State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2018

Name of Facility (as licensed) FILOSA FOR NURSING AND REHABILITATION		
Address (No. & Street, City, State, Zip Code) 13 HAKIM STREET, DANBURY, CT. 06810		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	461-C			07-5074

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	4614		

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)	License No.	Report for Year Ended	Page	of
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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 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 FILOSA FOR NURSING AND REHABILITATION [facility name], for the cost report period beginning October 1, 2017 and ending September 30, 2018, 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) MICHAEL D. MALONE			Printed Name (Owner) BARBARA A. MALONE	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility FILOSA FOR NURSING AND REHABILITATION	Period Covered:		From 10/1/2017	To 9/30/2018
Address of Facility 13 HAKIM STREET, DANBURY, CT. 06810				
Report Prepared By	Phone Number		Date	

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.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
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Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
FILOSA FOR NURSING AND REHABILITATION	13 HAKIM STREET, DANBURY, CT. 06810

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	461-C			07-5074

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Type of Ownership (Check appropriate box)

○ Proprietorship ○ LLC ○ Partnership ◉ Profit Corp. ○ Non-Profit Corp. ○ Government ○ 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? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
MICHAEL D. MALONE	001685

Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
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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
FILOSA CONVALESCENT HOME, INC	13 HAKIM STREET, DANBURY, CT. 06810	CONNECTIC UT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
FRANK D. MALONE	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	TREASURER	128
BARBARA A. MALONE	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	SECRETARY	491
JENNIFER MALONE-SEIXAS	592 MANVILLE ROAD, PLEASANTVILLE, NY 10570	ICE-PRESIDEN	119
MICHAEL D. MALONE	197 GUINEA ROAD, MONROE, CT 06468	PRESIDENT	129
JOHN M. MALONE	22 NORTH DUTCHER STREET, IRVINGTON, NY 10533	DIRECTOR	119
Names of Stockholders Owning at Least 10% of Shares			
FRANK D. MALONE	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	TREASURER	128
BARBARA A. MALONE	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	SECRETARY	491
JENNIFER MALONE-SEIXAS	592 MANVILLE ROAD, PLEASANTVILLE, NY 10570	ICE-PRESIDEN	129
MICHAEL D. MALONE	197 GUINEA ROAD, MONROE, CT 06468	PRESIDENT	119
JOHN M. MALONE	22 NORTH DUTCHER STREET, IRVINGTON, NY 10533	DIRECTOR	119

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ⊙ Yes ○ 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? ⊙ Yes ○ No

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
FILOSA CARE CENTER DBA HANCOCK HALL	31 STAPLES ST., DANBURY, CT 06811	○	⊙		SHARED EXPENSES	SEE ATTACHED	SEE ATTACI	SEE ATTACHED
BARBARA A. MALONE (BAMCO, LLC)	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	○	⊙		BUILDING RENTAL	22/9	635,123	635,123
SPACE PANTS, LLC	197 GUINEA ROAD, MONROE, CT 06468	○	⊙		PARKING LOT RENTAL	22/9	7,800	7,800
SPACE PANTS, LLC	197 GUINEA ROAD, MONROE, CT 06468	○	⊙		OFF SITE STORAGE	22/9	6,240	6,240
MICHAEL MALONE	197 GUINEA ROAD, MONROE, CT 06468	○	⊙		ADMINISTRATOR	10/A2	80,719	80,719
MICHAEL MALONE	197 GUINEA ROAD, MONROE, CT 06468	○	⊙		CORPORATE OFFICER	10/A1	8,006	8,006
JENNIFER MALONE-SEIXAS	592 MANVILLE ROAD, PLEASANTVILLE, NY 10570	○	⊙		CORPORATE OFFICER	10/A1	7,013	7,013
FILOSA CARE CENTER DBA HANCOCK HALL	31 STAPLES ST., DANBURY, CT 06811	○	⊙		ADVANCED FUNDS	34/B3		95,043
BARBARA A. MALONE (BAMCO, LLC)	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	○	⊙		RENT OWED	34/B3		12,779

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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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.

ALLOCATION OF RELATED PARTY COMPANY SHARED EXPENSES ARE BASED ON THE NUMBER OF BEDS IN EACH FACILTY AS FOLLOWS: HANCOCK HALL (96 BEDS) 60% AND FILOSA (64 BEDS) 40%. MAINTENANCE AND HOUSEKEEPING: HANCOCK HALL (56,300 SQ FT) 59% AND FILOSA (39,605 SQ FT) 41%

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.

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
WELLS FARGO/RICOH USA , PO BOX 41554, PHILADELPHIA, PA 19101	○	⊙	COPIER MACHINE LEASE	07/29/15	REPLACED		3,966
WELLS FARGO/RICOH USA , PO BOX 41554, PHILADELPHIA, PA 19101	○	⊙	COPIER MACHINE LEASE	08/01/18	60 MONTH LEASE	8,160	2,040
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total** *** 6,006

* 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.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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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	Address (No. & Street, City, State, Zip Code)
1	CLIFTON LARSON ALLEN, LLP	300 CROWN COLONY DRIVE, STE 310, QUINCY MA 02169
2	CLIFTON LARSON ALLEN, LLP	300 CROWN COLONY DRIVE, STE 310, QUINCY MA 02169
3		
4		

Services Provided by This Firm (*describe fully*)

1	FINANCIAL STATEMENT REVIEW	$ 11,200
2	PREPARATION OF ANNUAL PROPERTY TAX DECLARATION REPORT	$ 3,280
3		$
4		$
		Charge for Services Provided $ 14,480

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
⊙ Yes ○ No 15/1/D

Legal Services Information

	Name of Legal Firm or Independent Attorney	Telephone Number
1	MURTHA & CULLINA, LP	860-240-6000
2	MICHALIK, BAUER, SILVIA & CICCARILLO, LLP	860-225-8403
3		
4		
5		

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

1 185 ASYLUM STREET HARTFORD, CT, 06103-3469
2 35 PEARL STREET, SUITE 300, NEW BRITAIN, CT, 06051-2645
3
4
5

Services Provided by This Firm (*describe fully*)

1	PAYROLL RELATED	$ 112
2	COLLECTIONS	$ 6,080
3		$
4		$
5		$
		Charge for Services Provided $ 6,192

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
⊙ Yes ○ No 15/1/E

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	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	64	64			64	64			64	64		
B. On last day of THIS report period	64	64			64	64			64	64		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	62	62			62	62			61	61		
B. As of midnight of THIS report period	58	58			61	61			58	58		
3. Total Number of Days Care Provided During Period												
A. Medicare	667	667			592	592			75	75		
B. Medicaid (Conn.)	14,766	14,766			10,916	10,916			3,850	3,850		
C. Medicaid (other states)												
D. Private Pay	6,109	6,109			4,518	4,518			1,591	1,591		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	21,542	21,542			16,026	16,026			5,516	5,516		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	30	30			30	30						
B. Other Bed Reserve Days	73	73			23	23			50	50		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	21,645	21,645			16,079	16,079			5,566	5,566		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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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	RHNS	(Specify)	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents		43		15				
Per Diem Rate								
a. One bed rm.				510.00				
b. Two bed rms.	PPS	250.64		480.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	2,286	2,286		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	1,455	1,455		
D. ***Total Physical Therapy Treatments***	3,741	3,741		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	333	333		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	40	40		
D. ***Total Speech Therapy Treatments***	373	373		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,828	2,828		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	1,576	1,576		
D. ***Total Occupational Therapy Treatments***	4,404	4,404		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ 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)	15,019					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	80,719	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	99,829	5,210				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	29,416	983				
c. Dietary Workers	326,287	21,157				
6. Housekeeping Service						
a. Head Housekeeper	33,853	852				
b. Other Housekeeping Workers	171,103	13,660				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	44,650	852				
b. Other Maintenance Workers	84,887	2,972				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	72,832	4,555				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant	69,927	1,257				
b. Other Accountants	81,065	2,835				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	182,050	3,940				
b. RN						
1. Direct Care	629,023	19,027				
2. Administrative**	192,714	5,263				
c. LPN						
1. Direct Care	463,314	16,829				
2. Administrative**	30,237	879				
d. Aides and Attendants	1,056,412	63,327				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	131,495	5,749				
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	51,232	1,578				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	3,846,064	173,005				

* 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		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
RELIGOUS	$ 1,200	24				
DIRECTOR'S FEE	$ 2,000					
Total	$ 3,200	24	$ -	-	$ -	-

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

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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										
JENNIFER MALONE-SEIXAS	7,013				VICE-PRESIDENT		A1	HANCOCK HALL, 31 STAPLES ST, DANBURY, CT	2,080	170,436
MICHAEL MALONE	8,006				PRESIDENT		A1	HANCOCK HALL, 31 STAPLES ST, DANBURY, CT		108,245
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

** Include **all** employment worked during the cost year.

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

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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 III - Administrators* **										
MICHAEL MALONE	80,719				ADMINISTRATOR	2,080	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.

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B. Report of Expenditures - Professional Fees

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	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	20,295	451				
2. Dentist	7,296	19				
3. Pharmacist	5,244	117				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	80,013	1,164				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	27,600	141				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)	1,060	6				
2. Pharmaceutical Committee (Quarterly meetings)	1,060	6				
3. Staff Development Committee (Once annually)	880	5				
e. Other (Specify)						
PSYCHIATRIC EVALUATIONS	11,200	46				
9. Speech Therapist						
a. Resident Care	14,899	464				
b. Other						
10. Occupational Therapist						
a. Resident Care	96,756	1,332				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	3,200	24				
B-13 Total Fees Paid in Lieu of Salaries	269,503	3,775				

* 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2018	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
GRACE AHERN, R.D. 4 WESTMINSTER ROAD, DANBURY, CT, 06811	DIETICIAN - DIETARY NEEDS AND REPORTS	○	⊙	
SERAFIMA GLOUZGAL,MD, 388 GROVE ST, RIDGEFIELD, CT 06877	COORDINATION OF MEDICAL CARE FOR RESIDENTS	○	⊙	
DANIEL WOLLMAN,MD, 580 LONG HILL AVE, SHELTON, CT 06474	COORDINATION OF MEDICAL CARE FOR RESIDENTS	○	⊙	
HEALTH DRIVE DENTAL GROUP, 888 WORCHESTER ST, WELLESLEY, MA	EVALUATION AND DENTAL GROUP	○	⊙	
ALLIANCE REHAB OF CT, 1520 KENSINGTON RD, SUITE105, OAKBROOK,	PT, OT AND SPEECH EVALUATIONS AND TREATMENT	○	⊙	
SYMBRIA REHAB, 28100 TORCH PARKWAY, WARRENVILLE, IL 60555	PT, OT AND SPEECH EVALUATIONS AND TREATMENT	○	⊙	
ORESTES ARCUNI, MD , 4 BARTRAM DRIVE, WEST REDDING, CT 06896	PSYCHIATRIC EVALUATIONS AND SERVICES	○	⊙	
REV. DAVID FRANKLIN, ST. JOSEPH'S ROMAN CATHOLIC CHURCH, 8 ROBINSON	MASS AND CLERGY VISITS TO FACILITY RESIDENTS	○	⊙	
OMNICARE PHARMACY, 525 KNOTTER DRIVE, CHESHIRE, CT	INFECTION CONTROL REVIEW, PHARMACEUTICAL REVIEW,	○	⊙	
VALURX PHARMACY, 54 TUTTLE PLACE, MIDDLETOWN, CT 06457	GENERAL SUPERVISION OF DRUG ADMINISTRATION	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
FILOSA FOR NURSING AND REHABILITAT	461-C	9/30/2018		15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	111,885	111,885		
2. Disability Insurance	$	35,164	35,164		
3. Unemployment Insurance	$	47,136	47,136		
4. Social Security (F.I.C.A.)	$	288,183	288,183		
5. Health Insurance	$	345,249	345,249		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	15,774	15,774		
(not-owners and not-operators)					
8. Uniform Allowance	$	6,034	6,034		
9. Other (*Specify*)	$	9,301	9,301		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	82,232	82,232		
d. Accounting and Auditing	$	14,480	14,480		
e. Legal (*Services should be fully described on Page 7)*	$	6,192	6,192		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	20,616	20,616		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	9,783	9,783		
2. Cellular Phones	$	2,203	2,203		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$	313	313		
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$	(53,400)	(53,400)		
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	440,159	440,159		
Subtotal	$	1,381,304	1,381,304		

* 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**

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
PHYSICALS	$ 9,301		
Total	$ 9,301	$ -	$ -

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2018	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,381,304	1,381,304		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	5,520	5,520		
2. Holiday Parties for Staff	$	1,235	1,235		
3. Gifts to Staff and Residents	$	11,835	11,835		
4. Employee Travel	$	304	304		
5. Education Expenses Related to Seminars and Conventions	$	1,427	1,427		
6. Automobile Expense (*not purchase or depreciation*)	$	2,293	2,293		
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	5,191	5,191		
2. Advertising Telephone Directory (*all such expenses*)***	$	437	437		
3. Advertising Other (*Specify*)***	$	12,690	12,690		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$	3,992	3,992		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$	166	166		
7. Postage	$	2,806	2,806		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	6,120	6,120		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	687	687		
10. Contributions***	$	1,095	1,095		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	9,118	9,118		
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	100,494	100,494		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	1,546,714	1,546,714		

* 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)
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
PROMOTION-PUBLIC RELATIONS	$ 12,690		
Total Other Advertising	$ 12,690	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 5,067		
CLIA LABORATORY PROGRAM	$ 150		
AANAC	$ 243		
ACHCA	$ 620		
C.A.T.R.D	$ 40		
Total Dues	$ 6,120	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
ALZHEIMER'S ASSOCIATION	$ 100		
ASSOCIATION OF RELIGIOUS COMMUNITIES	$ 200		
DANBURY HOSPITAL & NEW MILFORD HOSPITAL FOUNDATION	$ 400		
DANBURY HIGH SCHOOL	$ 175		
CULTURAL ALLIANCE OF WESTERN CONNECTICUT	$ 220		
Total Contributions	$ 1,095	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
INSERVICE BOOKS & MATERIALS	$ 39		
EQUIPMENT RENTAL	$ 2,895		
SMALL EQUIPMENT	$ 821		
CABLE TV EXPENSE	$ 13,867		
REPAIRS/SERVICE OFFICE EQUIP.	$ 1,280		
INTERNET	$ 4,721		
SOFTWARE LICENSE AND MAINTENACE	$ 24,036		
COMPUTER HOSTING AND SERVICES	$ 14,067		
PAYROLL SERVICE	$ 17,615		
FACILITY LICENSES AND FEES	$ 1,422		
MISCELLANEOUS EXPENSE	$ 2,677		
BANK SERVICE CHARGES	$ 2,209		
RESIDENT RELATED MISC EXP	$ 45		
LOSS ON DISPOSED EQUIPMENT	$ 14,800		
Total Other Administrative and General	$ 100,494	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABI	461-C	9/30/2018	17 | 37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

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

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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
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2018	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	178,106	178,106		
2. Non-Food Supplies	$	24,754	24,754		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____	$	3,226	3,226		
DIETARY SMALL EQUIPMENT					
DIETARY EQUIPMENT REPAIR					
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	206,087	206,087		

		Total	CCNH	RHNS	(Specify)
2F. Dietary Questionnaire					
G. Resident Meals: Total no. of meals served per day:*		178	178		

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ 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.

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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
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2018	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. $	13,359	13,359		
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. $	15,217	15,217		
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) EQUIPMENT RENTAL AND REPAIR	$	10,187	10,187		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	38,763	38,763		

3F.	Laundry Questionnaire			
G.	Is cost of employee laundry included in 3E?	○ Yes	⊙ No	If yes, specify cost.
H.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	○ Yes	⊙ No	If yes, specify cost.
K.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
L.	Where is the revenue received reported in the 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.

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

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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
FILOSA FOR NURSING AND REHABILITA	461-C	9/30/2018	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel		39,605	39,605		
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	24,052	24,052		
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	24,052	24,052		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from OMNICARE/VALUERX PHARMACY SERVICE		$	19,695	19,695		
b. Medicine Cabinet Drugs		$	2,568	2,568		
c. Medical and Therapeutic Supplies		$	127,585	127,585		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	4,654	4,654		
f. X-rays and Related Radiological Procedures***		$	459	459		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	617	617		
i. Recreation		$	5,248	5,248		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	7,744	7,744		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	168,569	168,569		

* 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)
TECH. COMPONENT PART A CHARGES	$ 549		
EQUIPMENT RENTAL NURSING	$ 5,429		
SMALL EQUIPMENT NURSING	$ 1,766		
Total Other Resident Care	$ 7,744	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2018	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
ORESTES J. ARCUNI	WEST REDDING, CT 06896	○	⊙	EVALUATIONS AND SERVICES		11,200			13	B8E
GRACE AHERN, R.D.	ROAD, DANBURY, CT 06811	○	⊙	DIETICIAN - DIETARY NEEDS AND REPORTS		20,295			13	B1
SYMBRIA REHAB	PARKWAY, WARRENVILLE, IL	○	⊙	EVALUATIONS AND TREATMENT		191,668			13	VARI
SERAFIMA M. GLOUZGAL	RIDGEFIELD, CT 06877	○	⊙	MEDICAL DIRECTOR		27,600			13	B8A
CELTIC CONSULTING LLC	TORRINGTON, CT 06790	○	⊙	MDS COMPILANCE		5,110			16	M11
CLIFTON LARSON ALLEN LLP	DRIVE, STE 310, QUINCY MA 02169	○	⊙	ACCOUNTING SERVICES		14,480			15	1D
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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).

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABILIT	461-C	9/30/2018	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	65,689	65,689		
b. Heat	$	40,027	40,027		
c. Light & Power	$	64,997	64,997		
d. Water	$	28,426	28,426		
e. Equipment Lease (*Provide detail on page 6*)	$	6,006	6,006		
f. Other (*itemize*)	$	39,464	39,464		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	244,609	244,609		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	122,329	122,329		
c. Non-Movable Equipment	$				
d. Movable Equipment	$	62,099	62,099		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	184,428	184,428		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	92,098	92,098		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	92,098	92,098		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	649,163	649,163		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	14,416	14,416		
c. Personal property taxes	$	9,821	9,821		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	949,926	949,926		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
REFUSE	$ 24,069		
OUTSIDE MAINTENANCE AND REPAIRS	$ 11,648		
EXTERMINATING	$ 3,100		
BED ALARMS	$ 647		
Total Other Repairs and Maintenance	$ 39,464	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2018	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	4,835,483		4,835,483	2,923,719	SL	40	120,877	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	87,054		87,054		SL	20	1,452	
B-4. Subtotal								122,329
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. 2015 FORD F250 PICKUP	X		10	2015	44,463		44,463	22,324	SL	4	11,022	
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					603,865		603,865	321,256	SL	VARIOUS	47,919	
b. Disposals (attach schedule)					(15,714)		(15,714)	(14,346)	SL	VARIOUS	282	
c. Acquired during this report period (attach schedule)					36,627		36,627		SL	VARIOUS	2,876	
D-3. Subtotal												62,099
E. ***Total Depreciation***												184,428

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:					
6/1/2018	ELEVATOR	$ 87,054	20	$ 1,452	
Total additions for Building Improvement		$ 87,054		$ 1,452	*
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 peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Non-Movable Equipmen		$ -		$ -	*
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 peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
	SEE ATTACHED	$ 36,627		$ 2,876	
Total additions for Movable Equipmen		$ 36,627		$ 2,876	*
Deletions:					
	SEE ATTACHED	$ (15,714)		$ 282	
Total deletions for Movable Equipmen		$ (15,714)		$ 282	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
	SEE ATTACHED	$ 76,128		$ 10,817	
Total additions for Leasehold Improvemer		$ 76,128		$ 10,817	*
Deletions:					
	SEE ATTACHED	$ (34,331)		$ 3,129	
Total deletions for Leasehold Improvemer		$ (34,331)		$ 3,129	**

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2018	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
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			VARIOUS	798,872	366,452	SL	VARI	78,152	
2. Disposals (attach schedule)			VARIOUS	(34,331)	(20,251)	SL	VARI	3,129	
3. Acquired during this report period (attach schedule)			VARIOUS	76,128		SL	VARI	10,817	
C-4. Subtotal									92,098
D. ***Total Amortization***									92,098

* 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHA	461-C	9/30/2018	25	37

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	1995 MAJOR RENOVATION
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	1947
5. Total Licensed Bed Capacity	64
6. Square Footage	39,605
7. Acquisition Cost	
a. Land	398,123
b. Building	4,835,483

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	FIXED			
b. Date Mortgage Obtained	12/22/16			
c. Interest Rate for the Cost Year	3.23%			
d. Term of Mortgage (number of years)	10			
e. Amount of Principal Borrowed	2,476,000			
f. Principal balance outstanding as of 9/30/2018	2,010,643			
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.

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REH	461-C	9/30/2018	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*)

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND RE	461-C	9/30/2018	27 | 37

Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		$	828	828		
A. Item	Rate	Amount				
MAINTENANCE VEHICLE	6.00%	35,813				
Lender						
FORD MOTOR CREDIT						
Address of Lender						
PO BOX 220564PITTSBURGH, PA 15257						
2. Other (*Specify*)		$	8,900	8,900		
A. Item	Rate	Amount				
SEE ATTACHED						
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		$	9,728	9,728		
12. D. Other Interest Expense (*Specify*)		$	16,936	16,936		
SEE ATTACHED						
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)		$	26,664	26,664		
14. Insurance						
a. Insurance on Property (buildings only)		$	7,748	7,748		
b. Insurance on Automobiles		$	2,751	2,751		
c. Insurance other than Property (as specified above)						
1. Umbrella (*Blanket Coverage*)		$	6,950	6,950		
2. Fire and Extended Coverage		$	22,042	22,042		
3. Other (*Specify*)		$	9,628	9,628		
SEE ATTACHED						
14d. ***Total Insurance Expenditures (14a + b + c)***		$	49,118	49,118		
15. ***Total All Expenditures (A-13 thru C-14)***		$	7,370,070	7,370,070		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2018	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.	10	A/1	Salaries not related to Resident Care $	15,019	15,019		
3.			Occupational Therapy $				
4.			Other - See attached Schedule $	5,010	5,010		
Page 13 - Professional Fees							
5.	13	B/8a	Resident Care Physicians ** $	3,915	3,915		
6.			Occupational Therapy $				
7.			Other - See attached Schedule $	2,000	2,000		
Pages 15 & 16 - Administrative and General							
8.	15	1/A2	Discriminatory Benefits $	4,441	4,441		
9.	15	1/C	Bad Debts $	82,232	82,232		
10.	15	1/D	Accounting $	447	447		
10a.			Legal $	6,192	6,192		
11.			Telephone $				
12.	15	H/2	Cellular Telephone $	1,123	1,123		
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.	16	L/3	Gifts, flowers and coffee shops $	8,860	8,860		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.	16	M/3	Unallowable Advertising * $	12,690	12,690		
19.	15	9/K/1	Income Tax / Corporate Business Tax $	(53,400)	(53,400)		
20.	16	M/10	Fund Raising / Contributions $	1,095	1,095		
21.			Unallowable Management Fees $				
22.	16	M/6	Barber and Beauty $	166	166		
23.			Other - See attached Schedule $	17,878	17,878		
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) $	107,668	107,668		

* 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)
10	A/2	MICHAEL MALONE	$ 5,010		
Total Other Salaries Adjustment			$ 5,010	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B12	DIRECTOR FEES	$ 2,000		
Total Other Fees Adjustments			$ 2,000	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M/13	MISCELLANEOUS EXPENSE	$ 2,677		
16	M/13	BANK SERVICE CHARGES	$ 2,209		
16	M/13	RESIDENT RELATED MISC EXP	$ 45		
16	M/13	LOSS ON DISPOSED EQUIPMENT	$ 14,800		
15	1/A/4	FICA ON DISALLOWED SALARIES	$ 1,532		
15	1/A/1	WORKMENS COMPENSATION REFUND	$ (4,100)		
15	1/K/3	PROVIDER TAX	$ 715		
Total Other A&G Adjustments			$ 17,878	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2018	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	107,668	107,668		
Page 20 - Resident Care Supplies***							
27.	20	5/A/2	Prescription Drugs $	19,695	19,695		
28.			Ambulance/Limousine $				
29.	20	5/D	X-rays, etc $	459	459		
30.	20	5/H	Laboratory $	617	617		
31.	20	5/V	Medical Supplies $	6,991	6,991		
32.	20	5/E/2	Oxygen (non emergency) $	4,654	4,654		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	549	549		
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 $	828	828		
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.	27	14/C/	Property Insurance $	5,806	5,806		
Other - Miscellaneous							
42.			Other - Indirect $				
43.			Interest Income on Account Rec. $				
44.			Other - Miscellaneous Administrative $				
45.			Management Fees Direct $				
46.			Management Fees Indirect $				
47.			Other - Direct $	766	766		
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
49. ***Total Amount of Decrease (Items 1 - 48)***			$	148,033	148,033		

*** 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.

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5/L	TECH. COMPONENT PART A CHARGES	$ 549		
Total Other Ancillary Costs			$ 549	$ -	$ -

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)
2	12/C/1	INTEREST - FORD F-150	$ 828		
Total Other Property Adjustments			$ 828	$ -	$ -

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	12/C/2/D	FINANCE CHARGES	$ 766		
Total Other Adjustments			$ 766	$ -	$ -

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABI	461-C	9/30/2018	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	7,102,080	7,102,080		
b. Medicaid Room and Board Contractual Allowance **	$	(3,404,666)	(3,404,666)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	335,250	335,250		
b. Medicare Room and Board Contractual Allowance **	$	69,645	69,645		
4. a. Private-Pay Residents and Other	$	3,111,540	3,111,540		
b. Private-Pay Room and Board Contractual Allowance **	$	(151,279)	(151,279)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	3,588	3,588		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(151)	(151)		
c. Prescription Drugs - Non-Medicare	$				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$				
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	72,272	72,272		
b. Physical Therapy - Medicare Contractual Allowance **	$	(13,178)	(13,178)		
c. Physical Therapy - Non-Medicare	$				
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	17,268	17,268		
b. Speech Therapy - Medicare Contractual Allowance **	$	(318)	(318)		
c. Speech Therapy - Non-Medicare	$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	91,582	91,582		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(16,786)	(16,786)		
c. Occupational Therapy - Non-Medicare	$				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	(11,792)	(11,792)		
b. Other *(Specify)* - Non-Medicare	$	14,134	14,134		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	7,219,189	7,219,189		
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 *(Specify)*	$	80	80		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	150	150		
V. Total Other Revenue (1 thru 8)	$	230	230		
VI. Total All Revenue (III +V)	$	7,219,419	7,219,419		

* *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)
	SEQUESTER REDUCTION PART A&B	$ (11,792)		
Total Other Resident Revenue - Medicare		$ (11,792)	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	PRIOR RELATED CENSUS ADJUSTMENTS	$ 14,134		
Total Other Resident Revenue		$ 14,134	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	BANK INTEREST		$ 80		
Total Interest Income			$ 80	$ -	$ -

Schedule of Other Revenue

Page Ref	Description		CCNH	RHNS	(Specify)
	NON EMERGENCY FACILITY VAN TRANSPORT		$ 150		
Total Other Revenue			$ 150	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHAI	461-C	9/30/2018	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 50,134
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 604,136
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 13,579
4 Inventories				$
5. Prepaid Expenses				$ 29,126
a. INSURANCE		17,607		
b. CORPORATE TAX		2,379		
c.				
d. See Schedule		9,140		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 696,975
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	840,669		$ 402,370
	Accum. Depreciation	438,299	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	624,778		$ 266,791
	Accum. Depreciation	357,987	Net	
7. Motor Vehicles	*Historical Cost	44,463		$ 11,117
	Accum. Depreciation	33,346	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 680,278

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHA	461-C	9/30/2018	32	37

Account				Amount
		Total Brought Forward:	$	1,377,253
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			$	
2. Land Improvements	*Historical Cost			
	Accum. Depreciation	Net	$	
3. Buildings	*Historical Cost	4,922,537		
	Accum. Depreciation	3,046,048 Net	$	1,876,489
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)			$	1,876,489
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 (*itemize*)			$	
6. Loans to Owners or Related Parties (*itemize*)			$	
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)			$	122,501
BED LICENSE		48,001		
DEFERRED TAX ASSET		74,500		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)			$	122,501
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$	3,376,243

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

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
		MAINTENANCE	$ 7,077
		TELEPHONE	$ 302
		SOFTWARE	$ 1,570
		POSTAGE	$ 191
Total Prepaid Expenses			$ 9,140

Schedule of Other Current Assets (itemized) Page 31 Line A8

Page Ref	Line Ref	Description	
Total Other Current Assets (Itemize)			$ -

Schedule of Other Fixed Assets (Itemize) Page 31 Line B9

Page Ref	Line Ref	Description	
Total Other Other Fixed Assets (Itemize)			$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

Schedule of Other Current Liabilities (Itemize) Page 33 Line A12

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

Schedule of Other Long-Term Liabilities (Itemize) Page 34 Line B4

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITA	461-C	9/30/2018	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 310,404
	2. Notes Payable (*itemize*)				$ 376,646
	LINE OF CREDIT		376,646		
	See Schedule				
	3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$ 76,689
	Name of Lender	Purpose	Amount	Date Due	
	SEE ATTACHED		76,689		
	4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$ 216,951
	6. Accrued Payroll Taxes Payable				$ 16,398
	7. Medicare Final Settlement Payable				$
	8. Medicare Current Financing Payable				$
	9. Mortgage Payable (*Current Portion*)				$
	10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
	11. Accrued Income Taxes*				$
	12. Other Current Liabilities (*itemize*)				$ 25,964
	ACCRUED EXPENSES		25,964		
	See Schedule				
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 1,023,052

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILI	461-C	9/30/2018	34	37

Account	Amount
Total Brought Forward:	1,023,052
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$ 116,765

Name of Lender	Purpose	Amount	Date Due
SEE ATTACHED		116,765	

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ 107,823

Name and Address of Lender	Amount	Loan Date
HANCOCK HALL	95,043	
BAMCO, LLC	12,780	

4. Other Long-Term Liabilities (*itemize*)	$
See Schedule	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 224,588
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 1,247,640

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHA	461-C	9/30/2018	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	$ 1,877,941
3.	Reserve for depreciation value of leased personal property (*Equity)*	$
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	$ 1,877,941
B.	**Net Worth**	
1.	Owner's Capital	$
2.	Capital Stock	$ 90,310
3.	Paid-in Surplus	$ 183,510
4.	Treasury Stock	$
5.	Cumulated Earnings	$ 127,493
6.	Gain or Loss for Period 10/1/2017 thru 9/30/2018	$ (150,651)
7.	Total Net Worth	$ 250,662
C.	***Total Reserves and Net Worth***	$ 2,128,603
D.	***Total Liabilities, Reserves, and Net Worth***	$ 3,376,243

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHAB	461-C	9/30/2018	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2017			$ 401,313
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 7,219,419
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 7,370,070
D.	Net Income or Deficit			$ (150,651)
E.	Balance			$ 250,662
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period*** 09/30/18			$ 250,662

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND	461-C	9/30/2018	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. 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
BENJAMIN CHIANESE, CPA

Addres Address	Phone Number
31 STAPLES STREET	203-794-9466