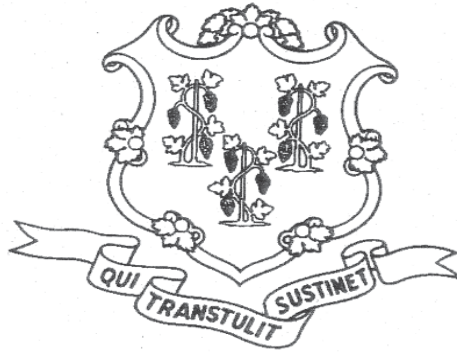


# State of Connecticut



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

Name of Facility (as licensed) Matulaitis Nursing Home	
Address (No. & Street, City, State, Zip Code) 10 Thurber Rd	
Type of Facility <input type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> Other	
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018

License Numbers:	CCNH 989	RHNS	Other	Medicare Provider 07-5411
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Medicaid Provider Numbers:	CCNH 07-A086	RHNS	ICF-IID
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**For Department Use Only**

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

**General Information**

Name of Facility (as licensed) Matulaitis Nursing Home	License No. 989	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 Matulaitis Nursing Home [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) Lisa Ryan			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 Matulaitis Nursing Home	Period Covered:	From 10/1/2017	To 9/30/2018	
Address of Facility 10 Thurber Rd				
Report Prepared By John Iovieno	Phone Number 860-928-7976	Date		
Item	Total	CCNH	RHNS	Other
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 860-928-7976	Report for Year Ended 9/30/2018	Page 2	of 37
Name of Facility (as shown on license) Matulaitis Nursing Home		Address (No. & Street, City, State, Zip) 10 Thurber Rd		
License Numbers:	CCNH 989	RHNS	Other	Medicare Provider No. 07-5411
Type of Facility (Check appropriate box(es))				
<input type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> Other				
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 Lisa Ryan		Nursing Home Administrator's License No.:	001191	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		









**General Information and Questionnaire  
 Related Parties\***

Name of Facility Matulaitis Nursing Home	License No. 989	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	%**				
Sisters of the Immaculate Conception	600 Liberty Highway, Putnam CT	<input type="radio"/>	<input checked="" type="radio"/>		Rent	pg 22 Line 9	224,400	224,400
		<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"/>					

\* 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 Matulaitis Nursing Home	License No. 989	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.

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

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

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

### General Information and Questionnaire 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 Matulaitis Nursing Home			License No. 989		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							
	<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 Matulaitis Nursing Home	License No. 989	Report for Year Ended 9/30/2018	Page 7	of 37
The records of this facility for the period covered by this report were maintained on the following basis:				
<input checked="" type="radio"/> Accrual <input type="radio"/> Cash <input type="radio"/> Modified Cash				
Is the accounting basis for this period the same as for the previous period? <input checked="" type="radio"/> Yes <input type="radio"/> No            If "No," explain.				
<b>Independent Accounting Firm</b>				
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)		
1 Marcum LLP		Hartford CT		
2				
3				
4				
Services Provided by This Firm ( <i>describe fully</i> )				
1 Compilation, Tax return, pension audit, Medicare cost report		\$	18,057	
2		\$		
3		\$		
4		\$		
			Charge for Services Provided	
			\$ 18,057	
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="radio"/> Yes <input type="radio"/> No				
<b>Legal Services Information</b>				
Name of Legal Firm or Independent Attorney			Telephone Number	
1 Wigin & Dana				
2 Robinson & Cole				
3 Murtha Cullina				
4				
5				
Address ( <i>No. &amp; Street, City, State, Zip Code</i> )				
1 New Haven CT				
2 Hartford CT				
3 Hartford CT				
4				
5				
Services Provided by This Firm ( <i>describe fully</i> )				
1 Collection litigation		\$	15,453	
2 Employee matters		\$	5,655	
3 Employee handbook issues		\$	2,750	
4		\$		
5		\$		
			Charge for Services Provided	
			\$ 23,858	
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="radio"/> Yes <input type="radio"/> No				

### Schedule of Resident Statistics

Name of Facility Matulaitis Nursing Home		License No. 989			Report for Year Ended 9/30/2018				Page 8	of 37			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total Other	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	Other	Total	CCNH	RHNS	Other	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	119	119			119	119			119	119			
B. On last day of THIS report period	119	119			119	119			119	119			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	112	112			112	112			114	114			
B. As of midnight of THIS report period	114	114			114	114			114	114			
3. Total Number of Days Care Provided During Period													
A. Medicare	3,363	3,363			2,391	2,391			972	972			
B. Medicaid (Conn.)	29,470	29,470			22,419	22,419			7,051	7,051			
C. Medicaid (other states)													
D. Private Pay	5,886	5,886			4,161	4,161			1,725	1,725			
E. State SSI for RCH													
F. Other (Specify) Commercial	1,885	1,885			1,595	1,595			290	290			
G. Total Care Days During Period (3A thru F)	40,604	40,604			30,566	30,566			10,038	10,038			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days													
B. Other Bed Reserve Days													
5. <b>Total Resident Days (3G + 4A + 4B)</b>	40,604	40,604			30,566	30,566			10,038	10,038			

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

Name of Facility Matulaitis Nursing Home			License No. 989			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? <span style="float: right;"><input type="radio"/> Yes <input checked="" type="radio"/> No</span>													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	Other	Lost			Gained			CCNH	RHNS	Other	
	(1)	(2)	(3)	(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	Other		
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	Other	R.C.H.	ICF-MR				
No. of Residents													
Per Diem Rate													
a. One bed rm.	pps		212.46		403.00								
b. Two bed rms.	pps		212.46		381.00								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	Other	
A. Medicare - Part B									1,138	1,138			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									3,611	3,611			
D. <b>Total Physical Therapy Treatments</b>									4,749	4,749			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									850	850			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									1,317	1,317			
D. <b>Total Speech Therapy Treatments</b>									2,167	2,167			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									442	442			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									3,455	3,455			
D. <b>Total Occupational Therapy Treatments</b>									3,897	3,897			

### Report of Expenditures - Salaries & Wages

Name of Facility Matulaitis Nursing Home	License No. 989	Report for Year Ended 9/30/2018	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input type="radio"/> Yes <input checked="" type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Other	Hours
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	170,588	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	408,119	17,007				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	71,910	2,080				
c. Dietary Workers	476,243	27,220				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	115,948	8,920				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	81,921	2,080				
b. Other Maintenance Workers	96,926	4,848				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	132,345	8,535				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	107,614	2,080				
b. RN						
1. Direct Care	974,442	30,451				
2. Administrative**	257,486	6,435				
c. LPN						
1. Direct Care	891,020	33,624				
2. Administrative**						
d. Aides and Attendants	2,066,776	119,820				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	152,427	6,486				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
Pastoral Care	61,131	1,910				
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	181,463	5,670				
n. Marketing						
o. Other (Specify)						
See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	6,246,359	279,246				

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

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

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





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

Name of Facility				License No.	Report for Year Ended			Page	of	
Matulaitis Nursing Home				989	9/30/2018			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Other							
<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
Matulaitis Nursing Home				989		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	Other							
<b>Section III - Administrators***</b>										
Jarrett McClurg	38,981					695	A2			
Lisa Ryan	53,077					865	A2			
Pat King	78,530					520	A2			
<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		
Matulaitis Nursing Home	989	9/30/2018	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	Other	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary</b> (For all such services complete Schedule B1)						
1. Dietitian	27,560	811				
2. Dentist	13,743	138				
3. Pharmacist	12,950	324				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	395,774	4,398				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	60,000	400				
b. Utilization Review (Title 18 and 19 only) monthly meeting	250	4				
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	34,492	460				
b. Other						
10. Occupational Therapist						
a. Resident Care	64,649	862				
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	13,484	327				
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>622,902</b>	<b>7,724</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 Matulaitis Nursing Home		License No. 989	Report for Year Ended 9/30/2018	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Margaret Higgins, Woodstock, CT	Consult Dietician	<input checked="" type="radio"/>	<input type="radio"/>	wife of board member	
Genesis Rehab, Philadelphia PA	Therapy services	<input type="radio"/>	<input checked="" type="radio"/>		
Phamerica, Philadelphia PA	Pharmacy	<input type="radio"/>	<input checked="" type="radio"/>		
Healthdrive, Berlin CT	Podiatrist, Optometrist	<input type="radio"/>	<input checked="" type="radio"/>		
Joseph Allessandro MD, Pomfret Center, CT	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Arthur Catsum MD, Pomfret CT	Physician meetings	<input type="radio"/>	<input checked="" type="radio"/>		
David Wilterdink MD, Danielson CT	Pyhsician Meetings	<input type="radio"/>	<input checked="" type="radio"/>		
Rev. Isadore Sadowski, Putnam Ct	Chaplin	<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"/>		
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		<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"/>		

\* 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
Matulaitis Nursing Home	989	9/30/2018	15	37
Item	Total	CCNH	RHNS	Other
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 136,816	136,816		
2. Disability Insurance	\$ 13,425	13,425		
3. Unemployment Insurance	\$ 24,917	24,917		
4. Social Security (F.I.C.A.)	\$ 419,555	419,555		
5. Health Insurance	\$ 428,810	428,810		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 37,568	37,568		
8. Uniform Allowance	\$ 13,367	13,367		
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 13,367	13,367		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 125,000	125,000		
d. Accounting and Auditing ***	\$ 41,915	41,915		
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$			
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$			
g. Office Supplies	\$ 48,234	48,234		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 13,363	13,363		
2. Cellular Phones	\$			
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	\$ 770,450	770,450		
<b>Subtotal</b>	\$ 2,086,787	2,086,787		

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

(Carry Subtotals forward to next page)

\*\*\* Contains both Accounting and Legal fees from Page 7. There is a \$99 reported less.RFI.



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

Name of Facility	License No.	Report for Year Ended		Page	of
Matulaitis Nursing Home	989	9/30/2018		16	37
Item	Total	CCNH	RHNS	Other	
<b>Subtotals Brought Forward:</b>		2,086,787	2,086,787		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$	4,874	4,874		
4. Employee Travel	\$	2,017	2,017		
5. Education Expenses Related to Seminars and Conventions	\$	11,178	11,178		
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$	1,075	1,075		
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$	2,271	2,271		
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	22,885	22,885		
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$	4,983	4,983		
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$				
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	2,766	2,766		
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> )	\$	145,101	145,101		
12. Administrative Management Services**	\$				
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	173,371	173,371		
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$	2,457,308	2,457,308		

\* 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	Other
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	Other
other adv	\$ 22,885		
<b>Total Other Advertising</b>	\$ 22,885	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	Other
<b>Total Dues</b>	\$ -	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	Other
<b>Total Contributions</b>	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	Other
Pastoral Care	\$ 28,680		
Chapel Expense	\$ 1,682		
Permits & License	\$ 1,766		
General Administrative	\$ 150		
Misc	\$ 17,048		
Background checks	\$ 3,100		
Interest expense	\$ 28,706		
Computer expense	\$ 90,232		
Employee physicals	\$ 2,007		
<b>Total Other Administrative and General</b>	\$ 173,371	\$ -	\$ -



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

Name of Facility Matulaitis Nursing Home	License No. 989	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 #

**\* 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 Matulaitis Nursing Home		License No. 989	Report for Year Ended 9/30/2018		Page 18	of 37
Item		Total	CCNH	RHNS	Other	
2. Dietary						
a. In-House Preparation & Service						
1.	Raw Food	\$ 269,164	269,164			
2.	Non-Food Supplies	\$ 26,592	26,592			
3.	Other ( <i>Specify</i> ) _____ Nutritional supplement	\$ 48,334	48,334			
b. Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )		\$				
c. Other ( <i>Specify</i> ) _____		\$				
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>		\$ 344,090	344,090			
2F. Dietary Questionnaire		Total	CCNH	RHNS	Other	
G.	Resident Meals: Total no. of meals served per day:*					
H.	Is cost of employee meals included in 2E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No			
I.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No			If yes, specify amt.
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No			If yes, specify cost.
L.	Is any revenue collected from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No			If yes, specify amt.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)					
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No			If yes, specify cost.
O.	Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No			If yes, specify amt.
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)					

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

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

Name of Facility Matulaitis Nursing Home		License No. 989	Report for Year Ended 9/30/2018	Page 19	of 37
Item		Total	CCNH	RHNS	Other
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. \$			
	2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.			
		Amt. \$			
	3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.			
		Amt. \$			
	4. Repair and/or purchase of linens.***	Lbs.			
		Amt. \$			
	b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$			
	c. Other ( <i>Specify</i> ) supplies	\$	94,597	94,597	
3D.	<b>Total Laundry Expenditures</b> (3a + b + c)	\$	94,597	94,597	
3F. Laundry Questionnaire					
G.	Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
H.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
I.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

\* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3E.

\*\*\* 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 Matulaitis Nursing Home		License No. 989	Report for Year Ended 9/30/2018		Page 20	of 37
Item			Total	CCNH	RHNS	Other
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
	a. In-House Care					
	1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$				
	b. Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )	Sq. Ft. Serviced by Personnel				
		Amt. \$				
	C. Other ( <i>Specify</i> ) supplies	\$	56,442	56,442		
<b>4D.</b>	<b>Total Housekeeping Expenditures (4a + b + c)</b>	\$	56,442	56,442		
5.	Resident Care (Supplies)**					
	a. Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from Pharmerica	\$	221,220	221,220		
	b. Medicine Cabinet Drugs	\$	27,549	27,549		
	c. Medical and Therapeutic Supplies	\$	107,832	107,832		
	d. Ambulance/Limousine***	\$				
	e. Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	38,042	38,042		
	f. X-rays and Related Radiological Procedures***	\$	8,764	8,764		
	g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
	h. Laboratory***	\$	9,110	9,110		
	i. Recreation	\$	6,018	6,018		
	j. Direct Management Services*	\$				
	k. Indirect Management Services*	\$				
	l. Other (Specify)**** See Attached Schedule	\$	157,049	157,049		
<b>5M.</b>	<b>Total Resident Care Expenditures (5a - 5j)</b>	\$	575,584	575,584		

\* 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.



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

Name of Facility Matulaitis Nursing Home			License No. 989	Report for Year Ended 9/30/2018	Page 21	of 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	Other	Pg	Line	
		<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"/>								
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		<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"/>								

\* 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
Matulaitis Nursing Home	989	9/30/2018			22	37
Item	Total	CCNH	RHNS	Other		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 22,733	22,733				
b. Heat	\$ 66,513	66,513				
c. Light & Power	\$ 108,595	108,595				
d. Water	\$ 21,456	21,456				
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$					
f. Other ( <i>itemize</i> )	\$ 59,950	59,950				
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$ 279,247</b>	<b>279,247</b>				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$ 90,829	90,829				
d. Movable Equipment	\$ 33,161	33,161				
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$ 123,990</b>	<b>123,990</b>				
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 145,395	145,395				
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$ 145,395</b>	<b>145,395</b>				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 224,400	224,400				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$					
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$ 493,785</b>	<b>493,785</b>				

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





### Depreciation Schedule

Name of Facility Matulaitis Nursing Home			License No. 989			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													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal													
<b>B. Building and Building Improvements</b>													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal													
<b>C. Non-Movable Equipment</b>													
1. Acquired prior to this report period			1,806,318		1,806,318	1,276,658	sl		90,347				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			4,821						482				
C-4. Subtotal										90,829			
		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. GMC Truck				5	95	23,814		23,814	23,814	sl			
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period						892,622		892,622	832,281	sl	various	19,952	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)						75,544						13,209	
D-3. Subtotal													33,161
<b>E. Total Depreciation</b>													123,990

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 Improvements</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Land Improvements</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>				
<b>Total additions for Building Improvements</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</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>				
11/1/2017	Phone system	\$ 4,821	10	\$ 482
<b>Total additions for Non-Movable Equipment</b>		\$ 4,821		\$ 482 *
<b>Deletions:</b>				

<b>Total deletions for Non-Movable Equipment</b>	\$	-	\$	-	** Attachment Pages 23 24
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\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2

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## Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
11/1/2017	Kubota Tractor	\$ 29,100	5	\$ 5,820
11/1/2017	Beds	\$ 2,460	10	\$ 246
1/1/2018	Printer	5535	10	553
1/1/2018	Computers	11565	5	1313
2/1/2018	Software	6710	5	1342
4/1/2018	Kubota Mower	8299	5	1660
4/1/2018	Computer Monitor	4750	5	950
5/1/2018	Computers	5368	5	1074
7/1/2018	Air Conditioner	1757	7	251
<b>Total additions for Movable Equipment</b>		<b>\$ 75,544</b>		<b>\$ 13,209</b> *
<b>Deletions:</b>				
<b>Total deletions for Movable Equipment</b>		<b>\$ -</b>		<b>\$ -</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>				
3/1/2018	Roof Repair	\$ 23,800	10	\$ 2,380
<b>Total additions for Leasehold Improvement</b>		<b>\$ 23,800</b>		<b>\$ 2,380</b> *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		<b>\$ -</b>		<b>\$ -</b> **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

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

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**Amortization Schedule\***

Name of Facility Matulaitis Nursing Home			License No. 989		Report for Year Ended 9/30/2018			Page 24	of 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.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period				2,996,993	1,382,478			143,015	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				23,800				2,380	
C-4. Subtotal									145,395
<b>D. Total Amortization</b>									145,395

\* 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 Matulaitis Nursing Home	License No. 989	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 type="radio"/> Yes	<input checked="" 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		10/01/67			
2. Date Structure Completed		10/01/68			
3. If <b>NOT</b> Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity		119			
6. Square Footage		55,742			
7. Acquisition Cost					
a. Land		17,525			
b. Building		1,355,638			
<b>Part B - Owner and Related Parties</b>		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)					
b. Date Mortgage Obtained					
c. Interest Rate for the Cost Year					
d. Term of Mortgage (number of years)					
e. Amount of Principal Borrowed					
f. Principal balance outstanding as of					
<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
Matulaitis Nursing Home		989	9/30/2018			26	37
Item		Total	CCNH	RHNS	Other		
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. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$					

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Matulaitis Nursing Home	989	9/30/2018	27	37
Item	Total	CCNH	RHNS	Other
Subtotals Brought Forward:				
12. C. Movable Equipment				
1. Automotive Equipment	\$			
A. Item	Rate	Amount		
Lender				
Address of Lender				
2. Other (Specify)	\$			
A. Item	Rate	Amount		
Lender				
Address of Lender				
B. Item	Rate	Amount		
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)	\$			
12. D. Other Interest Expense (Specify)	\$			
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>	\$			
14. Insurance				
a. Insurance on Property (buildings only)	\$	19,632	19,632	
b. Insurance on Automobiles	\$	1,633	1,633	
c. Insurance other than Property (as specified above)				
1. Umbrella (Blanket Coverage)	\$			
2. Fire and Extended Coverage	\$	64,279	64,279	
3. Other (Specify)	\$	7,874	7,874	
D&O				
14d. <b>Total Insurance Expenditures (14a + b + c)</b>	\$	93,418	93,418	
15. <b>Total All Expenditures (A-13 thru C-14)</b>	\$	11,263,732	11,263,732	



### D. Adjustments to Statement of Expenditures

Name of Facility Matulaitis Nursing Home				License No. 989	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	Other
<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	\$ 121,848	121,848		
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$ 125,000	125,000		
10.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.			Unallowable Advertising *	\$ 22,886	22,886		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$ 4,874	4,874		
23.			Other - See attached Schedule	\$			
<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>				\$ 274,608	274,608		

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

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Schedule of Fees Adjustments

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

---

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
<b>Total Other A&amp;G Adjustments</b>			\$ -	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Matulaitis Nursing Home			989	9/30/2018	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
Subtotals Brought Forward				\$ 274,608	274,608		
<b>Page 20 - Resident Care Supplies***</b>							
27.			Prescription Drugs	\$ 221,220	221,220		
28.			Ambulance/Limousine	\$			
29.			X-rays, etc	\$ 8,764	8,764		
30.			Laboratory	\$ 9,110	9,110		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$ 38,042	38,042		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$			
<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	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 551,744	551,744		

\*\*\* Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Other
<b>Total Other Ancillary Costs</b>			\$ -	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Other
<b>Total Excess Movable Equipment Depreciation</b>			\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
<b>Total Other Property Adjustments</b>			\$ -	\$ -	\$ -

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

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Other
<b>Total Unallowable Building Interest</b>			\$ -	\$ -	\$ -

**F. Statement of Revenue**

Name of Facility Matulaitis Nursing Home	License No. 989	Report for Year Ended 9/30/2018			Page 30	of 37
Item	Total	CCNH	RHNS	Other		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 6,230,140	6,230,140				
b. Medicaid Room and Board Contractual Allowance **	\$ (26,084)	(26,084)				
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 2,132,609	2,132,609				
b. Medicare Room and Board Contractual Allowance **	\$ (650,426)	(650,426)				
4. a. Private-Pay Residents and Other	\$ 3,480,901	3,480,901				
b. Private-Pay Room and Board Contractual Allowance **	\$ (23,678)	(23,678)				
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$					
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$					
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$ 253,112	253,112				
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$ 17,631	17,631				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 131,286	131,286				
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$ 4,310	4,310				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 358,713	358,713				
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$ 22,295	22,295				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other ( <i>Specify</i> ) - Medicare	\$ (237,021)	(237,021)				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ (359,751)	(359,751)				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 11,334,037	11,334,037				
<b>IV. Other Revenue*</b>						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income ( <i>Specify</i> )	\$ 11	11				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$ (24,953)	(24,953)				
<b>V. Total Other Revenue</b> (1 thru 8)	\$ (24,942)	(24,942)				
<b>VI. Total All Revenue</b> (III +V)	\$ 11,309,095	11,309,095				

\* 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	Other
	Contractual Allowance Med B	\$ (173,143)		
	Contractual Allowance 2%	\$ (63,878)		
	<b>Total Other Resident Revenue - Medicare</b>	\$ (237,021)	\$ -	\$ -

## Schedule of Other Non-Medicare Resident Revenue

## Related Exp

Page Ref	Description	CCNH	RHNS	Other
	HMO PT OT	\$ (359,751)		
	<b>Total Other Resident Revenue</b>	\$ (359,751)	\$ -	\$ -

## Interest Income

## Account

Page Ref	Account	Balance	CCNH	RHNS	Other
	Interst income		\$ 11		
	<b>Total Interest Income</b>		\$ 11	\$ -	\$ -

## Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Other
	Other revenue	\$ 10,577		
	Apartment rent	\$ 10,200		
	HMO prior year adj	\$ (23,217)		
	Private room & board	\$ 5,408		
	Accts Rec Adj	\$ (27,921)		
	<b>Total Other Revenue</b>	\$ (24,953)	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Matulaitis Nursing Home	989	9/30/2018	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	493,557
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,329,221
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	49,394
a. _____				
b. _____				
c. _____				
d. See Schedule		49,394		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	5,915
_____				
_____				
See Schedule		5,915		
<b>A-9. Total Current Assets (Lines A1 thru 8)</b>			\$	2,878,087
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 <u>3,020,793</u>		\$	1,492,920
	Accum. Depreciation <u>1,527,873</u> Net			
5. Non-Movable Equipment	*Historical Cost <u>1,811,139</u>		\$	443,652
	Accum. Depreciation <u>1,367,487</u> Net			
6. Movable Equipment	*Historical Cost <u>968,166</u>		\$	102,724
	Accum. Depreciation <u>865,442</u> Net			
7. Motor Vehicles	*Historical Cost <u>23,814</u>		\$	
	Accum. Depreciation <u>23,814</u> Net			
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	4,803
_____				
See Schedule		4,803		
<b>B-10. Total Fixed Assets (Lines B1 thru 9)</b>			\$	2,044,099

\* 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 Matulaitis Nursing Home	License No. 989	Report for Year Ended 9/30/2018	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	4,922,186
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements			*Historical Cost _____	
			Accum. Depreciation _____ Net	
			\$	
3. Buildings			*Historical Cost _____	
			Accum. Depreciation _____ Net	
			\$	
4. Non-Movable Equipment			*Historical Cost _____	
			Accum. Depreciation _____ Net	
			\$	
5. Movable Equipment			*Historical Cost _____	
			Accum. Depreciation _____ Net	
			\$	
6. Motor Vehicles			*Historical Cost _____	
			Accum. Depreciation _____ Net	
			\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 <b>Total Leasehold or Like Properties</b> (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense			*Historical Cost _____	
			Accum. Depreciation _____ Net	
			\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	
_____				
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	
Name and Address		Amount	Loan Date	
7. Other Assets ( <i>itemize</i> )			\$	
_____				
See Schedule				
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$	4,922,186

\* 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	
		Insurance Package	\$ 12,407
		D&O liability	\$ 1,987
		Supplies	\$ 35,000
		<b>Total Prepaid Expenses</b>	<b>\$ 49,394</b>

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

Page Ref	Line Ref	Description	
		Donation account	\$ 5,915
		<b>Total Other Current Assets (Itemize)</b>	<b>\$ 5,915</b>

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

Page Ref	Line Ref	Description	
		Statue	\$ 4,803
		<b>Total Other Fixed Assets (Itemize)</b>	<b>\$ 4,803</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	
		Ct User Fee	\$ 186,427
		Exchanges	\$ (59,314)
		Patients personel monies	\$ 21,376
		life insurance	20,058
		p/r attachments	-738
		<b>Total Other Current Liabilities (Itemize)</b>	<b>\$ 167,809</b>

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

Page Ref	Line Ref	Description	
		Mortgage payable	\$ 178,042
		<b>Total Other Current Liabilities (Itemize)</b>	<b>\$ 178,042</b>

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

Name of Facility		License No.	Report for Year Ended	Page	of
Matulaitis Nursing Home		989	9/30/2018	33	37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	523,290
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> )				\$	541,721
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	(59)
7. Medicare Final Settlement Payable				\$	(1,371)
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> )				\$	167,809
_____					
_____					
_____					
See Schedule				167,809	
A-13. <b>Total Current Liabilities</b> (Lines A1 thru 12)				\$	1,231,390

\* 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 Matulaitis Nursing Home		License No. 989	Report for Year Ended 9/30/2018	Page 34	of 37
Account				Amount	
Total Brought Forward:				1,231,390	
<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> )					\$ 178,042
_____					
_____					
See Schedule		178,042			
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)					\$ 178,042
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)					\$ 1,409,432

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

Name of Facility	License No.	Report for Year Ended	Page	of
Matulaitis Nursing Home	989	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			\$	3,429,841
6. Gain or Loss for Period	10/1/2017	thru 9/30/2018	\$	82,913
7. Total Net Worth			\$	3,512,754
<b>C. Total Reserves and Net Worth</b>			\$	3,512,754
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	4,922,186

### H. Changes in Total Net Worth

Name of Facility Matulaitis Nursing Home	License No. 989	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			\$	3,781,834
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	11,309,094
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	11,263,732
D. Net Income or Deficit			\$	45,362
E. Balance			\$	3,827,196
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <b>Balance at End of Period</b>		09/30/18	\$	3,827,196

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

Name of Facility Matulaitis Nursing Home	License No. 989	Report for Year Ended 9/30/2018	Page 37	of 37
<i>Check appropriate category</i>				
<input type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> Other		
<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				
John Iovieno				
Address Address			Phone Number	
Putnam CT			860-928-7976	