State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2015

Name of Facility (as licensed) FILOSA FOR NURSING AND REHABILITATION		
Address (No. & Street, City, State, Zip Code) 13 HAKIM STREET, DANBURY, CT, 06810		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015	

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	4614		

For Department Use Only

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

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General Information

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Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISIONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for FILOSA FOR NURSING AND REHABILITATION [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

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

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility FILOSA FOR NURSING AND REHABILITATION	Period Covered:		From 10/1/2014	To 9/30/2015
Address of Facility 13 HAKIM STREET, DANBURY, CT, 06810				
Report Prepared By CLIFTONLARSONALLLEN LLP	Phone Number 617-984-8100		Date 2/11/2016	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$				
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$				
5. All other wages paid	$				
6. ***Total Wages Paid***	$				
7. Total salaries paid	$				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

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

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

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

○ Proprietorship ○ LLC ○ Partnership ◉ Profit Corp. ○ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
Michael Malone		001685

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

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

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

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

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
FILOSA FOR NURSING AND REHABILITATION	13 HAKIM STREET, DANBURY, CT, 06810	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Frank D. Malone	105 Middle River Road, Danbury, CT 06811	Treasurer	128
Barbara A. Malone	105 Middle River Road, Danbury, CT 06811	Secretary	491
Michael D. Malone	197 Guinea Road, Monroe, CT 06468	President	129
Jennifer Malone-Seixas	592 Manville Road, Pleasantville, NY 10570	Vice-President	119
Names of Stockholders Owning at Least 10% of Shares			
Frank D. Malone	105 Middle River Road, Danbury, CT 06811	Treasurer	128
Barbara A. Malone	105 Middle River Road, Danbury, CT 06811	Secretary	491
Michael D. Malone	197 Guinea Road, Monroe, CT 06468	President	129
Jennifer Malone-Seixas	592 Manville Road, Pleasantville, NY 10570	Vice-President	119
John M. Malone	22 N. Dutcher St., Irvington, NY 10533	Director	119

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General Information and Questionnaire
Individual Proprietorship

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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

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

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? ⊙ Yes ○ No

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Filosa Care Center DBA Hancock Hall	31 Staples St., Danbury, CT 06810	○	⊙		Shared Expenses	See Attached	See Attached	See Attached
Barbara A Malone (Bamco, LLC)	105 Middle River Rd., Danbury, CT	○	⊙		Building Rental	Page 22 Line 9	684,000	684,000
Babara Filosa	31 Staples St., Danbury, CT 06810	○	⊙		Off Site Storage Rental & Parking Lot	Page 22 Line 9	10,800	10,800
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (*See listing page 13*)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

The preparer of this report must answer the following questions applicable to the cost information provided.

1. In the preparation of this Report, were all costs allocated as required? ⊙ Yes ○ No If "No," explain fully why such allocation was not made.

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

Allocation of Related Company expenses based on the number of beds in each facility as follows: Hancock Hall 96 Beds / 60% and Filosa for Nursing and Rehabilitation 64 Beds / 40%. Mainentance and housekeeping shared expenses allocated based on square feet. (Hancock Hall 59% and Filosa for Nursing and Rehabilitation 41%)

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
GE Capital/Ricoh USA, PO Box 41554, Philadelphia, PA 19101	○	⊙	Copier Machine Lease	07/29/15	60 Months	8,542	8,542
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total ***** 8,542

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
** Attach copies of newly acquired leases.
*** Amount should agree to Page 22, Line 6e.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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The records of this facility for the period covered by this report were maintained on the following basis:

◉ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 CLIFTONLARSONALLEN LLP	300 CROWN COLONY DR., STE 310, QUINCY, MA 02169
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Financial Statement review and preparation of Cost Reports and Tax Returns	$ 23,158
2		$
3		$
4		$
		Charge for Services Provided $ 23,158

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

◉ Yes ○ No — Page 15, Line 1.d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 N/A	
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		$
		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 — No Legal Expense for FY 2015

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Schedule of Resident Statistics

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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	64	64			64	64			64	64		
B. On last day of THIS report period	64	64			64	64			64	64		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	62	62			62	62			62	62		
B. As of midnight of THIS report period	60	60			61	61			60	60		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,241	1,241			1,079	1,079			162	162		
B. Medicaid (Conn.)	14,646	14,646			10,930	10,930			3,716	3,716		
C. Medicaid (other states)												
D. Private Pay	6,222	6,222			4,625	4,625			1,597	1,597		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	22,109	22,109			16,634	16,634			5,475	5,475		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	61	61			61	61						
B. Other Bed Reserve Days	12	12			4	4			8	8		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	22,182	22,182			16,699	16,699			5,483	5,483		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	3	40		17				
Per Diem Rate								
a. One bed rm.				490.00				
b. Two bed rms.	603.24	243.19		460.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	2,195	2,195		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	3,129	3,129		
D. ***Total Physical Therapy Treatments***	5,324	5,324		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	470	470		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	410	410		
D. ***Total Speech Therapy Treatments***	880	880		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,289	1,289		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	3,114	3,114		
D. ***Total Occupational Therapy Treatments***	4,403	4,403		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)	143,224					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	74,587	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	88,877	4,735				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	22,211	832				
c. Dietary Workers	306,739	19,594				
6. Housekeeping Service						
a. Head Housekeeper	32,595	858				
b. Other Housekeeping Workers	138,200	11,843				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	43,044	858				
b. Other Maintenance Workers	87,977	3,438				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	93,442	6,661				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant	41,129	832				
b. Other Accountants	87,489	2,720				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	87,617	2,080				
b. RN						
1. Direct Care	742,721	21,239				
2. Administrative**	94,282	3,992				
c. LPN						
1. Direct Care	395,260	14,780				
2. Administrative**	52,206	1,878				
d. Aides and Attendants	998,755	62,200				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	100,138	4,629				
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	65,125	2,020				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	3,695,618	167,269				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Religious Services	$ 1,000	24				
Total	$ 1,000	24	$ -	-	$ -	-

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

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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Frank Malone	33,937				Treasurer / CFO		Page 10, A1	Hancock Hall, 31 Staples St., Danbury, CT 06840		45,835
Jennifer Malone-Seixas					Vice-President		Page 10, A1	Hancock Hall, 31 Staples St., Danbury, CT 06840	2,080	150,794
Michael Malone	109,287				President		Page 10, A1	Hancock Hall, 31 Staples St., Danbury, CT 06840		
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Michael Malone	74,587				Administrator	2,080	Page 10, A2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian	18,968	422				
2. Dentist						
3. Pharmacist	4,756	106				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	108,984	1,840				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	27,600	122				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)	562	2				
2. Pharmaceutical Committee (Quarterly meetings)	562	2				
3. Staff Development Committee (Once annually)	281	1				
e. Other (Specify)						
Psychiatric Evaluations	8,800	49				
9. Speech Therapist						
a. Resident Care	25,444	679				
b. Other						
10. Occupational Therapist						
a. Resident Care	88,028	1,558				
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	1,000	24				
B-13 Total Fees Paid in Lieu of Salaries	284,985	4,805				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Grace Ahern, RD, 38 Pond Crest Rd., Danbury, Ct 06810	Dietary Needs & Reports	○	⊙	
Omnicare Pharmacy Services, 525 Knotter Dr., Cheshire, CT	General Supervision of Drugs	○	⊙	
Alliance Rehab of CT., 1520 Kennsington Rd., Suite 105, Oakbrook, IL 60523	PT Evaluations & Services	○	⊙	
Serafima Glouzgal, 38 Grove St., Ridgefield, CT. 06877	Coordination of Medical Care for Residents	○	⊙	
Members of Organized Medical Staff-Robert Ruxin, MD 30 Prospect St., Ridgefield, CT 06877	Infection Control Review	○	⊙	
Members of Organized Medical Staff-Robert Ruxin, MD 30 Prospect St., Ridgefield, CT 06877	Pharmacy Review	○	⊙	
Members of Organized Medical Staff-Robert Ruxin, MD 30 Prospect St., Ridgefield, CT 06877	Staff Development Review	○	⊙	
Orestes Arcuni,MD, 4 Bartrum Dr., West Redding, CT	Psychiatric Evaluations	○	⊙	
Alliance Rehab of CT., 1520 Kennsington Rd., Suite 105, Oakbrook, IL 60523	ST Evaluations & Services	○	⊙	
Alliance Rehab of CT., 1520 Kennsington Rd., Suite 105, Oakbrook, IL 60523	OT Evaluations & Services	○	⊙	
St. Joseph Roman Catholic Chruch, 8 Robinson Ave., Danbury, CT 06877 Rev. David Franklin	Routine visits to Facility/Residents	○	⊙	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITAT	461-C	9/30/2015	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	125,593	125,593		
2. Disability Insurance	$	24,525	24,525		
3. Unemployment Insurance	$	80,678	80,678		
4. Social Security (F.I.C.A.)	$	274,930	274,930		
5. Health Insurance	$	265,883	265,883		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	8,234	8,234		
(not-owners and not-operators)					
8. Uniform Allowance	$	7,790	7,790		
9. Other (*Specify*)	$	6,660	6,660		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	27,541	27,541		
d. Accounting and Auditing	$	23,158	23,158		
e. Legal (*Services should be fully described on Page 7)*	$				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	20,237	20,237		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	12,728	12,728		
2. Cellular Phones	$	2,202	2,202		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$	14,617	14,617		
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	440,202	440,202		
Subtotal	$	1,334,978	1,334,978		

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

(Carry Subtotals forward to next page)

***** DO NOT Include Holiday Parties / Awards / Gifts to Staff**

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Other Expense-Physicals	$ 6,660		
Total	$ 6,660	$ -	$ -

Schedule of Other Taxes

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

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2015	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,334,978	1,334,978		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	6,505	6,505		
2. Holiday Parties for Staff	$	1,042	1,042		
3. Gifts to Staff and Residents	$	8,017	8,017		
4. Employee Travel	$				
5. Education Expenses Related to Seminars and Conventions	$	3,542	3,542		
6. Automobile Expense (*not purchase or depreciation*)	$	2,418	2,418		
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	2,326	2,326		
2. Advertising Telephone Directory (*all such expenses*)***	$	1,008	1,008		
3. Advertising Other (*Specify*)***	$	3,146	3,146		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$	2,290	2,290		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	2,663	2,663		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	7,170	7,170		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	510	510		
10. Contributions***	$	2,025	2,025		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$	70,000	70,000		
13. Other (*Specify*)	$	90,214	90,214		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	1,537,854	1,537,854		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotion /Pubilc Relations	$ 3,146		
Total Other Advertising	$ 3,146	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Dues-NH Associations	$ 4,367		
Professional Dues/License Fees	$ 2,803		
Total Dues	$ 7,170	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Contributions	$ 2,025		
Total Contributions	$ 2,025	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Prior Year Adjustment	$ (20,768)		
Cable TV Expense	$ 13,561		
Contract Professional Services	$ 30,843		
Repair/Servic Office Equipment	$ 35,969		
Payroll Service	$ 19,523		
Bank Service Charges - disallowed Page 28	$ 1,565		
Other Interest non allowable - disallowed Page 28	$ 5,318		
Resident Related Misc. Expense - disallowed Page 28	$ 2,051		
Discounts Earned - disallowed Page 28	$ 483		
Adjustments - disallowed Page 28	$ 799		
Inservice Books & Materials $750 and Staff Training $120	$ 870		
Total Other Administrative and General	$ 90,214	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABIL	461-C	9/30/2015	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 #
Hancock Hall	70,000	Management Fee - self disallowed on Page 28	Page 16, Line m.12

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

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2015	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	188,348	188,348		
2. Non-Food Supplies	$	26,505	26,505		
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*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	214,853	214,853		

2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals:	Total no. of meals served per day:*	182	182		

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.
** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2015	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	8,873	8,873		
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. $	14,184	14,184		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*) Equip Rental -Laundry	$	8,295	8,295		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	31,352	31,352		

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

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3E.

** 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITA	461-C	9/30/2015	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel		39,605	39,605		
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	30,027	30,027		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	30,027	30,027		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Omnicare Pharmacy		$	38,632	38,632		
b. Medicine Cabinet Drugs		$	3,102	3,102		
c. Medical and Therapeutic Supplies		$	152,049	152,049		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	4,885	4,885		
f. X-rays and Related Radiological Procedures***		$	494	494		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	2,050	2,050		
i. Recreation		$	3,459	3,459		
j. Other (Specify)**** See Attached Schedule		$	18,244	18,244		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	222,915	222,915		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Tech Componet Part A Chnages	$ 694		
Med/Surg Supply Part A	$ 1,370		
DME Rental & Supply Part A	$ 5,242		
Equipment Rental Nursing	$ 10,857		
Small Equipment Nursing	$ 81		
Total Other Resident Care	$ 18,244	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
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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
Celtic Consulting, LLC	135 South Road, Suite 3, Farmington, CT 06032	○	⊙		regulatory compliance, staff competency and	10,882			16	M13
Operations, Inc	535 Connecticut Ave., Norwalk, CT 06854	○	⊙		Assist & advise during ADP Payroll conversion	10,838			16	M13
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* List all contracted services over $10,000. Use additional sheets if necessary.
** Refer to Page 4 for definition of related.
*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABILITA	461-C	9/30/2015	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	61,413	61,413		
b. Heat	$	51,129	51,129		
c. Light & Power	$	65,688	65,688		
d. Water	$	29,238	29,238		
e. Equipment Lease (*Provide detail on page 6*)	$	8,542	8,542		
f. Other (*itemize*)	$	76,586	76,586		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	292,596	292,596		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	120,877	120,877		
c. Non-Movable Equipment	$				
d. Movable Equipment	$	45,702	45,702		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	166,579	166,579		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	67,707	67,707		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	67,707	67,707		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	573,923	573,923		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	55,302	55,302		
c. Personal property taxes	$	5,444	5,444		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	868,955	868,955		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Refuse Removal	$ 20,519		
Exterminating	$ 3,664		
Bedchair Alarms	$ 337		
Repairs/Maintenace-Contracts	$ 25,935		
Interior Decor Maint/Supply	$ 6,094		
Repairs/Maintenace-Grounds	$ 20,037		
Total Other Repairs and Maintenance	$ 76,586	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2015	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	4,835,483		4,835,483	2,561,088	SL	40	120,877	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								120,877
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	378,928		378,928	378,928	SL	Various		
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. 2006 Toyota Tacoma	X		10	2006	28,780		28,780	23,024	SL	10	2,878	
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			Various		496,457		496,457	283,114	SL	Various	38,521	
b. Disposals (attach schedule)			Various		(15,502)		(15,502)	10,858	SL	Various	596	
c. Acquired during this report period (attach schedule)			Various		50,023		50,023		SL	Various	3,707	
D-3. Subtotal												45,702
E. ***Total Depreciation***												166,579

FILOSA FOR NURSING AND REHABILITATION
9/30/2015

Schedule of Land Improvements Acquired during this report period

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

***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:					
Total additions for Building Improvements		$ -		$ -	*
Deletions:					
Total deletions for Building Improvements		$ -		$ -	**

***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:					
	See Attached Schedule	$ 50,023	various	$ 3,707	
Total additions for Movable Equipment		$ 50,023		$ 3,707	*
Deletions:					
	See Attached Schedule	(15,502)	various	596	
Total deletions for Movable Equipment		$ (15,502)		$ 596	**

***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:					
	See Attached Schedule	75,712	various	11,818	
Total additions for Leasehold Improvement		$ 75,712		$ 11,818	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2015	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	Various		Various	616,759	201,668	SL	Variou	55,889	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	Various		Various	75,712		SL	variou	11,818	
C-4. Subtotal									67,707
D. ***Total Amortization***									67,707

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
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11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ⊙ Yes ○ No

If "Yes," complete Part B.
If "No," complete Part C.

*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total
1. Date Land Purchased	Various
2. Date Structure Completed	1995 Major Renov.
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	01/01/47
5. Total Licensed Bed Capacity	64
6. Square Footage	39,605
7. Acquisition Cost	
a. Land	398,123
b. Building	4,835,483

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed Mortgage			
b. Date Mortgage Obtained	02/18/05			
c. Interest Rate for the Cost Year	5.80%			
d. Term of Mortgage (number of years)	20			
e. Amount of Principal Borrowed	5,377,205			
f. Principal balance outstanding as of 9/30/2015	2,616,077			
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
Bamco LLC	13 Hakim St., Danbury, CT	01/01/14	9.67 Years	684,000
Barbara Filosa	10 Hakim St., Danbury, CT - Storage	06/01/14	2 Years	4,800
Barbara Filosa	11 Staples St., Danbury, CT 06810 - Parking Lot	06/01/14	2 Years	6,000

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

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REH	461-C	9/30/2015	26 | 37

Item	Total	CCNH	RHNS	(Specify)
12. Interest				
A. Building, Land Improvement & Non-Movable Equipment				
1. First Mortgage $				
Name of Lender / Rate				
Address of Lender				
2. Second Mortgage $				
Name of Lender / Rate				
Address of Lender				
3. Third Mortgage $				
Name of Lender / Rate				
Address of Lender				
4. Fourth Mortgage $				
Name of Lender / Rate				
Address of Lender				
B. CHEFA Loan Information				
1. Original Loan Amount $				
2. Loan Origination Date				
3. Interest Rate %				
4. Term				
5. CHEFA Interest Expense				
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $				

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND RE	461-C	9/30/2015	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*)		$	2,137	2,137		
A. Item	Rate	Amount				
Equip - Hot Water Sytem	4.00%					
Lender						
Union Savings Bank						
Address of Lender						
B. Item	Rate	Amount				
Improvements - Renovation	4.00%					
Lender						
Union Savings Bank						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		$	2,137	2,137		
12. D. Other Interest Expense (*Specify*)		$	7,408	7,408		
Union Savings Bank - Line of Credit						
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)		$	9,545	9,545		
14. Insurance						
a. Insurance on Property (buildings only)		$	9,816	9,816		
b. Insurance on Automobiles		$	2,302	2,302		
c. Insurance other than Property (as specified above)						
1. Umbrella (*Blanket Coverage*)		$	8,424	8,424		
2. Fire and Extended Coverage		$	23,857	23,857		
3. Other (*Specify*)		$	5,907	5,907		
SEE ATTACHED						
14d. ***Total Insurance Expenditures (14a + b + c)***		$	50,306	50,306		
15. ***Total All Expenditures (A-13 thru C-14)***		$	7,239,006	7,239,006		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2015	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 $	143,224	143,224		
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.	15	a.2.	Discriminatory Benefits $	4,441	4,441		
9.	15	1.c	Bad Debts $	27,541	27,541		
10.	15	1.e	Accounting & Legal $				
11.			Telephone $				
12.	15	1.h.2	Cellular Telephone $	1,101	1,101		
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.	16	l.3.	Gifts, flowers and coffee shops $	8,017	8,017		
15.	16	l.5.	Education expenditures to colleges or universities for tuition and related costs for owners and employees $	2,199	2,199		
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.	16	m.2 &	Unallowable Advertising * $	4,154	4,154		
19.	15	1.k.1.	Income Tax / Corporate Business Tax $	14,617	14,617		
20.	16	m.4	Fund Raising / Contributions $	2,025	2,025		
21.	16	m.12.	Unallowable Management Fees $	70,000	70,000		
22.	30	IV.7	Barber and Beauty $				
23.			Other - See attached Schedule $	21,173	21,173		
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) $	298,492	298,492		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	A.1.	Frank Malone	$ 33,937		
10	A.1.	Michael Malone	$ 109,287		
Total Other Salaries Adjustment			$ 143,224	$ -	$ -

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	m.13.	Bank Service Charges	$ 1,565		
16	m.13.	Resident Misc Expense	$ 2,051		
16	m.13.	Discounts	$ 483		
16	m.13.	Adjustments	$ 799		
16	m.13.	Non Allowable Interest Late Charges	$ 5,318		
15	a.4.	FICA on disallowed Owner/Officer salaries	$ 10,957		
Total Other A&G Adjustments			$ 21,173	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2015	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	298,492	298,492		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $	38,632	38,632		
28.			Ambulance/Limousine $				
29.			X-rays, etc $	494	494		
30.			Laboratory $	2,050	2,050		
31.			Medical Supplies $				
32.			Oxygen (non emergency) $	4,885	4,885		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	7,306	7,306		
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 $	4,730	4,730		
Other - Miscellaneous							
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 $				
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.			***Total Amount of Decrease (Items 1 - 50)*** $	356,589	356,589		

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

Attachment Page 29

FILOSA FOR NURSING AND REHABILITATION
9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
		Tech Component PT A	$ 694		
		Med Supply PT A	$ 1,370		
		DME Rental & Supply PT A	$ 5,242		
Total Other Ancillary Costs			$ 7,306	$ -	$ -

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			$ -	$ -	$ -

Schedule of Other 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			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABI	461-C	9/30/2015	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	6,594,156	6,594,156		
b. Medicaid Room and Board Contractual Allowance **	$	(3,017,620)	(3,017,620)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	518,195	518,195		
b. Medicare Room and Board Contractual Allowance **	$	149,212	149,212		
4. a. Private-Pay Residents and Other	$	2,989,662	2,989,662		
b. Private-Pay Room and Board Contractual Allowance **	$	(43,327)	(43,327)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	52,108	52,108		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(52,108)	(52,108)		
c. Prescription Drugs - Non-Medicare	$	3,992	3,992		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(3,992)	(3,992)		
2. a. Medical Supplies - Medicare	$	5,345	5,345		
b. Medical Supplies - Medicare Contractual Allowance **	$	(5,345)	(5,345)		
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	194,041	194,041		
b. Physical Therapy - Medicare Contractual Allowance **	$	(135,630)	(135,630)		
c. Physical Therapy - Non-Medicare	$	16,040	16,040		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(16,040)	(16,040)		
4. a. Speech Therapy - Medicare	$	51,478	51,478		
b. Speech Therapy - Medicare Contractual Allowance **	$	(30,859)	(30,859)		
c. Speech Therapy - Non-Medicare	$	739	739		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(739)	(739)		
5. a. Occupational Therapy - Medicare	$	209,989	209,989		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(163,841)	(163,841)		
c. Occupational Therapy - Non-Medicare	$	17,160	17,160		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(17,160)	(17,160)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	134	134		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	7,315,590	7,315,590		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	133	133		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	(2,410)	(2,410)		
V. Total Other Revenue (1 thru 8)	$	(2,277)	(2,277)		
VI. Total All Revenue (III +V)	$	7,313,313	7,313,313		

* *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)
30II6A-CCH	X-Ray	$ (599)		
30II6A-CCH	Lab	$ (1,787)		
30II6A-CCH	X-Ray C/A	$ 599		
30II6A-CCH	Lab C/A	$ 1,787		
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30II6b-CCH	Ambulance	$ 150		
30II6b-CCH	Lab	$ (16)		
30II6b-CCH	Lab	$ (88)		
30II6b-CCH	Lab C/A	$ 88		
Total Other Resident Revenue		$ 134	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30IV5-CCH	Interest Income - Union Savings Bank		$ 133		
Total Interest Income			$ 133	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30IV8-CCH	Loss on disposal of fixed asset	$ (2,427)		
30IV8-CCH	Miscellaneous Income	$ 17		
Total Other Revenue		$ (2,410)	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHAI	461-C	9/30/2015	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 114,255
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 586,898
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 30,970
a. Prepaid Insurance		14,395		
b. Prepaid Expenses		16,575		
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ (25,000)
Reserve for Doubtful Accounts		(25,000)		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 707,123
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	692,471		$ 423,096
	Accum. Depreciation	269,375	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	530,978		$ 205,040
	Accum. Depreciation	325,938	Net	
7. Motor Vehicles	*Historical Cost	28,780		$ 2,878
	Accum. Depreciation	25,902	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 631,014

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHAI	461-C	9/30/2015	32	37

Account				Amount
			Total Brought Forward:	$ 1,338,137
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$ 398,123
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost	4,835,483		
	Accum. Depreciation	2,681,965	Net	$ 2,153,518
4. Non-Movable Equipment	*Historical Cost	378,928		
	Accum. Depreciation	378,928	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)				$ 2,551,641
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 48,001
Bed License		48,001		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 48,001
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 3,937,779

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILIT	461-C	9/30/2015	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 136,190
	2. Notes Payable (*itemize*)				$ 233,824
	USB Line of Credit		180,761		
	USB Renovation Loan due 11/29/15		4,166		
	USB Renovation due 5/29/17 ($28,939 is current portion)		48,897		
	3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$ 23,446
	Name of Lender	Purpose	Amount	Date Due	
	Union Savings Bank	Hot Water System	23,446	04/05/17	
	4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 309,325
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 24,025
	7. Medicare Final Settlement Payable				$
	8. Medicare Current Financing Payable				$
	9. Mortgage Payable (*Current Portion*)				$
	10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
	11. Accrued Income Taxes*				$ (1,986)
	12. Other Current Liabilities (*itemize*)				$ 140,049
	Accrued Expenses		28,093		
	Liability Resident Trust		130		
	DSS Qtrly User Fee Liability		111,830		
	Rounding		(4)		
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 864,873

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILI	461-C	9/30/2015	34	37

Account	Amount
Total Brought Forward:	864,873
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$ 13,931

Name of Lender	Purpose	Amount	Date Due
Union Savings Bank	Hot Water System	90,000	4/5/17

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ 7,611

Name and Address of Lender	Amount	Loan Date
Hancock Hall	7,611	

4. Other Long-Term Liabilities (*itemize*)		$ (5,900)
Deferred Taxes	(5,900)	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 15,642
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 880,515

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHA	461-C	9/30/2015	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$ 398,123
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$ 2,153,518
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$ 2,551,641
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$ 90,310
	3. Paid-in Surplus	$ 183,510
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 157,496
	6. Gain or Loss for Period 10/1/2014 thru 9/30/2015	$ 74,307
	7. Total Net Worth	$ 505,623
C.	***Total Reserves and Net Worth***	$ 3,057,264
D.	***Total Liabilities, Reserves, and Net Worth***	$ 3,937,779

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHAB	461-C	9/30/2015	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2014			$ 441,954
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 7,313,313
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 7,239,006
D.	Net Income or Deficit			$ 74,307
E.	Balance			$ 516,261
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$ 10,638
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	SEE ATTACHED		10,638	
	2. Other Withdrawings *(Specify)*			$
	Purpose	Amount		
	3. Total Deductions			$ 10,638
H.	***Balance at End of Period*** 09/30/15			$ 505,623

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND	461-C	9/30/2015	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer	
CLIFTONLARSONALLEN LLP	
Addres Address	Phone Number
300 Crown Colony Dr., Ste 310, Quincy, MA 02169	617-984-8100