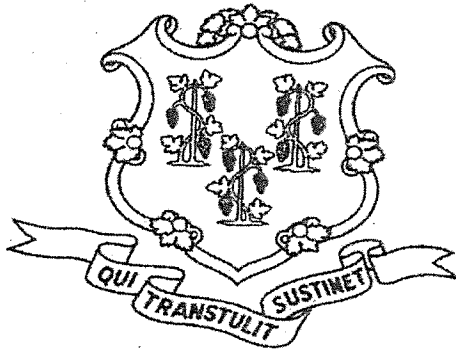


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2017

Name of Facility (as licensed) Mystic Healthcare & Rehabilitation Center, LLC	
Address (No. & Street, City, State, Zip Code) 475 High Street, Mystic, CT 06355	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)
<input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH 839-C	RHNS	(Specify)	Medicare Provider 07-5271
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Medicaid Provider Numbers:	CCNH 8391	RHNS	ICF-IID
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For Department Use Only

Sequence Number Assigned	Signed and Notarized	Date Received	Sequence Number Assigned	Signed and Notarized	Date Received

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General Information

Name of Facility (as licensed) Mystic Healthcare & Rehabilitation Center, LLC	License No. 839-C	Report for Year Ended 9/30/2017	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Mystic Healthcare & Rehabilitation Center, LLC [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, 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) <i>Kenneth Kopchik</i>		Date 2/13/18	Signed (Owner) <i>Martin Sbriglio</i>		Date 2/13/18
Printed Name (Administrator) Kenneth Kopchik			Printed Name (Owner) Martin Sbriglio		
Subscribed and Sworn to before me: <i>Michelle A. S. Joyner</i>	State of CT	Date 2/13/18	Signed (Notary Public) <i>Michelle A. S. Joyner</i>		MICHELLE A. SNEAD-JOYNER NOTARY PUBLIC State of Connecticut My Commission Expires 12/31/2022
Address of Notary Public 189 Union St Stratford CT 06615					

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Mystic Healthcare & Rehabilitation Center, LLC		Period Covered:	From 10/1/2016	To 9/30/2017
Address of Facility 475 High Street, Mystic, CT 06355				
Report Prepared By Elizabeth Maglio		Phone Number 203-381-1327	Date 2/9/2018	
Item	Total	CCNH	RHNS	(Specify)
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

Phone No. of Facility 203-381-1327	Report for Year Ended 9/30/2017	Page 2	of 37
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Name of Facility (as shown on license) Mystic Healthcare & Rehabilitation Center, LLC	Address (No. & Street, City, State, Zip) 475 High Street, Mystic, CT 06355
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License Numbers:	CCNH 839-C	RHNS (Specify)	Medicare Provider No. 07-5271
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Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)	

Type of Ownership (Check appropriate box)			
<input type="checkbox"/> Proprietorship	<input type="checkbox"/> LLC	<input type="checkbox"/> Partnership	<input checked="" type="radio"/> Profit Corp.
<input type="checkbox"/> Non-Profit Corp.	<input type="checkbox"/> Government	<input type="checkbox"/> Trust	

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," explain fully.
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Administrator

Name of Administrator Kenneth Kopchik	Nursing Home Administrator's License No.:	001904
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Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name N/A	License No.:	

**General Information and Questionnaire
Corporate Owners**

Name of Facility Mystic Healthcare & Rehabilitation Center, L	License No. 839-C	Report for Year Ended 9/30/2017	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address		State(s) in Which Incorporated	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
N/A				
Names of Stockholders Owning at Least 10% of Shares				
N/A				

General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Mystic Healthcare & Rehabilitation Center, LLC	839-C	9/30/2017	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

N/A

General Information and Questionnaire Related Parties*

Name of Facility Mystic Healthcare & Rehabilitation Center, LLC	License No. 839-C	Report for Year Ended 9/30/2017	Page 4	of 37	
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input checked="" type="radio"/> Yes <input type="radio"/> No					
If "Yes," provide the Name/Address and complete the information on Page 11 of the report.					
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? <input checked="" type="radio"/> Yes <input type="radio"/> No					
If "Yes," provide the following information:					
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		Indicate Where Costs are Included in Annual Report Page # / Line #	Actual Cost to the Related Party
		Yes	No %**		
Ryders Health Management Mystic Manor Properties, LLC	88 Ryders Lane, Stratford, CT 475 High Street, Mystic, CT 06355	<input type="radio"/>	<input checked="" type="radio"/>	Financial and Managerial Support 16, m12	262,699
Ryders Health Management (CT Healthcare W/C Trust)	PO Box 30393, Hartford, CT 06150	<input type="radio"/>	<input checked="" type="radio"/>	Rental Real Estate 22/9	600,000
AFCO	5600 North River Road, Suite 400, Rosemont, IL 60018-5187	<input type="radio"/>	<input checked="" type="radio"/>	Workers Comp Insurance 15/1a1	199,852
Innovative Health Plan	80 Iron Point Circle, Suite 200, Folsom, CA	<input checked="" type="radio"/>	<input type="radio"/>	Auto, Property and Liability Insurance 27/14c1, 27/14a, 27/14	52,316
		<input type="radio"/>	<input type="radio"/>	Health Insurance 15/1a5	369,816
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		

* 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 Mystic Healthcare & Rehabilitation Center, LLC	License No. 839-C	Report for Year Ended 9/30/2017	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

Yes No If "No," explain fully why such allocation was not made.

General Information and Questionnaire
Accounting Basis

Name of Facility Mystic Healthcare & Rehabilitation	License No. 839-C	Report for Year Ended 9/30/2017	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

- Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm 1 Marcum, LLP 2 3 4	Address (No. & Street, City, State, Zip Code) 555 Long Wharf Drive, New Haven, CT
---	--

Services Provided by This Firm (*describe fully*)

1 Corp tax returns and annual review of financial statements	\$ 11,073
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 11,073

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

- Yes No 15/1d

Legal Services Information

Name of Legal Firm or Independent Attorney 1 See Attached 2 3 4 5	Telephone Number
--	------------------

Address (*No. & Street, City, State, Zip Code*)

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	\$
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided
	\$

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

- Yes No 15/1e

Mystic Healthcare
 Legal Fees
 9/30/2017

<u>Vendor</u>	<u>Phone Number</u>	<u>Address</u>	<u>Services Provided</u>	<u>Amount</u>
Partners Pharmacy			Settlement - Disallowed	\$ 12,857
Julia Rice			Settlement - Disallowed	116,250
Murtha Cullina	860-240-6000	CityPlace I, 185 Asylum St., Hartford, CT	Health care regulatory issues, general matters	4,748
Joe D'Agostino	203-265-5222	88 Ryders Lane, Stratford, CT	Corporate Matters - Disallowed	7,965
Kainen, Escalera	860-493-0870	21 Oak St., Hartford, CT 06106	Settlement fees - Disallowed	8,248
CT State Marshall			Marshall fees - Disallowed	275
Treasurer, St of CT			Probate fees - Disallowed	900
Seiger Gfeiler Laurie, LLP	860-760-8400	977 Farmington Ave, West Hartford, CT 06107	Collections - Disallowed	866
Pullman & Comley	203-330-2000	850 Main St, Bridgeport, CT 06601	Julia Rice Settlement - Disallowed	24,731
			Total Legal Fees	<u>176,840</u>

Schedule of Resident Statistics

Name of Facility		License No.			Report for Year Ended				Page	of			
Mystic Healthcare & Rehabilitation Center, LLC		839-C			9/30/2017				8	37			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	100	100			100	100			100	100			
B. On last day of THIS report period	100	100			100	100			100	100			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	85	85			85	85			83	83			
B. As of midnight of THIS report period	79	79			83	83			79	79			
3. Total Number of Days Care Provided During Period													
A. Medicare	4,778	4,778			3,583	3,583			1,195	1,195			
B. Medicaid (Conn.)	18,321	18,321			13,645	13,645			4,676	4,676			
C. Medicaid (other states)													
D. Private Pay	5,110	5,110			3,699	3,699			1,411	1,411			
E. State SSI for RCH													
F. Other (Specify) Hospice, Managed Care	703	703			582	582			121	121			
G. Total Care Days During Period (3A thru F)	28,912	28,912			21,509	21,509			7,403	7,403			
Total Number of Days Not Included in Figures in													
4. 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days	241	241			183	183			58	58			
B. Other Bed Reserve Days	31	31			27	27			4	4			
5. Total Resident Days (3G + 4A + 4B)	29,184	29,184			21,719	21,719			7,465	7,465			

Schedule of Resident Statistics (Cont'd)

Name of Facility Mystic Healthcare & Rehabilitation Center, L	License No. 839-C	Report for Year Ended 9/30/2017	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? Yes No
 If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH (1)	RHNS (2)	(Specify) (3)	Lost			Gained			CCNH	RHNS	(Specify)	
				(1)	(2)	(3)	(1)	(2)	(3)				

5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.

Change in Resident Days	CCNH	RHNS	(Specify)
1st change			
2nd change			
3rd change			
4th change			

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

Item	Medicare		Medicaid		Self-Pay		Other State Assisted		
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	9		54		16				
Per Diem Rate									
a. One bed rm.					\$453-\$431				
b. Two bed rms.			224.40		\$435-\$383				
c. Three or more bed rms.									

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	2,399	2,399		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	13,489	13,489		
D. Total Physical Therapy Treatments	15,888	15,888		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	337	337		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	822	822		
D. Total Speech Therapy Treatments	1,159	1,159		

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	1,765	1,765		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	12,523	12,523		
D. Total Occupational Therapy Treatments	14,288	14,288		

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Mystic Healthcare & Rehabilitation Center, LLC	839-C	9/30/2017	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	117,791	2,124				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	227,939	12,838				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	57,091	2,126				
c. Dietary Workers	270,084	20,034				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	158,534	12,211				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	52,538	2,105				
b. Other Maintenance Workers	1,737	133				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	87,839	5,339				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	107,363	2,268				
b. RN						
1. Direct Care	851,781	25,471				
2. Administrative**	162,569	4,480				
c. LPN						
1. Direct Care	641,627	22,176				
2. Administrative**						
d. Aides and Attendants	1,189,607	74,895				
e. Physical Therapists	237,750	6,127				
f. Speech Therapists	39,984	661				
g. Occupational Therapists	268,370	6,452				
h. Recreation Workers	80,101	4,243				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	119,361	3,846				
n. Marketing						
o. Other (Specify)						
See Attached Schedule						
A-13. Total Salary Expenditures	4,672,066	207,525				

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

Name of Facility		License No.		Report for Year Ended		Page	of		
Mystic Healthcare & Rehabilitation Center, LLC		839-C		9/30/2017		11	37		
Name	Salary Paid		Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS (Specify)							
Section I - Operators/Owners									
Martin Sbriglio, RN, NHA									
Kenneth Kopchik, MBA, NHA	117,791		Health, Dental & 401K	Administrative	2,124	A2	Ryders Health Management, 88 Ryders Lane, Suite 208, Stratford, CT 06614	2,056	130,000
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).									

* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.
 ** Include all employment worked during the cost year.

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

Name of Facility (as licensed) Mystic Healthcare & Rehabilitation Center, LLC	License No. 839-C	Report for Year Ended 9/30/2017			Page 12	of 37
		Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10		
Name	CCNH	RHNS	Salary Paid		Total Hours Worked	Compensation Received
				(Specify)		
Section III - Administrators***						
Kenneth Kopchik, MBA, NHA	117,791		Health, Dental & 401K		2,124 A2	
Section IV - Assistant Administrators						

*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.
 ** Include all other employment worked during the cost year.
 *** If more than one Administrator is reported, include dates of employment for each.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Mystic Healthcare & Rehabilitation Center, LLC	839-C	9/30/2017	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	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	31,947	639				
2. Dentist	7,638	153				
3. Pharmacist	10,860	217				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	73,200	732				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify) Medical Staff	400	4				
9. Speech Therapist						
a. Resident Care	1,292	26				
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	65,553	1,311				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	41,664	695				
B-13 Total Fees Paid in Lieu of Salaries	232,554	3,777				

* 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 Mystic Healthcare & Rehabilitation Center, LLC		License No. 839-C	Report for Year Ended 9/30/2017	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Healthdrive Medical and Dental Practices, 25 Needham St., Newton, MA 02461	Dental Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
IPC Hospitalist of New England, PC 819 Worcester St., Springfield, MA 01151	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Partners Pharmacy of CT, PO Box 9689, Uniondale, NY 11555	Pharmacy Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Douglas Brandt, 20 Research Parkway, Old Saybrook, CT 06475	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Douglas Cooper, 365 Montauk Ave., New London, CT 06320	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Neer Zeevi, 365 Montauk Ave., New London, CT 06320	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
Kathleen S LaBella, 12 Wadsworth Lane, Waterford, CT 06385	Dietician Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
HealthPro, 307 International Circle, Suite 100, Hunt Valley, MD 21030	Therapy Management Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		

* Use additional sheets if necessary.
 ** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Mystic Healthcare & Rehabilitation Center, LLC	839-C	9/30/2017	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 199,852	199,852		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$			
4. Social Security (F.I.C.A.)	\$ 416,766	416,766		
5. Health Insurance	\$ 369,816	369,816		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 3,000	3,000		
8. Uniform Allowance	\$ 22,636	22,636		
9. Other (<i>Specify</i>) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 185,826	185,826		
d. Accounting and Auditing	\$ 11,073	11,073		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 176,840	176,840		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$ 829	829		
g. Office Supplies	\$ 11,967	11,967		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 9,838	9,838		
2. Cellular Phones	\$ 1,727	1,727		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 250	250		
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$			
2. Other (<i>Specify</i>) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 508,115	508,115		
Subtotal	\$ 1,918,534	1,918,534		

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

(Carry Subtotals forward to next page)

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

Mystic Healthcare & Rehabilitation Center, LLC
9/30/2017

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Total	\$ -	\$ -	\$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Total	\$ -	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended		Page	of
Mystic Healthcare & Rehabilitation Center, LLC	839-C	9/30/2017		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:					
	1,918,534	1,918,534			
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$ 130	130			
2. Holiday Parties for Staff	\$ 6,149	6,149			
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 5,328	5,328			
5. Education Expenses Related to Seminars and Conventions	\$ 2,485	2,485			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ (2,676)	(2,676)			
7. Other (<i>Specify</i>) See Attached Schedule	\$ 2,762	2,762			
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 5,407	5,407			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 6,332	6,332			
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 4,207	4,207			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 7,259	7,259			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 290	290			
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 63,569	63,569			
12. Administrative Management Services**	\$ 262,699	262,699			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 31,857	31,857			
C-14 Total Administrative & General Expenditures	\$ 2,314,333	2,314,333			

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

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Meals & Entertainment	\$ 2,762		
Total Other Travel and Entertainment	\$ 2,762	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Adv & Pub Rel Donation	\$ 5,982		
Charitable Donations	\$ 350		
Total Other Advertising	\$ 6,332	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 7,174		
ALTCFM	\$ 85		
Total Dues	\$ 7,259	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Total Contributions	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Fees & License	\$ 547		
Physician Care - Employee	\$ 8,582		
Bank Charges	\$ 6,298		
Unemployment Tax Management	\$ 1,516		
A/R Solutions - Billing Assistance	\$ 1,265		
Managed Care Contract Consulting	\$ 3,304		
Real Estate Consultant	\$ 10,295		
American Express	\$ 49		
Total Other Administrative and General	\$ 31,857	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Mystic Healthcare & Rehabilitation Center	License No. 839-C	Report for Year Ended 9/30/2017	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Ryders Health Management, 88 Ryders Land, Stratford, CT 06614	262,699	Financials and Managerial Support	16/m12

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

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

Name of Facility		License No.	Report for Year Ended	Page	of
Mystic Healthcare & Rehabilitation Center, LLC		839-C	9/30/2017	18	37
Item	Total	CCNH	RHNS	(Specify)	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$ 153,788	153,788			
2. Non-Food Supplies	\$ 12,253	12,253			
3. Other (Specify) _____	\$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)					
c. Management Services**					
d. Other (Specify) _____ Dietary Equipment	\$ 2,020	2,020			
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 168,061	168,061			
2F. Dietary Questionnaire					
G. Resident Meals: Total no. of meals served per day:*		Total	CCNH	RHNS	(Specify)
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No					
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
M. Where is the revenue received reported in the Cost Report? (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? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)					

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

** 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 No.	Report for Year Ended		Page	of
Mystic Healthcare & Rehabilitation Center, LLC		839-C	9/30/2017		19	37
Item		Total	CCNH	RHNS	(Specify)	
3. Laundry						
a. In-House Processing*		Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$	4,292	4,292		
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***		Lbs.				
		Amt. \$				
3. Personal clothing of residents washed, ironed, and/or processed.***		Lbs.				
		Amt. \$				
4. Repair and/or purchase of linens.***		Lbs.				
		Amt. \$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$				
c. Management Services**		\$				
d. Other (Specify) Laundry Supplies		\$	4,960	4,960		
3E. Total Laundry Expenditures (3a + b + c + d)		\$	9,252	9,252		
3F. Laundry Questionnaire						
G. Is cost of employee laundry included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H. Did you receive revenue from employees?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
I. Where is the revenue received reported in the Cost Report?		(Page/Line Item)				
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K. Did you receive revenue from these people?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
L. Where is the revenue received reported in the Cost Report?		(Page/Line Item)				

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

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

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Mystic Healthcare & Rehabilitation Center, LL		839-C	9/30/2017		20	37
Item		Total	CCNH	RHNS	(Specify)	
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	25,938	25,938		
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$				
c.	Management Services*	\$				
d.	Other (<i>Specify</i>)	\$				
4E.	Total Housekeeping Expenditures (4a + b + c + d)	\$	25,938	25,938		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from	\$	167,734	167,734		
b.	Medicine Cabinet Drugs	\$	36,239	36,239		
c.	Medical and Therapeutic Supplies	\$				
d.	Ambulance/Limousine***	\$	25,487	25,487		
e.	Oxygen					
	1. For Emergency Use	\$	18,839	18,839		
	2. Other***	\$				
f.	X-rays and Related Radiological Procedures***	\$	15,392	15,392		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	35,414	35,414		
i.	Recreation	\$	12,472	12,472		
j.	Other (<i>Specify</i>)**** See Attached Schedule	\$	277,108	277,108		
5K.	Total Resident Care Expenditures (5a - 5j)	\$	588,686	588,686		

* 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	(Specify)
Physician Care - Patients	\$ 11,522		
Medical Supplies	\$ 192,493		
Medical Supplements	\$ 20,040		
Medical Waste	\$ 217		
Medical Equipment	\$ 5,864		
Medical Equipment Rental	\$ 18,117		
OT Pool	\$ 7,334		
PT Supplies	\$ 21,521		
Total Other Resident Care	\$ 277,108	\$ -	\$ -

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

Name of Facility		License No.		Report for Year Ended		Page of				
Mystic Healthcare & Rehabilitation Center, LLC		839-C		9/30/2017		21 37				
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	(Specify)	Pg	Line
		Yes	No							
ADP	1 ADP Plaza, Milford, CT 06460	○	⊙		Payroll processing services	18,235			16	m11
Point Click Care	PO Box 8500, Philadelphia, PA 19178	○	⊙		Computer software support services	19,289			16	m11
CWPM		○	⊙		Garbage disposal	13,035			22	6a
B&M Landscaping		○	⊙		Landscaping & snow removal	30,960				
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Mystic Healthcare & Rehabilitation Center, L	839-C	9/30/2017			22	37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	112,768	112,768			
b. Heat	\$	63,658	63,658			
c. Light & Power	\$	66,678	66,678			
d. Water	\$	37,634	37,634			
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$	8,175	8,175			
f. Other <i>(itemize)</i>	\$					
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	288,912	288,912			
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$					
b. Building & Building Improvements	\$	232,122	232,122			
c. Non-Movable Equipment	\$	20,903	20,903			
d. Movable Equipment	\$	4,228	4,228			
*7e. Total Depreciation Costs (7a + b + c + d)	\$	257,253	257,253			
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other <i>(Specify)</i>	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	600,000	600,000			
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	71,164	71,164			
c. Personal property taxes	\$	4,650	4,650			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	933,067	933,067			

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

Mystic Healthcare & Rehabilitation Center, LLC
9/30/2017

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Land Improvement		\$ -		\$ - *
Deletions:				
Total deletions for Land Improvement		\$ -		\$ - **

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/29/2016	Spray foam insulation	\$ 33,255	10	\$ 3,048
11/1/2016	Catch Basin	1,550	15	95
3/16/2017	Sprinkler system	33,000	10	1,650
4/1/2017	Sprinkler system	1,476	10	111
4/1/2017	Sprinkler system	2,573	10	193
7/27/2017	Sprinkler system	2,145	10	36
Total additions for Building Improvement		\$ 73,999		\$ 5,133 *
Deletions:				
Total deletions for Building Improvement		\$ -		\$ - **

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/1/2016	Electrical boxes	\$ 2,969	5	\$ 594
12/14/2016	Replace 6" main in attic	1,364	5	227
2/17/2017	Electrical Work	2,768	5	323
3/8/2017	Exit doors	1,099	5	37
4/3/2017	Outlets & circuits	4,494	5	524
6/1/2017	Replace pendant heads	4,673	5	701
6/20/2017	Brance line replacement	28,035	5	1,402
8/11/2017	Electricl Work	1,800	5	60
10/31/2016	CBORD	3,456	3	1,056
1/2/2017	CBORD	951.83	3	238
Total additions for Non-Movable Equipment		\$ 51,609		\$ 5,162 *
Deletions:				

Total deletions for Non-Movable Equipmen		\$	-	\$ - **

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
11/16/2016	Bed	\$ 2,850	5	\$ 475
12/21/2016	Mobility chair	1,277	5	192
1/31/2017	Bladder scan	9,668	5	1,289
4/20/2017	Hot food table	2,390	5	199
4/27/2017	Chair lift	1,472	5	123
5/11/2017	Scrubber-20	3,988	5	332
5/10/2017	Chair lift	1,426	5	119
6/20/2017	TV's	1,053	5	53
6/19/2017	Bed	3,610	5	181
9/19/2017	EKG machine	2,828	5	-
9/25/2017	Ultracare beds	4,070	5	-
Total additions for Movable Equipmen		\$ 34,632		\$ 2,962 *
Deletions:				
Total deletions for Movable Equipmen		\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Leasehold Improvemer		\$ -		\$ - *
Deletions:				
Total deletions for Leasehold Improvemer		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Mystic Healthcare & Rehabilitation Center, LLC	Date of Acquisition		License No. 839-C	Report for Year Ended 9/30/2017	Page 24	of 37
	Month	Year				
A. Organization Expense						
1.						
2.						
3.						
A-4. Subtotal						
B. Mortgage Expense						
1.						
2.						
3.						
B-4. Subtotal						
C. Leasehold Improvements and Other						
1. Acquired prior to this report period						
2. Disposals (attach schedule)						
3. Acquired during this report period (attach schedule)						
C-4. Subtotal						
D. Total Amortization						

* 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 Mystic Healthcare & Rehabilitation Cc	License No. 839-C	Report for Year Ended 9/30/2017	Page 25	of 37
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11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* Yes No If "Yes," complete Part B. If "No," complete Part C.

*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total				
1. Date Land Purchased					
2. Date Structure Completed					
3. If NOT Original Owner, Date of Purchase	08/11/06				
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	100				
6. Square Footage					
7. Acquisition Cost					
a. Land					
b. Building					

Part B - Owner and Related Parties

1st Mortgage 2nd Mortgage 3rd Mortgage 4th Mortgage

1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained	08/11/06			
c. Interest Rate for the Cost Year	4.00%			
d. Term of Mortgage (number of years)	7			
e. Amount of Principal Borrowed	6,650,000			
f. Principal balance outstanding as of 9/30/2017				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Mystic Healthcare & Rehabilitation C		839-C	9/30/2017		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Mystic Healthcare & Rehabilitation		839-C		9/30/2017		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$			
12. D. Other Interest Expense (Specify) Interest & Finance Exp				\$	4,562	4,562	
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	4,562	4,562	
14. Insurance							
a. Insurance on Property (buildings only)				\$	9,919	9,919	
b. Insurance on Automobiles				\$	2,544	2,544	
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$	39,853	39,853	
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. Total Insurance Expenditures (14a + b + c)				\$	52,316	52,316	
15. Total All Expenditures (A-13 thru C-14)				\$	9,289,748	9,289,748	

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Mystic Healthcare & Rehabilitation Center, LLC				839-C	9/30/2017	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	12g	Occupational Therapy	\$ 268,370	268,370		
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 185,826	185,826		
10.	15	1e	Accounting & Legal	\$ 172,092	172,092		
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.	15	1f	Life insurance premiums on the life of Owners, Partners, Operators	\$ 829	829		
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.	16	17	Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$ 2,762	2,762		
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m3	Unallowable Advertising *	\$ 6,332	6,332		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 339	339		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 636,550	636,550		

* 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	(Specify)
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Fees Adjustments			\$ -	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m8a	Chamber of Commerce	\$ 290		
16	m13	American Express	\$ 49		
Total Other A&G Adjustments			\$ 339	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
Mystic Healthcare & Rehabilitation Center, LLC				839-C	9/30/2017	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 636,550	636,550		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 167,734	167,734		
28.	20	5d	Ambulance/Limousine	\$ 25,487	25,487		
29.	20	5f	X-rays, etc	\$ 15,392	15,392		
30.	20	5h	Laboratory	\$ 35,414	35,414		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 7,334	7,334		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
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, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$			
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51. Total Amount of Decrease (Items 1 - 50)				\$ 887,911	887,911		

*** 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.

Mystic Healthcare & Rehabilitation Center, LLC
 9/30/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	OT Pool	\$ 7,334		
Total Other Ancillary Costs			\$ 7,334	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Property Adjustments			\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Adjustments			\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility		License No.		Report for Year Ended		Page	of
Mystic Healthcare & Rehabilitation Cente 839-C				9/30/2017		30	37
Item	Total	CCNH	RHNS	(Specify)			
I. Resident Room, Board & Routine Care Revenue							
1. a. Medicaid Residents (<i>CT only</i>)	\$ 6,533,907	6,533,907					
b. Medicaid Room and Board Contractual Allowance **	\$ (2,584,784)	(2,584,784)					
2. a. Medicaid (<i>All other states</i>)	\$						
b. Other States Room and Board Contractual Allowance **	\$						
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,336,752	1,336,752					
b. Medicare Room and Board Contractual Allowance **	\$ 578,629	578,629					
4. a. Private-Pay Residents and Other	\$ 2,861,841	2,861,841					
b. Private-Pay Room and Board Contractual Allowance **	\$ (339,281)	(339,281)					
II. Other Resident Revenue							
1. a. Prescription Drugs - Medicare	\$ 138,308	138,308					
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (138,308)	(138,308)					
c. Prescription Drugs - Non-Medicare	\$ 45,556	45,556					
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	\$ 307,970	307,970					
b. Physical Therapy - Medicare Contractual Allowance **	\$ (307,970)	(307,970)					
c. Physical Therapy - Non-Medicare	\$ 249,310	249,310					
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$						
4. a. Speech Therapy - Medicare	\$ 41,901	41,901					
b. Speech Therapy - Medicare Contractual Allowance **	\$ (41,901)	(41,901)					
c. Speech Therapy - Non-Medicare	\$ 59,716	59,716					
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$						
5. a. Occupational Therapy - Medicare	\$ 302,944	302,944					
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (302,944)	(302,944)					
c. Occupational Therapy - Non-Medicare	\$ 230,987	230,987					
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$						
6. a. Other (<i>Specify</i>) - Medicare	\$						
b. Other (<i>Specify</i>) - Non-Medicare	\$ 14,260	14,260					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 8,986,894	8,986,894					
IV. Other Revenue*							
1. Meals sold to guests, employees & others	\$						
2. Rental of rooms to non-residents	\$						
3. Telephone	\$						
4. Rental of Television and Cable Services	\$						
5. Interest Income (<i>Specify</i>)	\$ 17	17					
6. Private Duty Nurses' Fees	\$						
7. Barber, Coffee, Beauty and Gift shops	\$						
8. Other (<i>Specify</i>)	\$						
V. Total Other Revenue (1 thru 8)	\$ 17	17					
VI. Total All Revenue (III + V)	\$ 8,986,910	8,986,910					

* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.
 ** Facility should report all contractual allowances and/or payer discounts.

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Oxygen	\$ 4,963		
	C/A - Oxygen	\$ (4,963)		
	X-Ray	\$ 17,522		
	C/A - X-Ray	\$ (17,522)		
	Lab	\$ 95,989		
	C/A - Lab	\$ (95,989)		
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Oxygen - Managed Care	\$ 770		
	X-Ray - Managed Care	\$ 3,410		
	Lab - Managed Care	\$ 10,080		
Total Other Resident Revenue		\$ 14,260	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Income		\$ 17		
Total Interest Income			\$ 17	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
Total Other Revenue		\$ -	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Mystic Healthcare & Rehabilitation Center	839-C	9/30/2017	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	226,445
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,206,870
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	
a. _____				
b. _____				
c. _____				
d. _____				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	6,439
Loans & Exchanges	(14,060)			
Prepaid Expenses	2,080			
Prepaid Insurance	967			
Refunds	17,452			
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,439,753
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost 2,544,167		\$	1,185,661
	Accum. Depreciation 1,358,506	Net		
4. Leasehold Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
5. Non-Movable Equipment	*Historical Cost 319,164		\$	89,201
	Accum. Depreciation 229,963	Net		
6. Movable Equipment	*Historical Cost 317,775		\$	46,293
	Accum. Depreciation 271,482	Net		
7. Motor Vehicles	*Historical Cost 8,158		\$	
	Accum. Depreciation 8,158	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

B-10. Total Fixed Assets (Lines B1 thru 9)			\$	1,321,155

* 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
Mystic Healthcare & Rehabilitation Center	839-C	9/30/2017	32	37
Account			Amount	
Total Brought Forward:			\$	2,760,908
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				
			\$	
2. Land Improvements				
*Historical Cost _____				
Accum. Depreciation _____			Net	\$
3. Buildings				
*Historical Cost _____				
Accum. Depreciation _____			Net	\$
4. Non-Movable Equipment				
*Historical Cost _____				
Accum. Depreciation _____			Net	\$
5. Movable Equipment				
*Historical Cost _____				
Accum. Depreciation _____			Net	\$
6. Motor Vehicles				
*Historical Cost _____				
Accum. Depreciation _____			Net	\$
7. Minor Equipment-Not Depreciable				
			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)				
			\$	
D. Investment and Other Assets				
1. Deferred Deposits				
			\$	
2. Escrow Deposits				
			\$	
3. Organization Expense				
*Historical Cost _____				
Accum. Depreciation _____			Net	\$
4. Goodwill (Purchased Only)				
			\$	
5. Investments Related to Resident Care (<i>itemize</i>)				
			\$	
6. Loans to Owners or Related Parties (<i>itemize</i>)				
			\$	
Name and Address		Amount	Loan Date	
7. Other Assets (<i>itemize</i>)				
Due from Greentree Manor			12,403	\$
Due from Lighthouse Home Health			3,875	
				16,278
D-8. Total Investments and Other Assets (Lines D1 thru 7)				
			\$	16,278
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)				
			\$	2,777,186

* 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 Mystic Healthcare & Rehabilitation Center, L		License No. 839-C	Report for Year Ended 9/30/2017	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	958,446
2. Notes Payable (<i>itemize</i>)				\$	

3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	83,678
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	294,730
Patient Fund		41,382	Accrued PTO	122,912	
Accrued Expenses		(11,726)	Accrued User Fee	132,867	
AFLAC - Individual		8,923			
AFLAC - Group		372			
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	1,336,854

* 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 Mystic Healthcare & Rehabilitation Center,		License No. 839-C	Report for Year Ended 9/30/2017	Page 34	of 37
Account				Amount	
Total Brought Forward:				1,336,854	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					
Name of Lender		Purpose	Amount	Date Due	\$
2. Mortgages Payable					
\$					
3. Loans from Owners or Related Parties (<i>itemize</i>)					
\$					
Name and Address of Lender		Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)					
Due to Martin Sbriglio			307,000	\$ 3,943,567	
Due to Aaron Manor			20,000		
Due to Bel-Air Manor			214,833		
Due to Related Parties			3,401,734		
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 3,943,567	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 5,280,422	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Mystic Healthcare & Rehabilitation Ce	839-C	9/30/2017	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	100,000
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(2,300,575)
6. Gain or Loss for Period			\$	(302,661)
	10/1/2016	thru	9/30/2017	
7. Total Net Worth			\$	(2,503,236)
C. Total Reserves and Net Worth			\$	(2,503,236)
D. Total Liabilities, Reserves, and Net Worth			\$	2,777,186

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of	
Mystic Healthcare & Rehabilitation Cent	839-C	9/30/2017	36	37	
Account			Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2016			\$		
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$		
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$		
D. Net Income or Deficit			\$		
E. Balance			\$		
F. Additions					
1. Additional Capital Contributed <i>(itemize)</i>					
2. Other <i>(itemize)</i>					
F-3. Total Additions			\$		
G. Deductions					
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>					
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount		
2. Other Withdrawings <i>(Specify)</i>			\$		
Purpose		Amount			
3. Total Deductions			\$		
H. Balance at End of Period			\$		
09/30/17					

I. Preparer's/Reviewer's Certification

Name of Facility Mystic Healthcare & Rehabilitation Center,	License No. 839-C	Report for Year Ended 9/30/2017	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer <i>Elizabeth Maglio</i>	Title <i>Controller</i>	Date Signed <i>2/14/18</i>		
Printed Name of Preparer Elizabeth Maglio				
Address 88 Ryders Lane, Stratford, CT 06614		Phone Number 203-381-1327		