	φ	1,100
Beetion 444 deposit		1,100		
	5		199	
D-8. Total Investments and Other)	\$	1,188
D-9. Total All Assets (Lines A9	+ R10 + C8 + D8)		\$	44,355

^{*} 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 Sta	r Res	idential Care Home, Inc.	1884	9/30/2016		33	37
			Account			Am	ount
Liabilities	~	~					
A.		rrent Liabilities				•	0.040
	1.	Trade Accounts Payable				\$	8,042
	2.	Notes Payable (itemize)		1.6.42			16,437
		Webster LOC		16,43	'		
	3.	Loans Payable for Equipr	nent (Current portio	n)(itemize)	9	\$	
		Name of Lender	Purpose	Amount	Date Due	4 3 3 6	
				1			
	4.	Accrued Payroll (Exclusive	e of Owners and/or	Stockholders only)		\$	4,835
	5.	Accrued Payroll (Owners	and/or Stockholders	s only)	5	\$	1,850
	6.	Accrued Payroll Taxes Pa	yable		5	5	
	7.	Medicare Final Settlemen	t Payable		5	5	
	8.	Medicare Current Financi	ng Payable		5	\$	
	9.	Mortgage Payable (Curre	nt Portion)			\$	
	10.	Interest Payable (Exclusiv	e of Owner and/or F	Related Parties)		\$	
		Accrued Income Taxes*			5	\$	
	12.	Other Current Liabilities	(itemize)			\$	14,941
		Accrued pension	14	,941		S STATE	THE RES
A-13	. To	tal Current Liabilities (Lin	nes A1 thru 12)		5	5	46,105

^{*} 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		Ended	Page		of
Morning Star Residential Care Home, Inc.	1884	9/30/2016		34		37
	Account				Amount	t
		Total Broug	nt Forward:			46,105
Liabilities (cont'd)						
B. Long-Term Liabilities						
1. Loans Payable-Equipment	(itemize)			\$		
Name of Lender	Purpose	Amount	Date Due	1	4 - 939	1000
						76
			1 1			
			1			
			1			
2. Mortgages Payable				\$		
Loans from Owners or Rel	ated Parties (itemize)			\$		27,902
Name and Address of Lender	Amount	Loan D	ate			
Brian Gulian	27,902	open				
4. Other Long-Term Liabilitie	es (itamiza)			\$		
4. Other Long-Term Liabilitie	ψ					
-						
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$		27,902
C. Total All Liabilities (Lines A-				\$		74,007
				·		.,,

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

Name of Facility License No. Report for Year		ear Ended	Pa	ge of		
Moı	ning Star Residential Care Home,	1884	9/30/2016		33	5 37
	Account					Amount
A.	A. Reserves					
	1. Reserve for value of leased land				\$	
	Reserve for depreciation value of leased buildings and appurtenances					
	to be amortized				\$	
	3. Reserve for depreciation value	ue of leased perso	nal property (Eq	uity)	\$	
	4. Reserve for leasehold real properties on which fair rental value is based					
	5. Reserve for funds set aside a	s donor restricted			\$	
	6. Total Reserves				\$	
B.	B. Net Worth					
	1. Owner's Capital				\$	
	2. Capital Stock				\$	5,000
	3. Paid-in Surplus				\$	
	4. Treasury Stock				\$	
	5. Cumulated Earnings				\$	(39,321)
	6. Gain or Loss for Period	10/1/20	15 thru	9/30/2016	\$	4,669
	7. Total Net Worth				\$	(29,652)
C.	Total Reserves and Net Worth				\$	(29,652)
D.	Total Liabilities, Reserves, and	Net Worth			\$	44,355

H. Changes in Total Net Worth

	e of Facility License No.	Report for Year	Ended	Page	of
Mon	ning Star Residential Care Home, In 1884	9/30/2016		36	37
	Account			Amount	
A.	Balance at End of Prior Period as shown on Report of 0	9/30/2015		\$	(39,321)
B.	Total Revenue (From Statement of Revenue Page 30)			\$	553,351
C.	Total Expenditures (From Statement of Expenditures Po	age 27)		\$	548,682
D.	Net Income or Deficit			\$	4,669
E.	Balance			\$	(34,652)
F.	Additions				
	Additional Capital Contributed (itemize) Other (itemize)				
F-3.				\$	X4TI
G.	Deductions				
	1. Drawings of Owners/Operators/Partners (Specify) Name and Address (No., City, State, Zip) Title Amount		T A	\$	
	Name and Address (No., City, State, Zip)	Title	Amount		
	2. Other Withdrawings (Specify)				
	Purpose Amount		ount	\$	
	•				
	3. Total Deductions			\$	
H.	Balance at End of Period 09/30/1	6		\$	(34,652)

I. Preparer's/Reviewer's Certification

Name of Facility		License No.	Report for Year Ended Page of					
Morning Star Residential Care Home, Inc.		1884	9/30/2016 37 37					
Check appropriate category								
	Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)	☑ Residential Care Home					
	Preparer/Reviewer Certification							
	I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.							
Signature of Preparer		Title	Date Signed					
Printed Name of Preparer								
Davis, Mascola & Phillip, LLC								
Addres Address			Phone Number					
1062 Barnes Rd - Ste. 203, Wallingford, CT 06492			203-265-0488					