

State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2018

Name of Facility (as licensed) Mattatuck Health Care Facility, Inc.	
Address (No. & Street, City, State, Zip Code) 9 Cliff St., Waterbury, CT 06710	
Type of Facility <input type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018

License Numbers:	CCNH	RHNS 144-RH	(Specify)	Medicare Provider 07-5432
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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

General Information

Name of Facility (as licensed) Mattatuck Health Care Facility, Inc.	License No. 144-RH	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 Mattatuck Health Care Facility, Inc. [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) Allen V. Desena			Printed Name (Owner) Allen V. Desena		
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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Mattatuck Health Care Facility, Inc.	Period Covered:	From 10/1/2017	To 9/30/2018	
Address of Facility 9 Cliff St., Waterbury, CT 06710				
Report Prepared By CJLC LLC	Phone Number 860-610-9009	Date 2/15/2019		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

Salaries - Compensation computed on a weekly or other basis which does not generally vary, based on the number of hours worked.

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-573-9924		Report for Year Ended 9/30/2018	Page 2	of 37
Name of Facility (as shown on license) Mattatuck Health Care Facility, Inc.		Address (No. & Street, City, State, Zip) 9 Cliff St., Waterbury, CT 06710		
License Numbers:	CCNH 144-RH	RHNS (Specify)	Medicare Provider No. 07-5432	
Type of Facility (Check appropriate box(es))				
<input type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
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.				
Administrator				
Name of Administrator Allen V. Desena		Nursing Home Administrator's License No.:	000297	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

General Information and Questionnaire Individual Proprietorship

Name of Facility Mattatuck Health Care Facility, Inc.	License No. 144-RH	Report for Year Ended 9/30/2018	Page 3B	of 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

N/A

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**General Information and Questionnaire
Related Parties***

Name of Facility Mattatuck Health Care Facility, Inc.	License No. 144-RH	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	%**				
Allen V. Desena d/b/a Tricare Unlimited	9 Cliff St., Waterbury, CT 06710	<input type="radio"/>	<input checked="" type="radio"/>		Rental of Facility	22/9	335,300	335,300
RSC Insurance Brokerage, Inc.	15 Pacella Park Dr. Ste. 240, Randolph, MA 2368	<input type="radio"/>	<input checked="" type="radio"/>		Shared Property/Liability Insurance	27/14a	25,720	25,720
Carriage Manor LLC	157 Hillside Ave., Waterbury, CT 06710	<input type="radio"/>	<input checked="" type="radio"/>		Loans for Expenses	31/A8	279,761	279,761
Tricare LLC	Tricare LLC	<input type="radio"/>	<input checked="" type="radio"/>		Loans for Expenses	31/A8	323,772	323,772
Allen V. Desena d/b/a Geron	157 Hillside Ave., Waterbury, CT 06710	<input type="radio"/>	<input checked="" type="radio"/>		Loans of Funds	31/A8	338,247	338,247
Michael Mara	9 Cliff St., Waterbury, CT 06710	<input type="radio"/>	<input checked="" type="radio"/>		Maintenance/34 hours	16/m13	560	560
		<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 Mattatuck Health Care Facility, Inc.	License No. 144-RH	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 Mattatuck Health Care Facility, Inc.			License No. 144-RH	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							
Great American Leasing Corp. 625 1st St SE #800, Cedar Rapids, IA 52401	<input type="radio"/>	<input checked="" type="radio"/>	Copier	10/13/11	60 months	2,076		2,076	
	<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	Total ***	2,076

* 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 Mattatuck Health Care Facility, Inc	License No. 144-RH	Report for Year Ended 9/30/2018	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

- Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm 1 CJLC LLC 2 3 4	Address (No. & Street, City, State, Zip Code) 225 Pitkin Street, East Hartford, CT 06108
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Services Provided by This Firm (*describe fully*)

1 Medicaid Cost Report, Accounting Services, Tax Services, Financial Statements	\$ 9,700
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 9,700

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 1 2 3 4 5	Telephone Number
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Address (*No. & Street, City, State, Zip Code*)

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

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

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

- Yes No Pg 15/1e

Schedule of Resident Statistics

Name of Facility Mattatuck Health Care Facility, Inc.		License No. 144-RH			Report for Year Ended 9/30/2018				Page 8	of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	43		43		43		43		43		43	
B. On last day of THIS report period	43		43		43		43		43		43	
2. Number of Residents												
A. As of midnight of PREVIOUS report period	41		41		41		41		41		41	
B. As of midnight of THIS report period	41		41		41		41		41		41	
3. Total Number of Days Care Provided During Period												
A. Medicare	348		348		319		319		29		29	
B. Medicaid (Conn.)	14,150		14,150		10,478		10,478		3,672		3,672	
C. Medicaid (other states)												
D. Private Pay	335		335		243		243		92		92	
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	14,833		14,833		11,040		11,040		3,793		3,793	
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	220		220		155		155		65		65	
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	15,053		15,053		11,195		11,195		3,858		3,858	

Schedule of Resident Statistics (Cont'd)

Name of Facility Mattatuck Health Care Facility, Inc.	License No. 144-RH	Report for Year Ended 9/30/2018	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? Yes No

If "YES", provide the following information:

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

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

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

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

Item	Medicare		Medicaid		Self-Pay			Other State Assisted	
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents				40		1			
Per Diem Rate									
a. One bed rm.						190.00			
b. Two bed rms.						180.00			
c. Three or more bed rms.						175.00			

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	244		244	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	83		83	
C. Other				
D. Total Physical Therapy Treatments	327		327	

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. Total Speech Therapy Treatments				

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. Total Occupational Therapy Treatments				

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Mattatuck Health Care Facility, Inc.	144-RH	9/30/2018	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)			37,074	1,040		
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)			41,767	1,248		
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor			48,690	2,549		
c. Dietary Workers			60,828	5,926		
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers			26,828	2,051		
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers			43,265	2,626		
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers			27,508	2,075		
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			62,882	2,100		
b. RN						
1. Direct Care			176,016	7,273		
2. Administrative**						
c. LPN						
1. Direct Care			18,622	938		
2. Administrative**						
d. Aides and Attendants			153,933	14,337		
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers			39,629	2,080		
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			9,907	520		
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>			746,948	44,763		

* 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
Mattatuck Health Care Facility, Inc.				144-RH	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	(Specify)							
Section I - Operators/Owners										
Allen V. Desena		37,074		Group Ins (15/1a5 Life Ins)	Administrator	1,040	A2	Carriage Manor, 157 Hillside Ave., Waterbury, CT 06720	1,040	37,074
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

** Include all employment worked during the cost year.

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
Mattatuck Health Care Facility, Inc.				144-RH	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	(Specify)							
Section III - Administrators***										
Section IV - Assistant Administrators										

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

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

*** If more than one Administrator is reported, include dates of employment for each.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Mattatuck Health Care Facility, Inc.	144-RH	9/30/2018	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian			2,000	60		
2. Dentist			4,670	Fee for Svc		
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care			14,861	Fee for Svc		
b. Other						
6. Social Worker			1,000	10		
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)			4,800	48		
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			186			
B-13 Total Fees Paid in Lieu of Salaries			27,517	118		

* 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 Mattatuck Health Care Facility, Inc.		License No. 144-RH		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			
Carolyn Hogrefe, RD, Woodbury, CT 06798	Dietician	<input type="radio"/>	<input checked="" type="radio"/>			
Access PT, Waterbury, CT	Physical Therapist	<input type="radio"/>	<input checked="" type="radio"/>			
Counseling Associates, Waterbury, CT	Social Workers	<input type="radio"/>	<input checked="" type="radio"/>			
Charles McNair, MC, Alliance Medical Group, Waterbury, CT	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
HealthDrive, 888 Worcester St, Wellesley, MA 02482	Dentist	<input type="radio"/>	<input checked="" type="radio"/>			
Kevin Czarzasty, RPH, Bunker Hill, Waterbury, CT	Pharmacy Consultant	<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"/>			

* 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
Mattatuck Health Care Facility, Inc.	144-RH	9/30/2018	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 24,595		24,595	
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 13,052		13,052	
4. Social Security (F.I.C.A.)	\$ 59,009		59,009	
5. Health Insurance	\$ 18,635		18,635	
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$			
8. Uniform Allowance	\$			
9. Other (Specify) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$			
d. Accounting and Auditing	\$ 9,700		9,700	
e. Legal (Services should be fully described on Page 7)	\$ 975		975	
f. Insurance on Lives of Owners and Operators (Specify)*	\$ 15,894		15,894	
g. Office Supplies	\$ 2,042		2,042	
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 4,755		4,755	
2. Cellular Phones	\$			
i. Appraisal (Specify purpose and attach copy)*	\$			
j. Corporation Business Taxes (franchise tax)	\$ 250		250	
k. Other Taxes (Not related to property - See Page 22)				
1. Income*	\$ 12,131		12,131	
2. Other (Specify) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 304,370		304,370	
Subtotal	\$ 465,408		465,408	

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Mattatuck Health Care Facility, Inc.	144-RH	9/30/2018	16	37
Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	465,408		465,408	
l. Travel and Entertainment				
1. Resident Travel and Entertainment \$				
2. Holiday Parties for Staff \$				
3. Gifts to Staff and Residents \$	2,700		2,700	
4. Employee Travel \$				
5. Education Expenses Related to Seminars and Conventions \$	565		565	
6. Automobile Expense (<i>not purchase or depreciation</i>) \$				
7. Other (<i>Specify</i>) \$				
See Attached Schedule				
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>) \$				
2. Advertising Telephone Directory (<i>all such expenses</i>)*** \$				
3. Advertising Other (<i>Specify</i>)*** \$	385		385	
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 \$	388		388	
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) \$				
See Attached Schedule				
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.*** \$	556		556	
9. Subscriptions \$	120		120	
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>) \$				
12. Administrative Management Services** \$				
13. Other (<i>Specify</i>) \$	21,518		21,518	
See Attached Schedule				
C-14 Total Administrative & General Expenditures	\$ 491,640		491,640	

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

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Advertising		\$ 385	
Total Other Advertising	\$ -	\$ 385	\$ -

Schedule of Dues

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

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Late Fees		\$ 160	
PR Processing		\$ 6,126	
Auto -Fuel		\$ 60	
Licenses and Permits		\$ 150	
MDS Support Service		\$ 1,391	
Fees & Permits		\$ 4,490	
Office Supplies:5010 - Bank Service Charges		\$ 801	
Casual labor		\$ 560	
Miscellaneous		\$ 7,480	
Lions Club of Waterbury		\$ 300	
Total Other Administrative and General	\$ -	\$ 21,518	\$ -

Annual Report of Long-Term Care Facility

CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Mattatuck Health Care Facility, Inc.	License No. 144-RH	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 #
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 Mattatuck Health Care Facility, Inc.		License No. 144-RH	Report for Year Ended 9/30/2018	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 89,578		89,578	
2.	Non-Food Supplies	\$ 5,496		5,496	
3.	Other (Specify) _____	\$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$			
c. Other (Specify) _____		\$			
2D. Total Dietary Expenditures (2a + b + c + d)		\$ 95,074		95,074	
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
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 Mattatuck Health Care Facility, Inc.		License No. 144-RH	Report for Year Ended 9/30/2018		Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)	
3. Laundry						
a. In-House Processing*		Lbs.				
1.	Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	7,554		7,554	
2.	Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
		Amt. \$				
3.	Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
		Amt. \$				
4.	Repair and/or purchase of linens.***	Lbs.				
		Amt. \$				
	b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$				
	c. Other (Specify)	\$				
3D. Total Laundry Expenditures (3a + b + c)		\$	7,554		7,554	
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		License No.	Report for Year Ended		Page	of
Mattatuck Health Care Facility, Inc.		144-RH	9/30/2018		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
	a. In-House Care					
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	12,214		12,214	
	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>)	\$				
4D.	Total Housekeeping Expenditures (4a + b + c)	\$	12,214		12,214	
5.	Resident Care (Supplies)**					
	a. Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from	\$				
	b. Medicine Cabinet Drugs	\$	3,544		3,544	
	c. Medical and Therapeutic Supplies	\$	22,678		22,678	
	d. Ambulance/Limousine***	\$				
	e. Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$				
	f. X-rays and Related Radiological Procedures***	\$	7,103		7,103	
	g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
	h. Laboratory***	\$	108		108	
	i. Recreation	\$	11,674		11,674	
	j. Direct Management Services*	\$				
	k. Indirect Management Services*	\$				
	l. Other (Specify)**** See Attached Schedule	\$	7,928		7,928	
5M.	Total Resident Care Expenditures (5a - 5j)	\$	53,036		53,036	

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

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Part A Expense: · PT		\$ 6,089	
Part A Expense: · MD		\$ 18	
Part A Expense: · Xray		\$ 136	
Part A Expense: · Medicare Transmission		\$ 1,684	
Total Other Resident Care	\$ -	\$ 7,928	\$ -

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

Name of Facility Mattatuck Health Care Facility, Inc.				License No. 144-RH	Report for Year Ended 9/30/2018	Page of 21 37				
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
N/A		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<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"/>							

* 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
Mattatuck Health Care Facility, Inc	144-RH	9/30/2018			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 38,361		38,361			
b. Heat	\$ 21,426		21,426			
c. Light & Power	\$ 21,121		21,121			
d. Water	\$ 9,757		9,757			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 2,076		2,076			
f. Other (<i>itemize</i>)	\$					
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 92,742		92,742			
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$ 4,943		4,943			
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 4,643		4,643			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 9,586		9,586			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 335,300		335,300			
10. Property Taxes						
a. Real estate taxes paid by owner	\$ 28,247		28,247			
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$ 2,114		2,114			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 375,247		375,247			

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Total Other Repairs and Maintenance	\$ -	\$ -	\$ -

Depreciation Schedule

Name of Facility Mattatuck Health Care Facility, Inc.			License No. 144-RH			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			
A. Land Improvements													
1. Acquired prior to this report period			149,113		149,113	149,113							
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal													
B. Building and Building Improvements													
1. Acquired prior to this report period			102,324		102,324	56,991			3,667				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			6,381						1,276				
B-4. Subtotal										4,943			
C. Non-Movable Equipment													
1. Acquired prior to this report period			25,738		25,738	21,258	SL	Ver					
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal													
		Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
		Yes	No	Month	Year								
D. Movable Equipment													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a.													
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period				Var	Var	86,342		86,342	76,053	SL	Var	4,643	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)													
D-3. Subtotal													4,643
E. Total Depreciation													9,586

Mattatuck Health Care Facility, Inc.
9/30/2018

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
3/29/2018	Camera/Phone System	\$ 6,381	5	\$ 1,276
Total additions for Building Improvement		\$ 6,381		\$ 1,276 *
Deletions:				
Total deletions for Building Improvement		\$ -		\$ - **

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

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

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

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

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

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Amortization Schedule*

Name of Facility			License No.		Report for Year Ended			Page	of
Mattatuck Health Care Facility, Inc.			144-RH		9/30/2018			24	37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									

* Straight-line method must be used.

** Specify which of the following bases were used:

- A. Minimum of 5 years or 60 months.
- B. Life of mortgage; OR
- C. Remaining Life of Lease; OR
- D. Actual Life if owned by Related Party.

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

Name of Facility Mattatuck Health Care Facility, Inc.	License No. 144-RH	Report for Year Ended 9/30/2018	Page 25	of 37
11. Property Questionnaire				
Part A				
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		07/06/78		
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase		07/06/78		
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity		43		
6. Square Footage		16,186		
7. Acquisition Cost				
a. Land				
b. Building				
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd 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 _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
Part C - Arms-Length Leases for Real Property Improvements Only				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility Mattatuck Health Care Facility, Inc.		License No. 144-RH	Report for Year Ended 9/30/2018		Page 26	of 37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Mattatuck Health Care Facility, Inc		144-RH		9/30/2018		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$			
12. D. Other Interest Expense (Specify)				\$	42,126	42,126	
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	42,126	42,126	
14. Insurance							
a. Insurance on Property (buildings only)				\$	25,720	25,720	
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$			
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. Total Insurance Expenditures (14a + b + c)				\$	25,720	25,720	
15. Total All Expenditures (A-13 thru C-14)				\$	1,969,816	1,969,816	

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Mattatuck Health Care Facility, Inc.			144-RH	9/30/2018	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.	15	1f	Life insurance premiums on the life of Owners, Partners, Operators	\$ 15,894		15,894	
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.	16	m3	Unallowable Advertising *	\$ 385		385	
19.	15	1k	Income Tax / Corporate Business Tax	\$ 12,131		12,131	
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 13,350		13,350	
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 41,760		41,760	

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Late Fees		\$ 160	
16	m13	Lions Club		\$ 300	
16	m13	Miscellaneous		\$ 7,480	
16	8a	Chamber of Commerce		\$ 556	
30	IV8	Other Income- WC Rebate		\$ 4,854	
Total Other A&G Adjustments			\$ -	\$ 13,350	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Mattatuck Health Care Facility, Inc.			144-RH	9/30/2018	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 41,760		41,760	
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$			
28.			Ambulance/Limousine	\$			
29.	20	5f	X-rays, etc	\$ 7,103		7,103	
30.	20	5h	Laboratory	\$ 108		108	
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 2,138		2,138	
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 51,109		51,109	

*** 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.

Mattatuck Health Care Facility, Inc.
9/30/2018

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
		Part A MD		\$ 18	
		Part A Xray		\$ 136	
		Part A Medicare Transmission		\$ 1,984	
Total Other Ancillary Costs			\$ -	\$ 2,138	\$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

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

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Mattatuck Health Care Facility, Inc	144-RH	9/30/2018			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 1,789,895		1,789,895			
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>)	\$ 118,749		118,749			
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$ 50,325		50,325			
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
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	\$ 15,195		15,195			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 1,974,164		1,974,164			
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 4,854		4,854			
V. Total Other Revenue (1 thru 8)	\$ 4,854		4,854			
VI. Total All Revenue (III +V)	\$ 1,979,018		1,979,018			

* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

** Facility should report all contractual allowances and/or payer discounts.

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30/II6b	Medicare - Part B		\$ 15,195	
Total Other Resident Revenue		\$ -	\$ 15,195	\$ -

Interest Income

Account

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

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30/IV8	Other income		\$ 4,854	
Total Other Revenue		\$ -	\$ 4,854	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Mattatuck Health Care Facility, Inc.	144-RH	9/30/2018	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	192,917
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	159,541
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	1,720
5. Prepaid Expenses			\$	653
a. _____				
b. _____				
c. _____				
d. See Schedule	653			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	941,780

See Schedule	941,780			
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,296,612
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	149,113	\$	
	Accum. Depreciation	149,113		Net
3. Buildings	*Historical Cost	108,706	\$	46,772
	Accum. Depreciation	61,934		Net
4. Leasehold Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		Net
5. Non-Movable Equipment	*Historical Cost	25,738	\$	4,480
	Accum. Depreciation	21,258		Net
6. Movable Equipment	*Historical Cost	86,342	\$	5,646
	Accum. Depreciation	80,696		Net
7. Motor Vehicles	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	20,459

See Schedule	20,459			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	77,358

* 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	License No.	Report for Year Ended	Page	of
Mattatuck Health Care Facility, Inc.	144-RH	9/30/2018	32	37
Account			Amount	
Total Brought Forward:			\$	1,373,969
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements		*Historical Cost _____		
	Accum. Depreciation	_____	Net	\$
3. Buildings		*Historical Cost _____		
	Accum. Depreciation	_____	Net	\$
4. Non-Movable Equipment		*Historical Cost _____		
	Accum. Depreciation	_____	Net	\$
5. Movable Equipment		*Historical Cost _____		
	Accum. Depreciation	_____	Net	\$
6. Motor Vehicles		*Historical Cost _____		
	Accum. Depreciation	_____	Net	\$
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense		*Historical Cost _____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	(9,341)
Name and Address		Amount	Loan Date	
Loans from Related Party		(9,341)		
7. Other Assets (<i>itemize</i>)			\$	

See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	(9,341)
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	1,364,628

* 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	
31	A5	Prepaid Insurance	\$ 241
31	A5	Prepaid Taxes	\$ 412
Total Prepaid Expenses			\$ 653

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

Page Ref	Line Ref	Description	
31	A8	Loans-Due to Carriage	\$ 286,215
31	A8	Due from Carriage	\$ (6,454)
31	A8	Loans Related-Geron	\$ 306,947
31	A8	Due from Geron	\$ 31,300
31	A8	Loans Related-Tricare	\$ 293,180
31	A8	Due from Tricare	\$ 30,592
Total Other Current Assets (Itemize)			\$ 941,780

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

Page Ref	Line Ref	Description	
31	B9	CON in Progress	\$ 18,587
31	B9	Cost vs Book	\$ 1,872
Total Other Other Fixed Assets (Itemize)			\$ 20,459

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

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

Page Ref	Line Ref	Description	
		Wells Fargo	\$ 300
		Due State of CT Use Tax	\$ 75,336
		Patient Trust Accounts	\$ 21,890
		Security Deposits	\$ 40,971
		Accrued Rent	\$ 15,000
		Accrued Property Tax	\$ 51
		Funding Circle	\$ 67,422
		Funding Circle 2	\$ 49,363
		Credit Line TD Banknorth	\$ 348,712
		Webster Credit Line	\$ 67,667
		First Niagara Credit Line	\$ 48,196
		Waterbuy Development Corp	\$ 23,738
		Loan Payable - Carriage	\$ 2,743
		Deferred Tax Liability	\$ 8,238
		Service Finance Company	\$ 38,058
Total Other Current Liabilities (Itemize)			\$ 807,684

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

Page Ref	Line Ref	Description	
		First Lease	\$ 165
Total Other Current Liabilities (Itemize)			\$ 165

G. Balance Sheet (cont'd)

Name of Facility Mattatuck Health Care Facility, Inc.		License No. 144-RH	Report for Year Ended 9/30/2018	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	118,086
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>)				\$	13,851
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	(4,118)
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*				\$	(1,590)
12. Other Current Liabilities (<i>itemize</i>)				\$	807,684
_____ _____ _____ See Schedule					
				807,684	
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	933,912

* 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 Mattatuck Health Care Facility, Inc.	License No. 144-RH	Report for Year Ended 9/30/2018	Page 34	of 37
Account				Amount
Total Brought Forward:				933,912
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 165
See Schedule				165
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 165
C. Total All Liabilities (Lines A-13 + B-5)				\$ 934,077

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

Name of Facility	License No.	Report for Year Ended	Page	of
Mattatuck Health Care Facility, Inc.	144-RH	9/30/2018	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	45,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	(138,391)
5. Cumulated Earnings			\$	514,741
6. Gain or Loss for Period				
	10/1/2017	thru 9/30/2018	\$	9,201
7. Total Net Worth			\$	430,551
C. Total Reserves and Net Worth			\$	430,551
D. Total Liabilities, Reserves, and Net Worth			\$	1,364,628

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Mattatuck Health Care Facility, Inc.	144-RH	9/30/2018	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2017			\$	525,947
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	1,979,018
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	1,969,816
D. Net Income or Deficit			\$	9,201
E. Balance			\$	535,148
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount	
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period	09/30/18		\$	535,148

I. Preparer's/Reviewer's Certification

Name of Facility Mattatuck Health Care Facility, Inc.	License No. 144-RH	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 checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
CJLC LLC				
Address Address		Phone Number		
225 Pitkin Street, East Hartford, CT 06108		860-610-9009		
Annual Report Contact		Phone Number		
CJLC		860-610-9009		
Annual Report Contact Email Address				
annualreports@cjlc.com				