

# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2018

Name of Facility (as licensed) Masonicare Health Center	
Address (No. & Street, City, State, Zip Code) 22 Masonic Avenue, Wallingford, CT 06492	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)
<input checked="" type="checkbox"/> Chronic Disease Hospital	
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018

License Numbers:	CCNH 119-C	RHNS 1274-RCH	Chronic Disease Hospital 11-CD, H0008	Medicare Provider 07-0039
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Medicaid Provider Numbers:	CCNH 1198	RHNS 1587	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

### General Information

Name of Facility (as licensed) Masonicare Health Center	License No. 119-C	Report for Year Ended 9/30/2018	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 Masonicare Health Center [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. {a}

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.

{a} Subject to Desk Audit Review

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) Amy Pellerin			Printed Name (Owner)		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires  / /	
Address of Notary Public					

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Masonicare Health Center	Period Covered:	From 10/1/2017	To 9/30/2018	
Address of Facility 22 Masonic Avenue, Wallingford, CT 06492				
Report Prepared By Marcum LLP	Phone Number 203-781-9600	Date 1/3/2019		
Item	Total	CCNH	RHNS	Chronic Disease Hospital
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (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 203-678-7862		Report for Year Ended 9/30/2018	Page 2	of 37
Name of Facility (as shown on license) Masonicare Health Center		Address (No. & Street, City, State, Zip ) 22 Masonic Avenue, Wallingford, CT 06492		
License Numbers:	CCNH 119-C	RHNS 1274-RCH	Chronic Disease Hospita 11-CD, H0008	Medicare Provider No. 07-0039
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input checked="" type="checkbox"/> Chronic Disease Hospital
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input checked="" type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> 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.				
<b>Administrator</b>				
Name of Administrator Amy Pellerin		Nursing Home Administrator's License No.:	1577	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		



## General Information and Questionnaire Corporate Owners

Name of Facility Masonicare Health Center	License No. 119-C	Report for Year Ended 9/30/2018	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation Masonicare Health Center	Business Address 22 Masonic Avenue, Wallingford, CT 06492	State(s) in Which Incorporated CT		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Please see attached				
Names of Stockholders Owning at Least 10% of Shares				
N/A				

**General Information and Questionnaire**  
**Individual Proprietorship**

Name of Facility Masonicare Health Center	License No. 119-C	Report for Year Ended 9/30/2018	Page 3B	of 37
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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 Masonicare Health Center	License No. 119-C	Report for Year Ended 9/30/2018	Page 4	of 37
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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	%**				
Masonicare	PO Box 70, Wallingford, CT 06492	<input type="radio"/>	<input checked="" type="radio"/>		Please see attached	Pg. 16 M11 & M12	3,737,283	3,737,283
Masonicare at Newtown (MAN)	139 Toddy Hill Road, Newtown, CT 06492	<input type="radio"/>	<input checked="" type="radio"/>		Please see attached	Various		
Masonicare Charity Foundation	35 No. Plains Road, Wallingford, CT 06492	<input type="radio"/>	<input checked="" type="radio"/>		Please see attached	Various		
Masonicare at Ashlar Village	Cheshire Road, Wallingford, CT 06492	<input type="radio"/>	<input checked="" type="radio"/>		Please see attached	Various		
Masonicare Management Services (MMS)	35 No. Plains Road, Wallingford, CT 06492	<input type="radio"/>	<input checked="" type="radio"/>		Please see attached	Various		
Masonicare Home, Health & Hospice (MHHH)	33 No. Plains Road, Wallingford, CT 06492	<input type="radio"/>	<input checked="" type="radio"/>		Please see attached	Various		
Keystone Indemnity Company, LTD	76 St. Paul Street, Suite 500, Burlington, VT 05401	<input type="radio"/>	<input checked="" type="radio"/>		Liability, Director, Crime & Other Insurance	Pg 27, 14c3	176,229	176,229
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" 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 Masonicare Health Center	License No. 119-C	Report for Year Ended 9/30/2018	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 ( <i>See listing page 13</i> )
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.

Please see attached allocation schedule. Also, please note that for cost reporting purposes, Rest Home with Nursing Supervision only (RHNS) refers to the Residential Care Home (RCH).

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

Please see page 4.

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 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 Masonicare Health Center			License No. 119-C		Report for Year Ended 9/30/2018		Page 6	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
Not Applicable	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes	<input checked="" type="radio"/> No
<b>Total ***</b>								

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

\*\* Attach copies of newly acquired leases.

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

**General Information and Questionnaire**  
**Accounting Basis**

Name of Facility Masonicare Health Center	License No. 119-C	Report for Year Ended 9/30/2018	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 Crowe Horwath 2 3 4	Address (No. & Street, City, State, Zip Code) 175 Powder Forest Drive, Simsbury, CT 06089
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Services Provided by This Firm (*describe fully*)

1 Annual Financial Statement Audit	\$ 28,032
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 28,032

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

**Legal Services Information**

Name of Legal Firm or Independent Attorney 1 Murtha Cullina LLP 2 Various Probate Court Fees 3 Wiggin & Dana 4 5	Telephone Number 860-240-6000  203-498-4400
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Address (*No. & Street, City, State, Zip Code*)  
 1 185 Asylum Street, Hartford, CT 06103  
 2  
 3 265 Church Street #17, New Haven, CT 06510  
 4  
 5

Services Provided by This Firm (*describe fully*)

1 Various General, Patient and HR Matters (Disallow \$280 for Marketing)	\$ 102,285
2 Probate Fees (Disallowed)	\$ 139,425
3 Various Regulatory Consulting	\$ 3,569
4	\$
5	\$
	Charge for Services Provided
	\$ 245,279

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

### Schedule of Resident Statistics

Name of Facility Masonicare Health Center		License No. 119-C			Report for Year Ended 9/30/2018				Page 8	of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total Chronic Disease Hospital	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Chronic Disease Hospital	Total	CCNH	RHNS	Chronic Disease Hospital
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	532	366	86	80	532	366	86	80	532	366	86	80
B. On last day of THIS report period	532	366	86	80	532	366	86	80	532	366	86	80
2. Number of Residents												
A. As of midnight of PREVIOUS report period	470	349	76	45	470	349	76	45	465	346	78	41
B. As of midnight of THIS report period	457	347	74	36	465	346	78	41	457	347	74	36
3. Total Number of Days Care Provided During Period												
A. Medicare	24,084	16,732		7,352	18,110	13,379		4,731	5,974	3,353		2,621
B. Medicaid (Conn.)	87,588	87,588			65,740	65,740			21,848	21,848		
C. Medicaid (other states)												
D. Private Pay	19,379	17,851	1,524	4	14,462	13,192	1,266	4	4,917	4,659	258	
E. State SSI for RCH	26,763		26,763		19,890		19,890		6,873		6,873	
F. Other (Specify) Other Insurance	11,744	6,666		5,078	8,622	5,158		3,464	3,122	1,508		1,614
G. Total Care Days During Period (3A thru F)	169,558	128,837	28,287	12,434	126,824	97,469	21,156	8,199	42,734	31,368	7,131	4,235
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	2,578	1,112	1,466		1,863	682	1,181		715	430	285	
B. Other Bed Reserve Days	225	181	44		136	120	16		89	61	28	
5. <b>Total Resident Days (3G + 4A + 4B)</b>	172,361	130,130	29,797	12,434	128,823	98,271	22,353	8,199	43,538	31,859	7,444	4,235

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

Name of Facility Masonicare Health Center			License No. 119-C			Report for Year Ended 9/30/2018			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input checked="" type="radio"/> Yes <input type="radio"/> 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)	Chronic Disease Hospital (3)	Lost			Gained			CCNH	RHNS	Chronic Disease Hospital	
				(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	Chronic Disease Hospital			
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	Chronic Disease Hospital	R.C.H.	ICF-MR					
No. of Residents	32	241	74	74		36							
Per Diem Rate													
a. One bed rm.	Various	238.42	119.52	548.00	250.00	1,417.00							
b. Two bed rms.	Various	238.42		483.00		1,223.00							
c. Three or more bed rms.	Various	238.42		455.00									
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	Chronic Disease Hospital		
A. Medicare - Part B								13,804	13,801		3		
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								931	931				
2. Restorative Treatments													
C. Other								41,941	41,876		65		
<b>D. Total Physical Therapy Treatments</b>								56,676	56,608		68		
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								1,243	1,243				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								165	165				
2. Restorative Treatments													
C. Other								5,236	5,236				
<b>D. Total Speech Therapy Treatments</b>								6,644	6,644				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								10,099	10,099				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								435	435				
2. Restorative Treatments													
C. Other								38,123	38,002		121		
<b>D. Total Occupational Therapy Treatments</b>								48,657	48,536		121		

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

CSP-10 Rev. 9/2002

**Report of Expenditures - Salaries & Wages**

Name of Facility Masonicare Health Center	License No. 119-C	Report for Year Ended 9/30/2018	Page 10	of 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	Chronic Disease Hospital	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)	154,834	1,722	35,454	394	14,794	165
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	321,142	11,070	14,911	530	263,829	8,362
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	1,514,202	82,852	346,721	18,971	144,683	7,917
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	706,650	39,054	117,523	6,495	98,971	5,470
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	337,943	11,704	121,736	4,216	55,330	1,916
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	550,284	32,016	11,030	642	55,305	3,218
9. Barber and Beautician Services						
10. Protective Services	112,869	5,131	40,658	1,848	18,480	840
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	176,244	2,737	11,031	171	49,402	767
b. RN						
1. Direct Care	2,596,231	59,857			1,882,810	45,275
2. Administrative**	1,222,540	27,931			364,665	8,322
c. LPN						
1. Direct Care	3,550,391	99,754	72,729	1,903	352,721	9,581
2. Administrative**						
d. Aides and Attendants	7,330,442	380,010	274,671	12,599	1,784,468	91,812
e. Physical Therapists	1,112,437	27,295			1,336	33
f. Speech Therapists	302,001	5,515				
g. Occupational Therapists						
h. Recreation Workers	389,345	15,012				
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	328,442	9,555	75,206	2,188	250,899	6,773
n. Marketing						
o. Other (Specify) See Attached Schedule	807,396	30,252	128,743	4,206	713,861	20,647
<i>A-13. Total Salary Expenditures</i>	21,513,393	841,467	1,250,413	54,163	6,051,554	211,098

\* 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)**

Position	CCNH		RHNS		Chronic Disease Hospital	
	\$	Hours	\$	Hours	\$	Hours
	0		0		0	
Unit Secretaries	\$ 290,589	14,439			\$ 155,343	6,143
Director of Independent Living & Residential Services Coord.			\$ 85,583	2,728		
Central Supply	\$ 68,307	3,238			\$ 6,527	310
Volunteer	\$ 45,145	1,795	\$ 16,263	647	\$ 7,391	294
Nursing Education	\$ 129,866	2,706	\$ 3,069	64	\$ 38,737	807
Information Management	\$ 192,911	5,378	\$ 5,377	150	\$ 317,709	8,857
Spiritual Services	\$ 80,578	2,696	\$ 18,451	617	\$ 7,699	258
Director of Psych & Clinical Services					\$ 180,455	3,978
<b>Total</b>	\$ 807,396	30,252	\$ 128,743	4,206	\$ 713,861	20,647

**Schedule of Other Fees (Page 13)**

Service	CCNH		RHNS		Chronic Disease Hospital	
	\$	Hours	\$	Hours	\$	Hours
	0		0		0	
Respiratory Therapy	\$ 135,075		\$ 30,929		\$ 12,907	
<b>Total</b>	\$ 135,075	-	\$ 30,929	-	\$ 12,907	-



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

Name of Facility Masonicare Health Center				License No. 119-C	Report for Year Ended 9/30/2018			Page 11	of 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	Chronic Disease Hospital							
<b>Section I - Operators/Owners</b>										
<b>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).</b>										

\* 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)				License No.		Report for Year Ended			Page	of
Masonicare Health Center				119-C		9/30/2018			12	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	Chronic Disease Hospital							
<b>Section III - Administrators***</b>										
John Sweeney (10/1/17 - 8/27/18)	144,307	33,044	13,788	Non Discriminatory	Administrator	2,081	A2	N/A		
Amy Pellerin (8/27/18 - 9/30/18)	10,527	2,410	1,006	Non Discriminatory	Administrator	200	A2	N/A		
<b>Section IV - Assistant Administrators</b>										

\*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		
Masonicare Health Center	119-C	9/30/2018	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	Chronic Disease Hospital	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian						
2. Dentist						
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	1,912,154	9,463	437,844	2,167	182,708	904
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)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	135,075		30,929		12,907	
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>2,047,229</b>	<b>9,463</b>	<b>468,773</b>	<b>2,167</b>	<b>195,615</b>	<b>904</b>

\* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.

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

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

### Report of Expenditures

#### Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis\*

Name of Facility	License No.	Report for Year Ended	Page	of
Masonicare Health Center	119-C	9/30/2018	14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
West Haven Medical Group	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>	
West Haven Medical Group	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>	
New England Geriatrics	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>	
Cardiology Association of Central CT	Cardiology Services	<input type="radio"/>	<input checked="" type="radio"/>	
Jefferson Radiology	X-Ray	<input type="radio"/>	<input checked="" type="radio"/>	
		<input type="radio"/>	<input checked="" type="radio"/>	
		<input type="radio"/>	<input checked="" type="radio"/>	
		<input type="radio"/>	<input checked="" type="radio"/>	
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		<input type="radio"/>	<input checked="" 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
Masonicare Health Center	119-C	9/30/2018	15	37
Item	Total	CCNH	RHNS	Chronic Disease Hospital
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 533,361	398,204	23,145	112,012
2. Disability Insurance	\$ 251,166	187,519	10,899	52,748
3. Unemployment Insurance	\$ 149,353	111,506	6,481	31,366
4. Social Security (F.I.C.A.)	\$ 2,114,702	1,578,825	91,765	444,112
5. Health Insurance	\$ 4,468,301	3,336,010	193,897	938,394
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 14,371	10,729	624	3,018
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 1,780,870	1,329,588	77,279	374,003
8. Uniform Allowance	\$ 764	575	111	78
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 15,839	11,826	687	3,326
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$			
d. Accounting and Auditing	\$ 28,032	21,164	4,846	2,022
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 245,279	185,182	42,403	17,694
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$			
g. Office Supplies	\$ 80,178	60,456	13,458	6,264
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 71,191	53,748	12,307	5,136
2. Cellular Phones	\$ 6,739	5,088	1,165	486
i. Appraisal ( <i>Specify purpose and         attach copy</i> )*	\$			
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$			
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	\$ 1,774,206	1,774,206		
<b>Subtotal</b>	\$ 11,534,352	9,064,626	479,067	1,990,659

\* 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**

Masonicare Health Center  
9/30/2018

Attachment Page 15

**Schedule of Other Employee Benefits**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>Chronic Disease Hospital</b>
	0	0	0
Benefit Allocation	\$ (31,253)	\$ (1,816)	\$ (8,790)
Education - Tuition	\$ 43,079	\$ 2,503	\$ 12,116
<b>Total</b>	<b>\$ 11,826</b>	<b>\$ 687</b>	<b>\$ 3,326</b>

**Schedule of Other Taxes**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>Chronic Disease Hospital</b>
	0	0	0
<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility	License No.	Report for Year Ended		Page	of
Masonicare Health Center	119-C	9/30/2018		16	37
Item	Total	CCNH	RHNS	Chronic Disease Hospital	
<b><i>Subtotals Brought Forward:</i></b>	11,534,352	9,064,626	479,067	1,990,659	
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	1,286	972	222	92
5. Education Expenses Related to Seminars and Conventions	\$	20,901	8,716	946	11,239
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$	7,503	4,787	4	2,712
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$	46,272	34,457	2,157	9,658
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$				
4. Fund-Raising***	\$				
5. Medical Records	\$	4,595	1,718	48	2,829
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$	12,227	5,048	479	6,700
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	59,577	44,774	10,074	4,729
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
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> )	\$	593,776	431,694	31,856	130,226
12. Administrative Management Services**	\$	3,533,668	2,667,865	610,886	254,917
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	97,688	45,619	17,142	34,927
<b><i>C-14 Total Administrative &amp; General Expenditures</i></b>	\$	15,911,845	12,310,276	1,152,881	2,448,688

\* 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	Chronic Disease Hospital
	0	0	0
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

**Schedule of Other Advertising**

Description	CCNH	RHNS	Chronic Disease Hospital
	0	0	0
<b>Total Other Advertising</b>	\$ -	\$ -	\$ -

**Schedule of Dues**

Description	CCNH	RHNS	Chronic Disease Hospital
	0	0	0
AANAC	\$ 588		\$ 175
AHIMA	\$ 135	\$ 4	\$ 221
AAPC	\$ 59	\$ 2	\$ 96
Leading Age	\$ 31,872	\$ 7,298	\$ 3,045
CHA	\$ 12,098	\$ 2,770	\$ 1,156
Posting Error (Disallowed)	\$ 22	\$ 1	\$ 36
<b>Total Dues</b>	\$ 44,774	\$ 10,074	\$ 4,729

**Schedule of Contributions**

Description	CCNH	RHNS	Chronic Disease Hospital
	0	0	0
<b>Total Contributions</b>	\$ -	\$ -	\$ -

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	Chronic Disease Hospital
	0	0	0
Grand Master's Day Celebration (Disallowed)	\$ 4,926	\$ 1,774	\$ 807
Food Service Employee Relations	\$ (3,794)	\$ (869)	\$ (363)
Food Service Bank Charges (Routine)	\$ 636	\$ 146	\$ 61
SNF & CDH Gift Shop and Main St. Caf� Supplies (Disallowed)	\$ 395		\$ 4,932
Minor Equipment Rental		\$ 4,554	\$ 9,615
Business Expense Reimbursement		\$ 397	\$ 133
RCH CHEFA Admin Fees (Disallowed)		\$ 5,942	
Nursing Admin Gift Shop (Disallowed)	\$ 18		\$ 6
Nursing Admin Business Expense Reimbursement	\$ 84		\$ 25
Human Resource Supplies / Employee Relations	\$ 20,933	\$ 1,310	\$ 5,868
Security Supplies	\$ 1,386	\$ 499	\$ 227
Nursing Education Supplies	\$ 315	\$ 7	\$ 95
Volunteer Supplies (Disallowed)	\$ 1,261	\$ 454	\$ 206
Social Services Gift Shop and Main St. Supplies (Disallowed)	\$ 45	\$ 10	\$ 4
Admissions Supplies	\$ 7,395	\$ 206	\$ 12,179
Administration Licenses	\$ 8,877	\$ 2,032	\$ 848
Quality of Life Expense (Disallowed)	\$ 1,210	\$ 277	\$ 116
Catering (Disallowed)	\$ 259	\$ 59	\$ 25
Admin Software Licenses	\$ 269	\$ 62	\$ 26
Switchboard Supplies	\$ 81	\$ 18	\$ 8
IT Supplies	\$ 463	\$ 106	\$ 44
Educational Supplies	\$ 110	\$ 25	\$ 10
Recreation Gift Shop Supplies (Disallowed)	\$ 173		
Spiritual Services Gift Shop Supplies (Disallowed)	\$ 522	\$ 120	\$ 50
Admin Gift Shop Supplies (Disallowed)	\$ 4	\$ 1	\$ 0
Library Supplies	\$ 51	\$ 11	\$ 5
<b>Total Other Administrative and General</b>	\$ 45,619	\$ 17,142	\$ 34,927



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

Name of Facility Masonicare Health Center	License No. 119-C	Report for Year Ended 9/30/2018	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 #
Masonicare, Inc.: 110 South Turnpike Road, Wallingford, CT 06492	3,533,668	Payroll, A/P, A/R, Purchasing, Data Processing, Communications, Human Resource, Property and Property Management, Corporate	Page 16 Line 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
Masonicare Health Center		119-C	9/30/2018		18	37
Item		Total	CCNH	RHNS	Chronic Disease Hospital	
2. Dietary						
a. In-House Preparation & Service						
1. Raw Food	\$	1,836,303	1,390,403	305,153	140,747	
2. Non-Food Supplies	\$	244,157	184,335	42,209	17,613	
3. Other ( <i>Specify</i> ) _____	\$					
b. Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )		\$	527,814	398,492	91,246	38,076
c. Other ( <i>Specify</i> ) _____ Other Dietary Supplies		\$	7,914	5,975	1,368	571
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>		\$	2,616,188	1,979,205	439,976	197,007
2F. Dietary Questionnaire		Total	CCNH	RHNS	Chronic Disease Hospital	
G. Resident Meals:	Total no. of meals served per day:*					
H. Is cost of employee meals included in 2E?	<input checked="" type="radio"/> Yes		<input type="radio"/> No			
I. Did you receive revenue from employees?	<input checked="" type="radio"/> Yes		<input type="radio"/> No	If yes, specify amt.	\$17,685	
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)					Not on Cost Report	
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	<input checked="" type="radio"/> Yes		<input type="radio"/> No	If yes, specify cost.		
L. Is any revenue collected from these people?	<input checked="" type="radio"/> Yes		<input type="radio"/> No	If yes, specify amt.	\$219,522	
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)					30 IV 1	
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.

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

Name of Facility Masonicare Health Center		License No. 119-C	Report for Year Ended 9/30/2018		Page 19	of 37
Item		Total	CCNH	RHNS	Chronic Disease Hospital	
3. Laundry						
a. In-House Processing*	Lbs.	2,673,556	2,385,943	47,824	239,789	
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	50,398	44,976	902	4,520	
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.	2,673,556	2,385,943	47,824	239,789	
	Amt. \$	56,103	50,067	1,004	5,032	
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$	3,373	3,010	60	303	
c. Other ( <i>Specify</i> ) Other Laundry Supplies	\$	-897	-801	-16	-80	
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	<b>\$</b>	<b>108,977</b>	<b>97,252</b>	<b>1,950</b>	<b>9,775</b>	
<b>3F. Laundry Questionnaire</b>						
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 checked="" type="radio"/> Yes	<input type="radio"/> No	If yes, specify cost.			
K. Did you receive revenue from these people?	<input checked="" type="radio"/> Yes	<input type="radio"/> No	If yes, specify amt. \$302,744			
L. Where is the revenue received reported in the Cost Report?	(Page/Line Item) Not on Cost Report					

\* 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.

**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	
Masonicare Health Center	119-C	9/30/2018	20	37	
				Chronic Disease Hospital	
Item		Total	CCNH	RHNS	
4. Housekeeping	Sq. Ft. Serviced by Personnel	379,531	249,044	89,712	40,775
a. In-House Care					
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	215,523	164,979	27,438	23,106
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	379,531	249,044	89,712	40,775
	Amt. \$	31,828	24,364	4,052	3,412
c. Other ( <i>Specify</i> )	\$				
<b>4D. Total Housekeeping Expenditures (4a + b + c)</b>	\$	247,351	189,343	31,490	26,518
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$				
b. Medicine Cabinet Drugs	\$	390	390		
c. Medical and Therapeutic Supplies	\$	755,728	643,418	665	111,645
d. Ambulance/Limousine***	\$	40,927	1,714		39,213
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$				
f. X-rays and Related Radiological Procedures***	\$				
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$				
i. Recreation	\$	27,277	23,072	4,205	
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (Specify)**** See Attached Schedule	\$	187,110	141,510		45,600
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	1,011,432	810,104	4,870	196,458

\* 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	Chronic Disease Hospital
	0	0	0
Physical Therapy Supplies	\$ 42,768		\$ 51
Speech Therapy Supplies	\$ 703		
Occupatoinal Therapy Supplies (Disallowed)	\$ 211		\$ 1
Department Supplies	\$ 97,325		\$ 45,500
Infection Control Supplies	\$ 503		\$ 48
<b>Total Other Resident Care</b>	<b>\$ 141,510</b>	<b>\$ -</b>	<b>\$ 45,600</b>

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

Name of Facility Masonicare Health Center			License No. 119-C		Report for Year Ended 9/30/2018			Page of 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	Chronic Disease Hospital	Pg	Line
Please see attached listing		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
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		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

\* 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
Masonicare Health Center	119-C	9/30/2018			22	37
Item	Total	CCNH	RHNS	Chronic Disease Hospital		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 2,651,190	1,907,435	499,633	244,122		
b. Heat	\$ 365,279	239,692	86,343	39,244		
c. Light & Power	\$ 447,229	293,467	105,714	48,048		
d. Water	\$ 198,930	130,536	47,022	21,372		
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$					
f. Other ( <i>itemize</i> )	\$ 74,724	59,444	7,663	7,617		
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$ 3,737,352</b>	<b>2,630,574</b>	<b>746,375</b>	<b>360,403</b>		
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$ 165,044	123,611	28,484	12,949		
b. Building & Building Improvements	\$ 855,564	501,235	269,571	84,758		
c. Non-Movable Equipment	\$ 97,704	63,298	23,702	10,704		
d. Movable Equipment	\$ 699,739	453,332	169,749	76,658		
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$ 1,818,051</b>	<b>1,141,476</b>	<b>491,506</b>	<b>185,069</b>		
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$ (5,721)		(5,721)			
c. Leasehold Improvements	\$					
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$ (5,721)</b>		<b>(5,721)</b>			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$					
10. Property Taxes						
a. Real estate taxes paid by owner	\$ 144,143		144,143			
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$ 4,409		4,409			
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$ 1,960,882</b>	<b>1,141,476</b>	<b>634,337</b>	<b>185,069</b>		

\* 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**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>Chronic Disease Hospital</b>
	0	0	0
R&M Contracts / Purchase Services	\$ 503	\$ 181	\$ 82
R&M Minor Equipment	\$ 1,456	\$ 525	\$ 239
Dietary Minor Equipment	\$ 7,175	\$ 1,643	\$ 686
Environmental Minor Equipment	\$ 12,853	\$ 2,137	\$ 1,800
SNF Minor Equipment	\$ 22,557		
CDH Minor Equipment			\$ 3,302
Nursing Admin Minor Equipment	\$ 282		\$ 84
Employee Health Minor Equipment	\$ 150	\$ 8	\$ 41
Central Supply Minor Equipment	\$ 628		\$ 60
IT Minor Equipment	\$ 4,386	\$ 1,004	\$ 419
Switchboard Minor Equipment	\$ 332	\$ 76	\$ 32
Equipment Rental	\$ 9,122	\$ 2,089	\$ 872
<b>Total Other Repairs and Maintenance</b>	<b>\$ 59,444</b>	<b>\$ 7,663</b>	<b>\$ 7,617</b>



### Depreciation Schedule

Name of Facility Masonicare Health Center			License No. 119-C			Report for Year Ended 9/30/2018			Page 23	of 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			
<b>A. Land Improvements</b>													
1. Acquired prior to this report period			4,109,083		4,109,083	2,827,900	S/L	Various	175,934				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal										175,934			
<b>B. Building and Building Improvements</b>													
1. Acquired prior to this report period			68,539,263		68,539,263	46,650,519	S/L	Various	1,185,781				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			1,061,687						35,417				
B-4. Subtotal										1,221,198			
<b>C. Non-Movable Equipment</b>													
1. Acquired prior to this report period			3,714,435		3,714,435	2,961,007	S/L	Various	138,353				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			36,250						1,564				
C-4. Subtotal										139,917			
		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								
<b>D. Movable Equipment</b>													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a. Acquired prior to 2018		X		Var	Var	342,301		342,301	258,578	S/L	Various	13,886	
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period				Var	Var	13,739,503		13,739,503	11,827,290	S/L	Various	968,118	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)						501,879						32,764	
D-3. Subtotal													1,014,768
<b>E. Total Depreciation</b>													2,551,817

Masonicare Health Center  
9/30/2018

Schedule of Land Improvements Acquired during this report period

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

\*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
<b>Additions:</b>				
Various	New Additions - See attached listing	\$ 754,548	Various	\$ 20,060
Various	Transfers from related entities	\$ 307,139	Various	\$ 15,357
<b>Total additions for Building Improvement</b>		\$ 1,061,687		\$ 35,417 *
<b>Deletions:</b>				
<b>Total deletions for Building Improvement</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
12/19/2018	Powernet Monitoring	\$ 21,333	10	\$ 1,067
6/18/2018	Tub Replacement	\$ 14,917	15	\$ 497
<b>Total additions for Non-Movable Equipment</b>		\$ 36,250		\$ 1,564 *
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
Various	New Additions - See attached listing	\$ 374,801	Various	\$ 20,056
Various	Transfers from related entities	\$ 127,078	Various	\$ 12,708
<b>Total additions for Movable Equipmen</b>		\$ 501,879		\$ 32,764 *
<b>Deletions:</b>				
<b>Total deletions for Movable Equipmen</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
<b>Total additions for Leasehold Improvemen</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvemen</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

<u>Description</u>	<u>Useful Life</u>	<u>Acquisition Date</u>	<u>Cost</u>	<u>Cost To Be Depreciated</u>	<u>Method</u>	<u>2017 Accum Depreciation</u>	<u>2018* Depreciation</u>	<u>2018 Accum Depreciation</u>
Land Improvements								
Prior Period Acq. (Per 9/30/2017 Cost Report)	Various	Various	4,109,083	4,109,083	S/L	2,827,900	175,934	3,003,834
<b>Total Land Improvements</b>			<b>4,109,083</b>	<b>4,109,083</b>		<b>2,827,900</b>	<b>175,934</b>	<b>3,003,834</b>

<u>Description</u>	<u>Useful Life</u>	<u>Acquisition Date</u>	<u>Cost</u>	<u>Cost To Be Depreciated</u>	<u>Method</u>	<u>2017 Accum Depreciation</u>	<u>2018* Depreciation</u>	<u>2018 Accum Depreciation</u>
Building Improvements								
Prior Period Acq. (Per 9/30/2017 Cost Report)	Various	Various	68,539,262	68,539,262	S/L	46,650,519	1,185,781	47,836,300
Asset Transfers from Other Entities	Various	Various	307,139	307,139	S/L	-	15,357	15,357

<u>9/30/2018 Asset Additions</u>	<u>Useful Life</u>	<u>Acquisition Date</u>	<u>Cost</u>	<u>Cost To Be Depreciated</u>	<u>Method</u>	<u>2017 Accum Depreciation</u>	<u>2018* Depreciation</u>	<u>2018 Accum Depreciation</u>
Six Fire Doors Ramage 6	15	12/14/2017	8,200	8,200	S/L	-	273	273
Air Handling Unit	20	5/18/2018	78,869	78,869	S/L	-	1,972	1,972
Replace Air Handling Unit	20	12/14/2017	20,065	20,065	S/L	-	502	502
F an Coil Units Wooster Building	20	4/12/2018	15,104	15,104	S/L	-	378	378
Blow Down Separator Boiler	15	2/5/2018	5,611	5,611	S/L	-	187	187
B&G Air separator	15	6/19/2018	7,245	7,245	S/L	-	242	242
Overhead Door Dietary	15	3/14/2018	5,057	5,057	S/L	-	169	169
Elevator Upgrades	20	4/20/2018	165,423	165,423	S/L	-	4,136	4,136
Seclusion Room Sturges	20	9/11/2018	44,650	44,650	S/L	-	1,116	1,116
Air Handling Unit Wright	20	7/10/2018	8,435	8,435	S/L	-	211	211
Fire Door Replacement	15	6/13/2018	16,848	16,848	S/L	-	562	562
Fire Door Replacement and Repairs	15	3/28/2018	60,625	60,625	S/L	-	2,021	2,021
Removal Tray Line	15	8/7/2018	11,367	11,367	S/L	-	379	379
Laundry Door Replacement	15	5/22/2018	11,958	11,958	S/L	-	399	399
Carpet Johnson	20	5/7/2018	13,000	13,000	S/L	-	325	325
Hot Water Cross Over	15	6/22/2018	5,360	5,360	S/L	-	179	179
Air Handling Wooster 2&3	20	9/27/2018	34,915	34,915	S/L	-	873	873
Chiller Replacement Wright/Johnson	20	7/23/2018	85,360	85,360	S/L	-	2,134	2,134
EGA Architects 201619-6	20	7/11/2018	2,550	2,550	S/L	-	64	64
Sliktown Roofing # 17055 053017	20	7/11/2018	63,040	63,040	S/L	-	1,576	1,576
Seclusion Room Sturges	20	9/11/2018	44,650	44,650	S/L	-	1,116	1,116
Air Handling Wooster 2&3	20	9/27/2018	34,915	34,915	S/L	-	873	873
Hydrant Replacement	15	3/1/2018	11,300	11,300	S/L	-	377	377
<b>Total Building Improvements</b>			<b>69,600,949</b>	<b>69,600,949</b>		<b>46,650,519</b>	<b>1,221,198</b>	<b>47,871,717</b>





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

CSP-24 Rev. 10/2006

**Amortization Schedule\***

Name of Facility			License No.		Report for Year Ended			Page	of
Masonicare Health Center			119-C		9/30/2018			24	37
Item	Date of Acquisition		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
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1. Mortgage Expense	11	16	25 Years	290,067		B		(5,721)	
2.									
3.									
B-4. Subtotal									(5,721)
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
<b>D. Total Amortization</b>									(5,721)

\* 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 Masonicare Health Center	License No. 119-C	Report for Year Ended 9/30/2018	Page 25	of 37
<b>11. Property Questionnaire</b>				
<b>Part A</b>				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> 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		9/27/1894		
2. Date Structure Completed		05/25/05		
3. If <b>NOT</b> Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity		532		
6. Square Footage		487,433		
7. Acquisition Cost				
a. Land				
b. Building				
<b>Part B - Owner and Related Parties</b>		1st Mortgage	2nd Mortgage	3rd Mortgage
1. Financing		2nd Mortgage	3rd Mortgage	4th Mortgage
a. Type of Financing (e.g., fixed, variable)		CHEFA - Variable R		
b. Date Mortgage Obtained		11/02/16		
c. Interest Rate for the Cost Year		2%-5%		
d. Term of Mortgage (number of years)		25		
e. Amount of Principal Borrowed		17,942,645		
f. Principal balance outstanding as of 9/30/2018		16,478,224		
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
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				
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>				
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
Masonicare Health Center		119-C	9/30/2018			26	37
Item		Total	CCNH	RHNS	Chronic Disease Hospital		
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		\$	17,942,645				
2. Loan Origination Date			11/02/16				
3. Interest Rate %			2% - 5%				
4. Term			25				
5. CHEFA Interest Expense			272,167		272,167		
12 B7. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$	272,167		272,167		

(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
Masonicare Health Center		119-C		9/30/2018			27	37
Item				Total	CCNH	RHNS	Chronic Disease Hospital	
Subtotals Brought Forward:				272,167		272,167		
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)				\$				
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>				\$ 272,167		272,167		
14. Insurance								
a. Insurance on Property (buildings only)				\$ 106,806	80,637	18,464	7,705	
b. Insurance on Automobiles				\$ 16,054	12,121	2,775	1,158	
c. Insurance other than Property (as specified above)								
1. Umbrella (Blanket Coverage)				\$				
2. Fire and Extended Coverage				\$				
3. Other (Specify) Liability, Director, Crime & Other Insurance				\$ 323,527	244,258	55,930	23,339	
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$ 446,387	337,016	77,169	32,202	
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$ 57,839,558	43,055,868	5,080,401	9,703,289	

### D. Adjustments to Statement of Expenditures

Name of Facility Masonicare Health Center				License No. 119-C	Report for Year Ended 9/30/2018	Page 28	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Chronic Disease Hospital
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.			Accounting	\$			
10a.	15	1e	Legal	\$ 139,705	105,475	24,152	10,078
11.	30	IV3	Telephone	\$ 19	14	1	4
12.	15	1h2	Cellular Telephone	\$ 3,365	2,540	582	243
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.	15	1a9	Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$ 57,697	43,079	2,503	12,116
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.			Unallowable Advertising *	\$			
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.	16	m12	Unallowable Management Fees	\$ 1,516,777	1,145,144	262,214	109,419
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 27,127	11,457	9,238	6,432
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
<b>Subtotal (Items 1 - 26)</b>				\$ 1,744,690	1,307,709	298,689	138,291

\* 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	Chronic Disease Hospital
<b>Total Other Salaries Adjustment</b>			\$ -	\$ -	\$ -

**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	Chronic Disease Hospital
<b>Total Other Fees Adjustments</b>			\$ -	\$ -	\$ -

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	Chronic Disease Hospital
16	m13	Grand Master's Day Celebration (Disallowed)	\$ 4,926	\$ 1,774	\$ 807
16	m13	SNF & CDH Gift Shop and Main St. Café Supplies (Disallowed)	\$ 395	\$ -	\$ 4,932
16	m13	RCH CHEFA Admin Fees (Disallowed)	\$ -	\$ 5,942	\$ -
16	m13	Nursing Admin Gift Shop (Disallowed)	\$ 18	\$ -	\$ 6
16	m13	Volunteer Supplies (Disallowed)	\$ 1,261	\$ 454	\$ 206
16	m13	Social Services Gift Shop and Main St. Supplies (Disallowed)	\$ 45	\$ 10	\$ 4
16	m13	Quality of Life Expense (Disallowed)	\$ 1,210	\$ 277	\$ 116
16	m13	Catering (Disallowed)	\$ 259	\$ 59	\$ 25
16	m13	Recreation Gift Shop Supplies (Disallowed)	\$ 173	\$ -	\$ -
16	m13	Spiritual Services Gift Shop Supplies (Disallowed)	\$ 522	\$ 120	\$ 50
16	m13	Admin Gift Shop Supplies (Disallowed)	\$ 4	\$ 1	\$ 0
16	m8	Posting Errors	\$ 22	\$ 1	\$ 36
30	IV 8	Gain on Disposal of Asset (A&G Disallowance)	\$ 2,620	\$ 600	\$ 250
30	IV 8	Administration Misc. Income (A&G Disallowance)	\$ 2	\$ -	\$ -
<b>Total Other A&amp;G Adjustments</b>			\$ 11,457	\$ 9,238	\$ 6,432

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

Name of Facility				License No.	Report for Year Ended	Page	of
Masonicare Health Center				119-C	9/30/2018	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Chronic Disease Hospital
Subtotals Brought Forward				\$ 1,744,690	1,307,709	298,689	138,291
<b>Page 20 - Resident Care Supplies***</b>							
27.			Prescription Drugs	\$			
28.	20	5d	Ambulance/Limousine	\$ 40,927	1,714		39,213
29.			X-rays, etc	\$			
30.			Laboratory	\$			
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 659,644	548,609	523	110,512
<b>Page 22 - Maintenance and Property</b>							
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	\$ (5,721)		(5,721)	
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.	20	IV1	Other - Indirect	\$ 301,668	229,252	22,112	50,304
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$ 101,702	76,783	17,582	7,337
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$ 90,694		90,694	
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 2,933,603	2,164,068	423,879	345,657

\*\*\* 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.



Page Ref	Line Ref	Description	CCNH	RHNS	Chronic Disease Hospital
30	IV8	Nursing Support Income (Direct Disallowance)	\$ 76,783	\$ 17,582	\$ 7,337
<b>Total Other Adjustments</b>			\$ 76,783	\$ 17,582	\$ 7,337

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Chronic Disease Hospital
30	12B5	MHC Wright Bond Interest		\$ 90,694	
<b>Total Unallowable Building Interest</b>			\$ -	\$ 90,694	\$ -

## F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Masonicare Health Center	119-C	9/30/2018			30	37
Item	Total	CCNH	RHNS	Chronic Disease Hospital		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 49,592,627	42,616,315	6,977,692	(1,380)		
b. Medicaid Room and Board Contractual Allowance **	\$					
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 18,052,591	7,508,010		10,544,581		
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$ 19,864,349	12,994,263	256,433	6,613,653		
b. Private-Pay Room and Board Contractual Allowance **	\$					
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 2,532,561	2,155,579		376,982		
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$ 3,779,795	3,478,912		300,883		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
2. a. Medical Supplies - Medicare	\$ 24,279	14,566		9,713		
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$ 18,280	11,653		6,627		
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$ 2,683,617	2,680,397		3,220		
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$					
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 904,554	904,554				
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$ 305,701	305,701				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$					
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$					
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other ( <i>Specify</i> ) - Medicare	\$ (8,604,537)	(5,403,155)	296,942	(3,498,324)		
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ (40,959,288)	(29,704,600)	(3,603,885)	(7,650,803)		
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 48,194,529	37,562,195	3,927,182	6,705,152		
<b>IV. Other Revenue*</b>						
1. Meals sold to guests, employees & others	\$ 219,522	165,354	9,310	44,858		
2. Rental of rooms to non-residents	\$					
3. Telephone	\$ 19	14	1	4		
4. Rental of Television and Cable Services	\$					
5. Interest Income ( <i>Specify</i> )	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$ 199,937	152,829	33,165	13,943		
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 419,478	318,197	42,476	58,805		
<b>VI. Total All Revenue</b> (III +V)	\$ 48,614,007	37,880,392	3,969,658	6,763,957		

\* 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	Chronic Disease Hospital
	Various Other Medicare Resident Revenue - Available Upon Audit	(5,403,155)	296,942	(3,498,324)
	<b>Total Other Resident Revenue - Medicare</b>	<b>\$ (5,403,155)</b>	<b>\$ 296,942</b>	<b>\$ (3,498,324)</b>

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

**Related Exp**

Page Ref	Description	CCNH	RHNS	Chronic Disease Hospital
	Various Other Non-Medicare Resident Revenue - Available Upon Audit	(29,704,600)	(3,603,885)	(7,650,803)
	<b>Total Other Resident Revenue</b>	<b>\$ (29,704,600)</b>	<b>\$ (3,603,885)</b>	<b>\$ (7,650,803)</b>

**Interest Income**

		Account			
Page Ref	Account	Balance	CCNH	RHNS	Chronic Disease Hospital
			0	0	0
	<b>Total Interest Income</b>		<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	Chronic Disease Hospital
		0	0	0
30 IV 8	Environmental Services Income (Indirect Disallowance)	\$ 7,745	\$ 2,790	\$ 1,268
30 IV 8	Vending Machine Income (Indirect Disallowance)	\$ 43,723	\$ 10,012	\$ 4,178
30 IV 8	Gain on Disposal of Asset (A&G Disallowance)	\$ 2,620	\$ 600	\$ 250
30 IV 8	Nursing Support Income (Direct Disallowance)	\$ 76,783	\$ 17,582	\$ 7,337
30 IV 8	Administration Misc. Income (A&G Disallowance)	\$ 2	\$ -	\$ -
30 IV 8	Recreation Income (Indirect Disallowance)	\$ 12,430	\$ -	\$ -
30 IV 8	Spiritual Income (Expense Already Disallowed)	\$ 9,526	\$ 2,181	\$ 910
	<b>Total Other Revenue</b>	<b>\$ 152,829</b>	<b>\$ 33,165</b>	<b>\$ 13,943</b>

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Masonicare Health Center	119-C	9/30/2018	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	2,070
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	8,027,030
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	8,961
4. Inventories			\$	170,846
5. Prepaid Expenses			\$	577,515
a. _____				
b. _____				
c. _____				
d. See Schedule		577,515		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	(198,672)
_____				
_____				
See Schedule		(198,672)		
<b>A-9. Total Current Assets (Lines A1 thru 8)</b>			\$	8,587,750
B. Fixed Assets				
1. Land				
2. Land Improvements	*Historical Cost	4,109,083	\$	1,105,249
	Accum. Depreciation	3,003,834		Net
3. Buildings	*Historical Cost	69,600,950	\$	21,729,233
	Accum. Depreciation	47,871,717		Net
4. Leasehold Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		Net
5. Non-Movable Equipment	*Historical Cost	3,750,685	\$	649,761
	Accum. Depreciation	3,100,924		Net
6. Movable Equipment	*Historical Cost	14,241,382	\$	1,413,210
	Accum. Depreciation	12,828,172		Net
7. Motor Vehicles	*Historical Cost	342,301	\$	69,837
	Accum. Depreciation	272,464		Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	(436,713)
_____		(436,713)		
See Schedule				
<b>B-10. Total Fixed Assets (Lines B1 thru 9)</b>			\$	24,530,577

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

(Carry Total forward to next page)

### G. Balance Sheet (cont'd)

Name of Facility Masonicare Health Center	License No. 119-C	Report for Year Ended 9/30/2018	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	33,118,327
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			\$	
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$	
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> )			\$	
_____				
See Schedule				
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$	
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$	33,118,327

\* 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
Masonicare Health Center		119-C	9/30/2018	33	37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	2,187,726
2. Notes Payable ( <i>itemize</i> )				\$	
_____					
_____					
See Schedule					
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> )				\$	1,594,734
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	365,888
7. Medicare Final Settlement Payable				\$	36,315
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> )				\$	1,260,540
_____					
_____					
_____					
			See Schedule	1,260,540	
<b>A-13. Total Current Liabilities</b> (Lines A1 thru 12)				\$	<b>5,445,203</b>

\* 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 Masonicare Health Center	License No. 119-C	Report for Year Ended 9/30/2018	Page 34	of 37
Account			Amount	
Total Brought Forward:			5,445,203	
<b>Liabilities (cont'd)</b>				
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> )				\$ 918,407
See Schedule				918,407
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 918,407
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 6,363,610

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	A5	Prepaid Insurance	\$ 3,978
31	A5	Prepaid Postage Meter	\$ 39,487
31	A5	Prepaid Other	\$ 344,223
31	A5	Prepaid Dues	\$ 11,265
31	A5	Prepaid Rent	\$ 2,363
31	A5	Prepaid Morrison	\$ 176,199
<b>Total Prepaid Expenses</b>			<b>\$ 577,515</b>

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

Page Ref	Line Ref	Description	
30	A8	Capital Purchases	\$ (330,675)
30	A8	Intercompany Rec.	\$ (29,583)
30	A8	Resident Personal Funds	\$ 159,402
30	A8	Insurance Payments	\$ 272
30	A8	Under Patient Asset Management	\$ 1,912
<b>Total Other Current Assets (Itemize)</b>			<b>\$ (198,672)</b>

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

Page Ref	Line Ref	Description	
<b>Total Other Other Fixed Assets (Itemize)</b>			<b>\$ -</b>

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
<b>Total Other Assets</b>			<b>\$ -</b>

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
<b>Total Notes Payable</b>			<b>\$ -</b>

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

Page Ref	Line Ref	Description	
33	A12	Due to Remedy	\$ 273,776
33	A12	Accrued Liabilities	\$ 160,450
33	A12	Accrued RE Taxes	\$ (71,683)
33	A12	Accrued Provider Tax	\$ 432,607
33	A12	Accrued Audit Fees	\$ 23,025
33	A12	Patient Reserves	\$ 125,946
33	A12	Accrued Security Deposits	\$ 185,582
33	A12	Accrued edicaid Settlement	\$ 98,000
33	A12	Applied Income	\$ 17,021
33	A12	Refunds	\$ 15,816
<b>Total Other Current Liabilities (Itemize)</b>			<b>\$ 1,260,540</b>

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

Page Ref	Line Ref	Description	
34	B4	Asbestos Removal	\$ 814,274
34	B4	Patient Asset Liability	\$ 104,133
<b>Total Other Current Liabilities (Itemize)</b>			<b>\$ 918,407</b>

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

Name of Facility	License No.	Report for Year Ended	Page	of
Masonicare Health Center	119-C	9/30/2018	35	37
Account			Amount	
<b>A. Reserves</b>				
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>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	34,520,524
6. Gain or Loss for Period	10/1/2017	thru 9/30/2018	\$	(7,765,807)
7. Total Net Worth			\$	26,754,717
<b>C. Total Reserves and Net Worth</b>			\$	26,754,717
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	33,118,327

### H. Changes in Total Net Worth

Name of Facility Masonicare Health Center	License No. 119-C	Report for Year Ended 9/30/2018	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2017			\$	30,391,575
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$	63,020,687
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$	70,786,494
D. Net Income or Deficit			\$	(7,765,807)
E. Balance			\$	22,625,768
F. Additions				
1. Additional Capital Contributed ( <i>itemize</i> )				
Total Expenses per Pg 27			55,388,690	
Add: Non Reimb.			15,397,804	
Total Expenses			70,786,494	
2. Other ( <i>itemize</i> )				
Total Revenue per Pg 30			48,614,007	
Add: Non Reimb.			14,406,680	
Total Revenue			63,020,687	
Close out of Intercompany to Fund Balance			4,128,949	
F-3. Total Additions			\$	4,128,949
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. <b>Balance at End of Period</b>			\$	26,754,717



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

Name of Facility Masonicare Health Center	License No. 119-C	Report for Year Ended 9/30/2018	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> Chronic Disease Hospital		
<b>Preparer/Reviewer Certification</b>				
<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		Title		Date Signed
Printed Name of Preparer				
Matthew S. Bivolack				
Address Address			Phone Number	
555 Long Wharf Drive, New Haven, CT 06511			203-781-9600	
Annual Report Contact			Phone Number	
Rob Leake			203-678-7865	
Annual Report Contact Email Address				
Rleake@Masonicare.org				