

# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2016

Name of Facility (as licensed) Brookside Rest Home, Inc.	
Address (No. & Street, City, State, Zip Code) 134 Franklin Street Extention, Danbury, CT 06811	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input checked="" type="checkbox"/> Residential Care Home	
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016

License Numbers:	CCNH	RHNS	Residential Care Home 1771	Medicare Provider
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Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
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**For Department Use Only**

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

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### General Information

Name of Facility (as licensed) Brookside Rest Home, Inc.	License No. 1771	Report for Year Ended 9/30/2016	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 Brookside Rest Home, Inc. [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 2016, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

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

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Brookside Rest Home, Inc.		Period Covered:	From 10/1/2015	To 9/30/2016
Address of Facility 134 Franklin Street Extention, Danbury, CT 06811				
Report Prepared By CJLC LLC		Phone Number 860-610-9009	Date 1/17/2017	
Item	Total	CCNH	RHNS	Residential Care Home
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 203-743-9130	Report for Year Ended 9/30/2016	Page 2	of 37
Name of Facility (as shown on license) Brookside Rest Home, Inc.		Address (No. & Street, City, State, Zip) 134 Franklin Street Extention, Danbury, CT 06811		
License Numbers:	CCNH	RHNS	Residential Care Home 1771	Medicare Provider No.
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"/> Residential Care Home				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input 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 Heidi Zandri			Nursing Home Administrator's License No.:	
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 Brookside Rest Home, Inc.	License No. 1771	Report for Year Ended 9/30/2016	Page 3A	of 37
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated	
Brookside Rest Home, Inc.	134 Franklin Street Extension, Danbury, CT 06811	CT	

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Estate of Sonja Zandri	134 Franklin Street Extension, Danbury, CT 06811	Pres./Treas.	320
Michael Zandri	134 Franklin Street Extension, Danbury, CT 06811	Vice President	
Heidi Zandri	134 Franklin Street Extension, Danbury, CT 06811	Secretary	180

Names of Stockholders Owning at Least 10% of Shares	Business Address	Title	No. Shares Held by Each
Estate of Sonja Zandri	134 Franklin Street Extension, Danbury, CT 06811	Pres./Treas.	320
Heidi Zandri	134 Franklin Street Extension, Danbury, CT 06811	Secretary	180





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

Name of Facility Brookside Rest Home, Inc.	License No. 1771	Report for Year Ended 9/30/2016	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	%**				
Sonja Zandri	134 Franklin Street Extension, Danbury, CT 06811	<input type="radio"/>	<input checked="" type="radio"/>		Rental Real Estate	22/9	1,450	1,450
Sonja Zandri	134 Franklin Street Extension, Danbury, CT 06811	<input type="radio"/>	<input checked="" type="radio"/>		Loan of Funds to Facility	34/B3	66,274	66,274
Sonja Zandri	134 Franklin Street Extension, Danbury, CT 06811	<input type="radio"/>	<input checked="" type="radio"/>		Clerical	10/A4	3,700	3,700
Sonja Zandri	134 Franklin Street Extension, Danbury, CT 06811	<input type="radio"/>	<input checked="" type="radio"/>		Interest on Loan to Facility	27/12d	1,196	1,196
Heidi Zandri	134 Franklin Street Extension, Danbury, CT 06811	<input type="radio"/>	<input checked="" type="radio"/>		Apartment	29/37, 39, 41	3,903	3,903
Heidi Zandri	134 Franklin Street Extension, Danbury, CT 06811	<input type="radio"/>	<input checked="" type="radio"/>		Administrator	10/A2	80,209	80,209
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					

\* Use additional sheets if necessary.

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

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility Brookside Rest Home, Inc.	License No. 1771	Report for Year Ended 9/30/2016	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 Brookside Rest Home, Inc.			License No. 1771			Report for Year Ended 9/30/2016		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							
N/A	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
							<b>Total ***</b>		

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes       No

\* 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 Brookside Rest Home, Inc.	License No. 1771	Report for Year Ended 9/30/2016	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	Address (No. & Street, City, State, Zip Code)
1 CJLC LLC	225 Pitkin Street, East Hartford, CT 06108
2 Brigano Associates	1100 New Britain Ave, West Hartford, CT 06511
3 Kerin Fazio	1129 Post Road, Fairfield, CT 06824
4	

Services Provided by This Firm (*describe fully*)

1 Medicaid Cost Report/Accounting Services/Preparation of Tax Returns	\$ 7,740
2 Bookkeeping	\$ 400
3 Appraisal	\$ 5,500
4	\$
<b>Charge for Services Provided</b>	
\$ 13,640	

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

**Legal Services Information**

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

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

1

2

3

4

5

Services Provided by This Firm (*describe fully*)

1	\$
2	\$
3	\$
4	\$
5	\$
<b>Charge for Services Provided</b>	
\$	

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

**Schedule of Resident Statistics**

Name of Facility Brookside Rest Home, Inc.		License No. 1771			Report for Year Ended 9/30/2016				Page 8	of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total Residential Care Home	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Residential Care Home	Total	CCNH	RHNS	Residential Care Home
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	20			20	20			20	20			20
B. On last day of THIS report period	20			20	20			20	20			20
2. Number of Residents												
A. As of midnight of PREVIOUS report period	19			19	19			19	19			19
B. As of midnight of THIS report period	17			17	19			19	17			17
3. Total Number of Days Care Provided During Period												
A. Medicare												
B. Medicaid (Conn.)												
C. Medicaid (other states)												
D. Private Pay	516			516	393			393	123			123
E. State SSI for RCH	6,078			6,078	4,576			4,576	1,502			1,502
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	6,594			6,594	4,969			4,969	1,625			1,625
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>	6,594			6,594	4,969			4,969	1,625			1,625

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

Name of Facility Brookside Rest Home, Inc.	License No. 1771	Report for Year Ended 9/30/2016	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?       Yes       No  
 If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	Residential Care Home	Lost			Gained			CCNH	RHNS	Residential Care Home	
	(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	Residential Care Home
1st change			
2nd change			
3rd change			
4th change			

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

Item	Medicare		Medicaid		Self-Pay			Other State Assisted	
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	Residential Care Home	R.C.H.	ICF-IID
No. of Residents							1	16	
Per Diem Rate							85.00		
a. One bed rm.									
b. Two bed rms.									
c. Three or more bed rms.									

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	Residential Care Home
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. <b>Total Physical Therapy Treatments</b>				

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. <b>Total Speech Therapy Treatments</b>				

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. <b>Total Occupational Therapy Treatments</b>				

### Report of Expenditures - Salaries & Wages

Name of Facility Brookside Rest Home, Inc.	License No. 1771	Report for Year Ended 9/30/2016	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	Residential Care Home	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)					80,209	2,971
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)					3,700	211
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers					25,895	2,045
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers					19,717	1,512
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers						
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers					6,572	504
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						
b. RN						
1. Direct Care						
2. Administrative**						
c. LPN						
1. Direct Care						
2. Administrative**						
d. Aides and Attendants					65,081	5,024
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers					12,782	992
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						
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>					213,957	13,259

\* 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		Residential Care Home	
	\$	Hours	\$	Hours	\$	Hours
<b>Total</b>	\$ -	-	\$ -	-	\$ -	-

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

Service	CCNH		RHNS		Residential Care Home	
	\$	Hours	\$	Hours	\$	Hours
<b>Total</b>	\$ -	-	\$ -	-	\$ -	-

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**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	
Brookside Rest Home, Inc.				1771	9/30/2016			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	Residential Care Home							
<b>Section I - Operators/Owners</b>										
Sonja Zandri (10/1/15 to 4/9/16)			3,700		Bookkeeping, driving residents	211	A4			
<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	
Brookside Rest Home, Inc.				1771	9/30/2016			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	Residential Care Home							
<b>Section III - Administrators***</b>										
Heidi Zandri (10/1/15 to 9/30/16)			80,209		Administrator	2,971	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		
Brookside Rest Home, Inc.	1771	9/30/2016	13	37		
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	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						
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)						
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						
<b>B-13 Total Fees Paid in Lieu of Salaries</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 Brookside Rest Home, Inc.		License No. 1771	Report for Year Ended 9/30/2016	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
N/A		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
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		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		

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

**C. Expenditures Other Than Salaries - Administrative and General**

Name of Facility	License No.	Report for Year Ended	Page	of
Brookside Rest Home, Inc.	1771	9/30/2016	15	37
Item	Total	CCNH	RHNS	Residential Care Home
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 6,140			6,140
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 3,343			3,343
4. Social Security (F.I.C.A.)	\$ 16,336			16,336
5. Health Insurance	\$ 37,889			37,889
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$			
8. Uniform Allowance	\$			
9. Other ( <i>Specify</i> ) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$			
d. Accounting and Auditing	\$ 13,640			13,640
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	\$ 1,348			1,348
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 2,730			2,730
2. Cellular Phones	\$ 285			285
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	\$			
<b>Subtotal</b>	\$ 81,710			81,710

\* 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**

Brookside Rest Home, Inc.  
9/30/2016

Attachment Page 15

**Schedule of Other Employee Benefits**

Description	CCNH	RHNS	Residential Care Home
<b>Total</b>	\$ -	\$ -	\$ -

**Schedule of Other Taxes**

Description	CCNH	RHNS	Residential Care Home
<b>Total</b>	\$ -	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Brookside Rest Home, Inc.	1771	9/30/2016	16	37
Item	Total	CCNH	RHNS	Residential Care Home
<b><i>Subtotals Brought Forward:</i></b>	81,710			81,710
1. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$			
3. Gifts to Staff and Residents	\$			
4. Employee Travel	\$			
5. Education Expenses Related to Seminars and Conventions	\$ 1,780			1,780
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$ 602			602
7. Other ( <i>Specify</i> ) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$ 1,350			1,350
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$			
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$			
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	\$ 300			300
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 630			630
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$ 15			15
10. Contributions*** See Attached Schedule	\$ 100			100
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$			
12. Administrative Management Services**	\$			
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 2,412			2,412
<b><i>C-14 Total Administrative &amp; General Expenditures</i></b>	\$ 88,900			88,900

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

**Schedule of Other Advertising**

Description	CCNH	RHNS	Residential Care Home
<b>Total Other Advertising</b>	\$ -	\$ -	\$ -

**Schedule of Dues**

Description	CCNH	RHNS	Residential Care Home
16m8 · Dues			\$ 630
ALTCFM \$80 + CARCH \$550 = \$630			
<b>Total Dues</b>	\$ -	\$ -	\$ 630

**Schedule of Contributions**

Description	CCNH	RHNS	Residential Care Home
Loom Contribution			\$ 100
<b>Total Contributions</b>	\$ -	\$ -	\$ 100

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	Residential Care Home
16m13.1 · Bank Service Fees			\$ 5
16m13.2 · Late Fee/Finance Charges			\$ 38
16m13.3 · Payroll Processing Fees			\$ 1,349
16m13.4 · Licenses			\$ 450
16m13.5 · Miscellaneous Expense			\$ 370
16m8a · Chamber of Commerce			\$ 200
<b>Total Other Administrative and General</b>	\$ -	\$ -	\$ 2,412



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

Name of Facility Brookside Rest Home, Inc.	License No. 1771	Report for Year Ended 9/30/2016	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 #
N/A			

\* 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 Brookside Rest Home, Inc.		License No. 1771	Report for Year Ended 9/30/2016		Page 18	of 37
Item		Total	CCNH	RHNS	Residential Care Home	
2. Dietary						
a. In-House Preparation & Service						
1.	Raw Food	\$ 51,157			51,157	
2.	Non-Food Supplies	\$ 1,009			1,009	
3.	Other (Specify) _____	\$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$				
c. Management Services**		\$				
d. Other (Specify) _____		\$				
<b>2E. Total Dietary Expenditures (2a + b + c + d)</b>		\$ 52,166			52,166	
2F. Dietary Questionnaire		Total	CCNH	RHNS	Residential Care Home	
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.  
 \*\* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Name of Facility Brookside Rest Home, Inc.		License No. 1771	Report for Year Ended 9/30/2016	Page 19	of 37
Item		Total	CCNH	RHNS	Residential Care Home
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. \$	982		982
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. \$	218		218
b.	Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$			
c.	Management Services**	\$			
d.	Other (Specify)	\$			
<b>3E. Total Laundry Expenditures (3a + b + c + d)</b>		\$	1,200		1,200
<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 type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

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

All allocations should add to total recorded in 3E.

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of	
Brookside Rest Home, Inc.	1771	9/30/2016	20	37	
Item		Total	CCNH	RHNS	Residential Care Home
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care					
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	1,847			1,847
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. \$	14,127			14,127
c. Management Services*		\$			
d. Other ( <i>Specify</i> )		\$			
<b>4E. Total Housekeeping Expenditures (4a + b + c + d)</b>		\$ 15,974			15,974
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$				
b. Medicine Cabinet Drugs	\$				
c. Medical and Therapeutic Supplies	\$				
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
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	\$	2,352			2,352
j. Other (Specify)**** See Attached Schedule	\$	186			186
<b>5K. Total Resident Care Expenditures (5a - 5j)</b>		\$ 2,538			2,538

\* 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	Residential Care Home
205j · Other Resident Care			\$ 186
includes 1st aide supplies			
<b>Total Other Resident Care</b>	\$ -	\$ -	\$ 186

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

Name of Facility Brookside Rest Home, Inc.			License No. 1771	Report for Year Ended 9/30/2016			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	Residential Care Home	Pg	Line
N/A		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

\* 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
Brookside Rest Home, Inc.	1771	9/30/2016	22	37
Item	Total	CCNH	RHNS	Residential Care Home
6. Maintenance & Operation of Plant				
a. Repairs & Maintenance	\$ 9,018			9,018
b. Heat	\$ 5,613			5,613
c. Light & Power	\$ 8,227			8,227
d. Water	\$ 1,581			1,581
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$			
f. Other ( <i>itemize</i> )	\$ 15,887			15,887
See Attached Schedule				
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$ 40,326</b>			<b>40,326</b>
7. Depreciation ( <i>complete schedule page 23*</i> )				
a. Land Improvements	\$			
b. Building & Building Improvements	\$			
c. Non-Movable Equipment	\$			
d. Movable Equipment	\$			
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$</b>			
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )				
a. Organization Expense	\$ 125			125
b. Mortgage Expense	\$			
c. Leasehold Improvements	\$ 21,876			21,876
d. Other ( <i>Specify</i> )	\$			
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$ 22,001</b>			<b>22,001</b>
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 1,450			1,450
10. Property Taxes				
a. Real estate taxes paid by owner	\$ 12,849			12,849
b. Real estate taxes paid by lessor	\$			
c. Personal property taxes	\$ 927			927
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$ 37,227</b>			<b>37,227</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**

Description	CCNH	RHNS	Residential Care Home
226f.1 · R&M - Minor Equipment			\$ 967
226f.2 · R&M - Purchased Services			\$ 14,920
<b>Total Other Repairs and Maintenance</b>	\$ -	\$ -	\$ 15,887

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Brookside Rest Home, Inc.  
9/30/2016

**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>				
<b>Total additions for Non-Movable Equipment</b>		\$ -		\$ - *
<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>				
<b>Total additions for Movable Equipment</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Movable Equipment</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>				
10/1/2015	Roof	36,569	10	\$ 3,657
3/16/2017	Wall Repair & Paint	3,342	5	\$ 668
5/1/2016	Window Replacement	1,165	5	\$ 233
6/1/2016	Replace Pump	1,515	5	\$ 303
7/16/2017	Masonry Work	2,000	5	\$ 400
<b>Total additions for Leasehold Improvement</b>		\$ 44,591		\$ 5,261 *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Amortization Schedule\***

Name of Facility Brookside Rest Home, Inc.			License No. 1771		Report for Year Ended 9/30/2016			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. Goodwill		1983	40	5,000	4,000	A		125	
2.									
3.									
A-4. Subtotal									125
<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	Var	Var	Various	344,774	309,768	A		16,615	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				44,591				5,261	
C-4. Subtotal									21,876
<b>D. Total Amortization</b>									22,001

\* 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 Brookside Rest Home, Inc.	License No. 1771	Report for Year Ended 9/30/2016	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	1975				
2. Date Structure Completed					
3. If <b>NOT</b> Original Owner, Date of Purchase	4/15/1975				
4. Date of Initial Licensure	4/15/1975				
5. Total Licensed Bed Capacity	20				
6. Square Footage	7,829				
7. Acquisition Cost					
a. Land	20,000				
b. Building	103,000				
<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
Brookside Rest Home, Inc.		1771	9/30/2016			26	37
Item		Total	CCNH	RHNS	Residential Care Home		
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 Brookside Rest Home, Inc.		License No. 1771		Report for Year Ended 9/30/2016		Page 27   37	
Item				Total	CCNH	RHNS	Residential Care Home
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) 2712D · Interest				\$	1,196		1,196
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)				\$	1,196		1,196
14. Insurance							
a. Insurance on Property (buildings only)				\$	11,037		11,037
b. Insurance on Automobiles				\$	2,807		2,807
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$			
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$	13,844		13,844
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$	467,327		467,327

### D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Brookside Rest Home, Inc.				1771	9/30/2016	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
<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.	15	1a1d	Accounting & Legal	\$ 5,500			5,500
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 *	\$			
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m10	Fund Raising / Contributions	\$ 100			100
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 243			243
<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>				\$ 5,843			5,843

\* All except "Help Wanted".

(Carry Subtotal forward to next page)

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



**Schedule of Other Salaries Adjustment**

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
<b>Total Other Salaries Adjustment</b>			\$ -	\$ -	\$ -

**Schedule of Fees Adjustments**

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

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
16	M13.1	Bank Fees			\$ 5
16	M8a	Greater Danbury Chamber			\$ 200
16	m13.2	Late Fees			\$ 38
<b>Total Other A&amp;G Adjustments</b>			\$ -	\$ -	\$ 243

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Brookside Rest Home, Inc.			1771	9/30/2016	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward				\$ 5,843			5,843
<b>Page 20 - Resident Care Supplies***</b>							
27.			Prescription Drugs	\$			
28.			Ambulance/Limousine	\$			
29.			X-rays, etc	\$			
30.			Laboratory	\$			
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
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.	22	10a	Unallowable Property and Real Estate Taxes	\$ 1,329			1,329
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 1,557			1,557
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.	27	14a	Property Insurance	\$ 1,142			1,142
<b>Other - Miscellaneous</b>							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$			
<b>Not For Profit Providers Only</b>							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51.	<b>Total Amount of Decrease (Items 1 - 50)</b>			\$ 9,871			9,871

\*\*\* 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.

Brookside Rest Home, Inc.  
9/30/2016

**Schedule of Other Ancillary Costs**

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

**Schedule of Excess Movable Equipment Depreciation**

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

**Schedule of Other Property Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
22	8a	Goodwill			\$ 125
22	6b	Heat - Personal Use of Apartment			\$ 581
22	6c	Electricity - Personal Use of Apartment			\$ 851
<b>Total Other Property Adjustments</b>			\$ -	\$ -	\$ 1,557

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

Schedule of Unallowable Building Interest

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

**F. Statement of Revenue**

Name of Facility Brookside Rest Home, Inc.	License No. 1771	Report for Year Ended 9/30/2016			Page 30	of 37
Item	Total	CCNH	RHNS	Residential Care Home		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 468,448			468,448		
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> )	\$					
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$ 37,134			37,134		
b. Private-Pay Room and Board Contractual Allowance **	\$					
<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	\$					
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$					
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$					
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$					
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$					
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$					
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other ( <i>Specify</i> ) - Medicare	\$					
b. Other ( <i>Specify</i> ) - Non-Medicare	\$					
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 505,582			505,582		
<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> )	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$					
<b>V. Total Other Revenue</b> (1 thru 8)	\$					
<b>VI. Total All Revenue</b> (III +V)	\$ 505,582			505,582		

\* 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	Residential Care Home
<b>Total Other Resident Revenue - Medicare</b>		\$ -	\$ -	\$ -

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

Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
<b>Total Other Resident Revenue</b>		\$ -	\$ -	\$ -

**Interest Income**

Account

Page Ref	Account	Balance	CCNH	RHNS	Residential Care Home
<b>Total Interest Income</b>			\$ -	\$ -	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	Residential Care Home
<b>Total Other Revenue</b>		\$ -	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Brookside Rest Home, Inc.	1771	9/30/2016	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	14,601
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	40,898
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	11,954
a. 31A5.2 · Prepaid - Insurance	5,597			
b. 31A5.3 · Prepaid - Other	6,357			
c. _____				
d. _____				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	
_____				
_____				
_____				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	67,453
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>389,364</u>		\$	57,721
	Accum. Depreciation <u>331,644</u>	Net		
5. Non-Movable Equipment	*Historical Cost <u>38,188</u>		\$	
	Accum. Depreciation <u>38,188</u>	Net		
6. Movable Equipment	*Historical Cost <u>61,938</u>		\$	
	Accum. Depreciation <u>61,938</u>	Net		
7. Motor Vehicles	*Historical Cost <u>22,479</u>		\$	
	Accum. Depreciation <u>22,479</u>	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
_____				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	57,721

\* 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 Brookside Rest Home, Inc.	License No. 1771	Report for Year Ended 9/30/2016	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	125,173
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)			\$	875
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> )			\$	
_____				
_____				
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	875
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$	126,048

\* 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 Brookside Rest Home, Inc.		License No. 1771	Report for Year Ended 9/30/2016	Page 33	of 37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	11,523
2. Notes Payable ( <i>itemize</i> )				\$	
_____					
_____					
_____					
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$	3,079
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	(238)
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable ( <i>Current Portion</i> )				\$	
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities ( <i>itemize</i> )				\$	1,559
33A12.4 · Pension Payable		1,559			
_____					
_____					
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>				<b>\$</b>	<b>15,923</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 Brookside Rest Home, Inc.	License No. 1771	Report for Year Ended 9/30/2016	Page 34	of 37
Account				Amount
Total Brought Forward:				15,923
<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> )				\$ 66,274
Name and Address of Lender	Amount	Loan Date		
Sonja Zandri	66,274	Ongoing		
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$
_____				
_____				
_____				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 66,274
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 82,198

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

Name of Facility	License No.	Report for Year Ended	Page	of
Brookside Rest Home, Inc.	1771	9/30/2016	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			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	4,596
6. Gain or Loss for Period			\$	38,254
	10/1/2015	thru	9/30/2016	
7. Total Net Worth			\$	43,851
<b>C. Total Reserves and Net Worth</b>			\$	43,851
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	126,048

### H. Changes in Total Net Worth

Name of Facility Brookside Rest Home, Inc.	License No. 1771	Report for Year Ended 9/30/2016	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2015			\$	5,476
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$	505,582
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$	467,327
D. Net Income or Deficit			\$	38,254
E. Balance			\$	43,730
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>			\$	43,730
				09/30/16

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

Name of Facility Brookside Rest Home, Inc.	License No. 1771	Report for Year Ended 9/30/2016	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"/> Residential Care Home		
<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				
CJLC LLC				
Address			Phone Number	
225 Pitkin Street, East Hartford, CT 06108			860-610-9009	