### **State of Connecticut**



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

Cost Year 2016

Name of Facility (as li	censed)							
Naugatuck Health Car			Health Care Cer	iter				
Address (No. & Street								
89 Weid Drive Nauga	tuck CT 0677	0						
Type of Facility								
Chronic and Co Nursing Home			☐ Rest Home v Supervision				□ (S	Specify)
Report for Year Begin	ning		Report for Year	r Ending				
10/1/2015	5		9/30/2016					
10, 1, 10								
License Numbers:		CCNH	RHNS		(Speci	ify)	Med	dicare Provider
Life in the life i								No.
		2182-C						07-5390
Medicaid Provider No	umbers:	CC	CNH	RHN	S		ICF-N	MR
		218	82-C					
For Department Use	Only							
Sequence Number	Signed and	Date	Sequence N	lumber	Sio	ned and Notari	ized	Date Received
Assigned	Notarized	Received	Assign	ed	J.S.	iid dia 110tai		
		I						

### **Table of Contents**

		1
Gene	ral Information - Administrator's/Owner's Certification	<u> </u>
Gene	ral Information and Questionnaire - Data Required for Real Wage Adjustment	1 <u>A</u>
	ral Information and Questionnaire - Type of Facility - Organization Structure	3
Gene	ral Information and Questionnaire - Partners	
Gene	eral Information and Questionnaire - Corporate Owners	3A
Gene	eral Information and Questionnaire - Individual Proprietorship	3B
Gene	eral Information and Questionnaire - Related Parties	4
	eral Information and Questionnaire - Basis for Allocation of Costs	5
Gene	eral Information and Questionnaire - Leases	6
Gene	eral Information and Questionnaire - Accounting Basis	7
Sche	dule of Resident Statistics	8
Sche	dule of Resident Statistics (Cont'd)	9
<u>A.</u>	Report of Expenditures - Salaries & Wages	10
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant	
	Administrators and Other Relatives	11
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant	
	Administrators and Other Relatives (Cont'd)	12
B.	Report of Expenditures - Professional Fees	13
	Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee	
	for Service Basis	14
C.	Expenditures Other than Salaries - Administrative and General	15
<u>C.</u> <u>C.</u>	Expenditures Other than Salaries (Cont'd) - Administrative and General	16
	Schedule C-1 - Management Services	17
$\overline{C}$ .	Expenditures Other than Salaries (Cont'd) - Dietary	18
C. C.	Expenditures Other than Salaries (Cont'd) - Laundry	19
C.	Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
	Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C.	Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
	Depreciation Schedule	23
<u></u>	Amortization Schedule	24
C.	Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C.	Expenditures Other than Salaries (Cont'd) - Interest	26
C.	Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D.	Adjustments to Statement of Expenditures	28
D.	Adjustments to Statement of Expenditures (Cont'd)	29
F.	Statement of Revenue	30
G.	Balance Sheet	31
G.	Balance Sheet (Cont'd)	32
G.	Balance Sheet (Cont'd)	33
G.	Balance Sheet (Cont'd)	34
G.	Balance Sheet (Cont'd)	35
H.	Changes in Total Net Worth	36
<u>I.</u>	Preparer's/Reviewer's Certification	37

### **General Information**

Name of Facility (as licensed) Naugatuck Health Care LLC d/b/a Beacon	License No.	Report for Year Ended	Page	of
D 177 17 G G	2182-C	9/30/2016	1	37

### 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 abo	ve statement and that I	have examined the
accompanying Cost Report and su	upporting sch	edules prepared for	
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	ole	name] for the cost repo	rt period beginning
October 01, 2015	and ending	September 30, 2016	, and that to the best of
my knowledge and belief, it is a transfer and records of the provider(s) in a	rue, correct, a	and complete statement	prepared from the books

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 penalities 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)	de	Date,	Signed (Owner)	Date
Jula V	Jacken	2/15/17	4/	2/15/17
Printed Name (Administ	rator)		Printed Name (Owner)	
Linda Garcia			Lawrence G Santilli	
Subscribed and Sworn	State of	Date	Signed (Notary Public)	Comm. Expires
to before me:	COMM	2/15/17	Harn I prusced	313/120
Address of Notary Public			) UI Terrace BRISTOL CT	Ln
2 1/2 ( 22			BRISTOP CT	0600



December 11, 2013

Mr. Michael E. Mosier Chief Financial Officer Athena Health Care Systems 135 South Road Farmington, CT 06032

Subject:

Alternative Annual Report Approval

Dear Mr. Mosier:

This letter is a follow-up to your verbal approval regarding your request for alternative annual report utilization. We have reviewed your request for approval of the Athena Health Care Systems version of the 2013 Annual Report for the State of Connecticut. Based on our review, your version of the annual report has been approved.

It is not necessary to request approval on an annual basis. This approval will remain in effect until modifications have been made to the Annual Report by the Department of Social Services. The provider community will be notified should such changes occur. At that time, you will be required to submit a new request for approval based on the modified annual report.

Should you have any questions, please feel free to contact me at (860) 687-0790.

Sincerely,

Brittany L. Hester, Administrative Assistant

CC: Glaudette B. Pickens, CPA

CC: Chris Lavigne

### State of Connecticut **Department of Social Services**

### 25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustm	ient		Page 1A	of 37
Name of Facility	Period Cover	ed:	From	То
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center			10/1/2015	9/30/2016
Address of Facility				
89 Weid Drive Naugatuck CT 06770				
Report Prepared By	Phone Numb	er	Date	
Athena Health Care Associates, Inc	(860) 751-39	00	2/15/	2017
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.

State of Connecticut
<b>Annual Report of Long-Term Care Facility</b>
CSP-2 Rev 10/2005

### General Information and Questionnaire Type of Facility - Organization Structure

		Phone No. of Facility	V	Report for Year En	nded	Page	of
		203-729-988		09/30/10	6	2	37
Name of Facility (as shown on license)		,	). & S	Street, City, State	?, Zip)		
Naugatuck Health Care LLC d/b/a Beacon Br Center	ook Health Car	89 Weld Driv	e Nau	igatuck CT 06770	MINUTE		
	CCNH	RHNS		(Specify)		Medicare Pr	
License Numbers:	2182-C					07-53	390
Type of Facility (Check appropriate box(	es))						
Chronic and Convalescent Nursing Home only (CCNH)		Rest Home with Supervision only			(Specify)	)	
Type of Ownership (Check appropriate b	ox)						
	PARTNERSHIP	PROFIT CORP.	,	NON-PROFIT CORP.			□ <sub>TRUST</sub>
			Date	Opened	Date Clo	sed	
If this facility opened or closed during re	port year prov	ide:	ļ				
Has there been any change in ownership			L				
or operation during this report year?		□ Yes	7	No If "Y	es," expl	ain fully.	
Administrator							
Name of Administrator					ng Home		- 4
Linda Garcia				1	istrator's	100	54
01-01-0	at odm::	>== (full a= ==+ +!	<u> ۱۵۱</u> م		ense No.:	<u> </u>	<del>~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~</del>
Other Operators/Owners who are assistant Name	ui administrate	ors (ruit or part tin	10) 01		ense No.:		
Ivaliic				Lice	10		
		***************************************					
Not Applicable	····		<del></del>				
						-	

### General Information and Questionnaire Partners/Members

Name of Facility Naugatuck Health Care LLC d/b/s	a Reacon Brook Health	License No.	Report for Y	ear Ended	Page	of I
Care Center	a beacon brook freath	2182-C	9/3	0/2016	3	37
				State(s) and/o		
Legal Name of Parti		Business A		Which R		<u> </u>
Naugatuck Health Care, LL	C	234 Church St, S		C	T	
		Haven, CT 0651				
Name of Partners/Members	Business A	Address		Γitle	% Ov	vned
Lawrence G Santilli	135 South Road, F 0603	-	Ma	ınager	63.67	00%
Conservators for Lawrence E Santilli	135 South Road, F 0603				14.00	00%
	<u> </u>					

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

CSP-3A Rev. 10/2005

### General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year Ende	d	Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	2182-C	9/30/20	1.6	3A	37
	<u> </u>	· · · · · · · · · · · · · · · · · · ·		JA.	31
If this facility is owned or operated as a corp				1 Y	
Legal Name of Corporation	Busine	ss Address	State(s) in Whi	ch Incorp	porated
				1	
				No. S	hares
Name of Directors, Officers	Busine	ss Address	Title	Held by	
				11010	, 20011
Not Applicable					
1 Tot Applicable					
				<u> </u>	
Names of Stockholders Owning at Least					
10% of Shares					
1070 of Shares					
					<del></del>
					·····
				[	

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-3B Rev. 10/2005

### General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	2182-C	9/30/2016	3B	37
If this facility is owned or operated as an individual p		vide the following information	1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1	
Owner(s) of Facility				
	MICHAEL CONTRACTOR CON			
				***************************************
Not Applicable				
	************************************		<u> </u>	
	***************************************			
	<b></b>			<del></del>
				<u>,</u>
				Marriem

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-4 Rev. 10/2005

## General Information and Questionnaire Related Parties\*

Name of Facility	Name of Facility	License No.		Report for Year Ended		Page	Jo
Care Center		2182-C		9/30/2016		4	37
Are any individuals rece	Are any individuals receiving compensation from the facility related through	cility relat	ed through		If "Yes," provide the Name/Address and	e Name/Add	ress and
marriage, ability to cont	marriage, ability to control, ownership, family or business association?	ss associat	ion?	☐ Yes ☑ No	complete the information on Page 11 of the report.	ation on Pag	ge 11 of the report.
Are any individuals or c	Are any individuals or companies which provide goods or services,	or services	.6				
including the rental of p	including the rental of property or the loaning of funds to this facility,	o this facil	ity,				
related through family a	related through family association, common ownership, control, or business	control, or	r business				
association to any of the	association to any of the owners, operators, or officials of this facility?	of this faci	lity?	☑ Yes □ No	If "Yes," provide the following information:	e following i	nformation:
		Also I	Also Provides		Indicate Where		
		Goods/S	Goods/Services to		Costs are Included	***************************************	Actual Cost to the
Name of Related	Business	Non-Rela	Non-Related Parties	Description of Goods/Services	in Annual Report	Cost	Related
Individual or Company	Address	Yes	No   %**	Provided	Page # / Line #	Reported	Party
Miscellaneous Facilities	Various	<u> </u>	>86<	Interfacility Loans	Page 33, A2		
Athena Health Care	135 South Road Farmington, CT		76097	Management Services, Lobby Fees,	Pages 16, 18, & 20	6246 500	
	136 South Dood Boundardon CT	+		remp bookeching, mis	Crinici gd	00060	
Athena Health Care 401k	155 South Koad Farmington, C.1 06032	<u> </u>		Facility participates in common 401K plan			
Athena Health Care Systems	135 South Road Farmington, CT 06032	<u> </u>	] >50%	Workers Comp Captive	Page 15 1a	\$449,577	\$449,577
Athena Health Care	135 South Road Farmington, CT	-					
Insurance	06032	<u> </u>		Health Insurance	Page 15 1a5	\$1,252,416	\$1,252,416
	301 Rope Ferry Road Waterford,						
Bayview Health Care	CT 06385	3	%86<	Software Settlement	Page 16 m13	\$1,512	\$1,512
						:	
							4. 4. 4.

<sup>\*</sup> 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	License No		Report for Year Ended	Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook				_	27
Health Care Center	2182-C		9/30/2016	5	37
If the facility is licensed as CDH and/or RCH of	•	IDS or TB	services with special Medicaid	l rates, c	costs
must be allocated to CCNH and RHNS as follow	ws:				
Item			Method of Allocation		
Dietary			meals served to residents		
Laundry			pounds processed		
Housekeeping			square feet serviced		
		Number of	hours of routine care provided	by EAC	H
Nursing		employee c	lassification, i.e., Director (or C	Charge 1	Vurse),
		Registered	Nurses, Licensed Practical Nur	ses, Aid	les and
		Attendants			
Direct Resident Care Consultants		Number of	hours of resident care provided	by EA	CH
		specialist (	(See listing page 13)		
Maintenance and operation of plant		Square feet			
Property costs (depreciation)		Square feet			
Employee health and welfare		Gross salar	ies		
Management services		Appropriat	e cost center involved		
All other General Administrative expenses		Total of Di	rect and Allocated Costs		
The preparer of this report must answer the following	owing quest	ions applica	able to the cost information pro-	vided.	
1. In the preparation of this Report, were all	C) 37	□ No	If "No," explain fully why such	allocat	ion was
costs allocated as required?	Yes	□ No	not made.		
Not Applicable				*******	
	.,				
2. Explain the allocation of related company ex	penses and	attach copy	of appropriate supporting data.		· · · · · · · · · · · · · · · · · · ·
Not Applicable					
3. Did the Facility appropriately allocate and se	elf-disallow	direct and i	ndirect costs to non-nursing hor	ne cost	centers?
(e.g., Assisted Living, Home Health, Outpati	ient Services	s, Adult Day	y Care Services, etc.)		
			If "No," explain fully why such	allocat	ion was
	Yes	140	not made.	i amocat	ioii was
Outpatient services			110 11144 ·		
Outpution survives				·····	
				······································	
				······································	

Annual Report of Long-Term Care Facility State of Connecticut CSP-6 Rev. 9/2002

## General Information and Ouestionnaire 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

\$7,043 \$814 \$2,025 \$22,302 \$14,395 ot 37 Amount Claimed Page 9 \$14,395 \$22,302 \$7,043 \$1,091 \$2,025 of Lease Amount Annual 9/30/2016 Report for Year Ended Term of 66 Months 38 months 48 months 36 months 60 months Lease Lease\*\* Date of 05/22/15 02/13/13 06/24/13 12/10/10 08/19/13 Description of Items Leased 2182-C **Felephone System** Postal Equipment PCC Equipment PCC Equipment License No. Copier Related \* to % Operators, Officers Owners, >  $\Box$ D 5  $\Box$ Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Yes Pitney Bowes P.O. Box 856390, Louisville, KY 40285 Webster Capital Finance P.O. Box 330 Hartford, CT Hewlett Packard Financial Services, PO Box 402582, Atlanta, GA Hewlett Packard Financial Services, PO Box 402582, should not be included in these amounts. Name and Address of Lessor Name of Facility Atlanta, GA 06141-0330 Center LEAF

Not Applicable - No Vehicles Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also Is a Mileage Log Book Maintained for All Leased Vehicles?

\$46,579

Total \*\*\*

ž

Yes

<sup>\*\*</sup> Attach copies of newly acquired leases.

<sup>\*\*\*</sup> Amount should agree to Page 22, Line 6e.

### General Information and Questionnaire Accounting Basis

Name of Facility	License No.	Report for Year Ended		Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	2182-C	9/30/2016		7	37
		were maintained on the following basis:			
The records of and racincy for the p	Julia co. oron of ano roport				
☑ Accrual □ Cash □	Modified Cash				
Is the accounting basis for this					
[ F	Yes □	No If "No," explain.			
previous period?					
Independent Accounting Firm					
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)	<del>-</del> -		
1 Marcum LLP		555 Long Wharf Drive New Haven, C			
2 Marcum LLP		555 Long Wharf Drive New Haven, C	i		
3 4					
Services Provided by This Firm (de	escribe fully)	<u>I</u>			
2016 Tax Return & Audit				\$ 26,125	
2 9/30/15 Medicare Cost Report				\$ 2,650	
3				\$ -	
4			***************************************	s -	
·			Charge for	Services Pr	ovided
				\$28,775	
Are These Charges Reflected in the Exper	diture Portion of This Report? If Y	Yes, Specify Expense Classification and Line No.	<u> </u>		
✓ Yes □ No	Pg 15, Line1d				
Legal Services Information					
Name of Legal Firm or Independer			Telephone		
1 Goldman, Gruder, & Woods	s, LLC		203-899-89		
2 Treasurer, State of CT			860-231-24		
3 Murtha Cullina LLP	N*-4*-4		860-240-60		
4 State of CT Probate Court I	District of Naugatuck		203-720-70	U <del>4</del> 0	
Address (No. & Street, City, State,	Zip Code )		<u> </u>		
1 200 Connecticut Avenue Noi	= *				
2 186 Newington Road West H					
3 City Place 185 Asylum Stree					
4 229 Church Street Naugatud					
5					
Services Provided by This Firm (de	escribe fully ) ————————————————————————————————————			<del></del>	
1 A/R Collections (Disallow)				\$ 6,477	
2 Conservator Request (Disallow)				\$ 375	
3 UCC Filings \$345 (Disallow) Yr 20	016 file Annual report \$76 (Allow	Audit Letter \$791 (Allow) Resident Care Issue \$135	(Disallow)	\$ 1,347	
4 Conservator Request (Disallow)				\$ 82	
5			ı	<b>S</b>	
			Charge for	Services Pr	ovided
				\$8,281	
Are These Charges Reflected in the Exper	nditure Portion of This Report? If Y	Yes, Specify Expense Classification and Line No.			
☑ Yes □ No	Pg 15, Line1e				

State of Connecticut Annual Report of Long-Term Care Facility CSP-8 Rev. 9/2002

## Schedule of Resident Statistics

Na	Name of Facility			License No.	Vo.			Report	Report for Year Ended	Ended		Page	Jo
Na.	Naugatuck Health Care LLC d/b/a Beacon Brook Health C	th Care Center	_		2182-C	<i>p</i> s			09/30/16	91		∞	37
						Per	Period 10/1 Thru 6/30	1 Thru	96/30	Pe	Period 7/1	Thru 9/30	/30
<del></del>		Total All	Total	Total RHNS	Total								
		Levels	Level	Level	(Specify)	Total	CCNH	RHINS	(Specify)	Total	CCNH	RHINS (	(Specify)
<u> </u>	Certified Bed Capacity A. On last day of PREVIOUS report period	126	126			126	126			126	126		
	B. On last day of THIS report period	126	126			126	126			126	126		
5.	Number of Residents A. As of midnight of PREVIOUS report neriod	123	173			9	110			173	133		
	B. As of midnight of THIS report period	117	117			119	611			117	1117		
3.	Total Number of Days Care Provided During Peri												
	A. Medicare	989'8	8,686			7,018	7,018			1,668	1,668		
	B. Medicaid (Conn.)	33,341	33,341			24,388	24,388			8,953	8,953		
	C. Medicaid (other states)												
	D. Private Pay	1,724	1,724			1,243	1,243			481	481		
	E. State SSI for RCH												
	F. Other (Specify) Managed Care	522	522			409	409			113	113		
	G. Total Care Days During Period (3A thru F)	44,273	44,273			33,058	33,058			11,215	11,215		
4	Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved												
	Beds						•••••						•••
	A. Medicaid Bed Reserve Days	230	230			173	173			57	57		
	B. Other Bed Reserve Days	16	16			16	16						
5.	Total Resident Days (3G + 4A + 4B)	44,519	44,519			33,247	33,247			11,272	11,272		

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

CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Facil				Licer	ise No.				Report	for Year	Ended		Page	of
Naugatuck H														
Beacon Broo	k Heal	th Car	e Center		2182-C						9/30	/2016	9	37
4. Were the	re any	changes	s in the certified b	ed ca	pacity du	ring t	he repo	rt year	r?			YES 🗵	NO	
If "YES"	, provi	de the f	ollowing informa	tion:										
		Place o	of Change		С	hange	in Bed	s		С	apacity A	After Change		
			(Specify)		Lost			Gaine	d				1	
Date of	CCNH	RHNS	(1)											
Change	1		(2)	(1)	(2)	(2)	(1)	(2)	(2)	CCNILI	DLINIC	(Specify)	Donger fo	or Change
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	KUNS	(Specify)	Reason ic	or Change
													ļ	
					···						<del></del>		<u> </u>	
					· · · · · · · · · · · · · · · · · · ·									
	L	L		L	***************************************	L						L	1	
5. If there v	vas anv	change	in certified bed	canaci	tv during	the re	eport ve	ar (as	reporte	d in iten	n 4 above	e) provide the num	ber of	
		-	r 90 days followi	_	-	,	-p	(	1000110			-) provide and man		
100101	2111 122	11010	yo days follows	15 1110	onango.						·····	I	T	
			Change in R	anida.	at Davis						NH	RHNS	(Sno	aifu)
1st chang	ne en		Change in N		-						INIT	Knino	(Spe	city)
													-	
									<del></del>				<u> </u>	
6. Number of Residents and Rates on September 30 of Cost Year						L								
Medicare Medicaid						S	elf-Pay		Other Stat	e Assisted				
Item CCNH CCNH RHNS CCNH					~NIH		INS	(Specify)	R.C.H.	ICF-MR				
						2	1/1	1113	(Specify)	R.C.II.	ICI-WIK			
No. of Residents 14 98 Per Diem Rate						-								
a. One b			547.56		230.83			5/	7.00			434.14		
b. Two l		,	547.56		230.83				2.00			·		
c. Three			347.30		230.03			44.3	2.00			434.14	<u> </u>	
c. Thee														
		f Physic	cal Therapy Treat	mente		L				TO	TAL	CCNH	RHNS	(Specify)
		are - Pa		memo						10	8,800	8,800	KHING	(Specify)
			clusive of Part B)								o,c.c.	0,000		
			ce Treatments								1,507	1,507		
	2. Res	storative	Treatments		***************************************									
C.	Other										23,137	23,137		
			l Therapy Treatr								33,444	33,444		
		-	h Therapy Treatn	nents							and succession	and the second second		
		are - Pa						***************************************			1,245	1,245		
В.			clusive of Part B)											
			ce Treatments								98	98		
	<del>~~~~~~~~</del>	storative	Treatments		·····						2066			
	Other	Spaach	Therapy Treatm	ante							2,966	2,966		
			national Therapy		nente						4,309	4,309		
		are - Pa		ricaui	ilents						5,297	5,297		
			clusive of Part B)	<del></del>	······································		······································				39231	3,297		
Д,			ce Treatments								1,240	1,240		
			Treatments									2,240		
	Other										21,637	21,637		
D.	Total	Оссира	tional Therapy T	reatm	ents						28,174	28,174		

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

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

1 Copole of 122	xpenditures	- Salati				
Name of Facility	License No.		Report for Yea	r Ended	Page	. of
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	2182		9/30/2	1016	10	27
			<u> </u>	1010	10	37
Are time records maintained by all individuals receiving co	ompensation?	☑ Yes	☐ No Total Cost a	ad Harra	<del></del>	
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*	CCNH	Hours	KIINS	nouis	(Specify)	nouis
Operators/Owners (Complete also Sec. I						
of Schedule A1)						
Administrator(s) (Complete also Sec. III						
of Schedule A1)	122,516	2,120				
3. Assistant Administrator (Complete also Sec. IV		-,				
of Schedule A1)						
4. Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)	253,015	10,619				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	54,989					
c. Dietary Workers	422,662	30,977			Controllation of the Control	
Housekeeping Service						
a. Head Housekeeper	54,504	2,120				
b. Other Housekeeping Workers	274,874	21,687				
7. Repairs & Maintenance Services	55.040	2.000				
a. Engineer or Chief of Maintenance b. Other Maintenance Workers	55,842 43,695	2,099 2,623		<del> </del>		
8. Laundry Service	43,093	2,023				
a. Supervisor						
b. Other Laundry Workers	92,341	7,643				<b> </b>
Barber and Beautician Services	2=,5.1					
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	193,877	3,746				
b. RN						
1. Direct Care	579,572	16,802				<u> </u>
2. Administrative**	441,717	16,892				
c. LPN 1. Direct Care	1 112 473	42,425				
2. Administrative**	1,112,472	42,423				
d. Aides and Attendants	1,811,778	119,682		<b></b>		
e. Physical Therapists	517,248	16,378				
f. Speech Therapists	126,041					
g. Occupational Therapists	436,116	12,054				
h. Recreation Workers	144,383	7,644				
i. Physicians						
Medical Director						
Utilization Review						
3. Resident Care***						
4. Other (Specify)						
i Dontista						
j. Dentists k. Pharmacists	<del></del>	<u> </u>		<b> </b>		<b></b>
k. Pharmacists I. Podiatrists	_			ļ		
m. Social Workers/Case Management	222,244	8,155				
n. Marketing	222,244	0,133		<u> </u>		
o. Other (Specify)						
A-13. Total Salary Expenditures	6,959,886	328,614		1		

<sup>\*</sup> 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.

<sup>\*\*</sup> 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.

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

Schedule of Other Salaries and Wages (Page 10)
--

Position	S CCNH	Hours CCNH	\$ RHNS	Hours RHNS	\$ (Specify)	Hours (Specify)
					Γ ΄	
				175		
					100000	
			1000000			
Total	S -	-	S -		S -	-

### Schedule of Physician: Other Fees (Page 13)

	\$	Hours	\$	Hours	\$	Hours
Service	CCNH	CCNH	RHNS	RHNS	(Specify)	(Specify)
				0.00		
Total	\$ -	-	S -	-	S -	-

### Schedule of Other Fees (Page 13)

Service	\$ CCNH	Hours CCNH	\$ RHNS	Hours RHNS	\$ (Specify)	Hours (Specify)
		100				
		100				
			100			
				la de la company		
Total	S -	-	\$ -	-	S -	-

State of Connecticut

Annual Report of Long-Term Care Facility CSP-11 Rev. 10/2005

Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties\*

			T.	Solotant Frank	ליין ביי ליי ליי ליי ליי ליי ליי ליי ליי ליי		וארומורת ז	aruco	-	
Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health	I/b/a Beace	n Brook 1	Health	License No.		Report fo	Report for Year Ended		Page	o
Care Center				2	2182-C		9/3	9/30/2016	,I	37
		Salary Paid	-ti							
			,	Fringe Benefits and/or Other		Total	Line Where		Total	
Name	HNOO	SNHa	(Snecify)		Full Description of Services Rendered	Hours	Claimed on	Name and Address of All Other Funloyment**	Hours	Compensation
Section I - Operators/Owners										
Not Applicable										
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).										
Not Applicable										
		To an an annual control contro								

<sup>\*</sup> No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

<sup>\*\*</sup> Include all employment worked during the cost year.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

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

				A	Administrators and Other Related Farties:		ler Kelale	a Farues:		
Name of Facility (as licensed) Naugatuck Health Care LLC d/b/a Beacon Brook Health Care	b/a Beacon	Brook He	ealth Care	License No.		Report for	Report for Year Ended		Page	Jo
Center	_			2	2182-C		9/30	9/30/2016	12	37
		Salary Paid								
				Fringe Benefits						
M				and/or Other	£	Total			Total	
Name	CCNIE	DEINIC	(Specify)	Payments (decomine fully)	Full Description of	Hours Westerd		Name and Address of All	Hours	Compensation
Section III - Administrators***	CCIVII	CNILLY	(abecury)	(describe runy)	Services relidered	w orked	rage 10	Other Employment	w orked	Received
Linda P. Garcia (10/1/2015 -	713 661				Day to day operations of the nursing home					
09/30/2016)	122,516			Payroll Laxes	tacılıty.	2,120	A2			
Section IV - Assistant Administrators										
										-

<sup>\*</sup> No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

<sup>\*\*</sup> Include all other employment worked during the cost year.

<sup>\*\*\*</sup> If more than one Administrator is reported, include dates of employment for each.

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

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	<u> </u>	Report for Y		Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook Health			_			
Care Center	2182	2-C	9/30/2		13	37
			Total Cost a	nd Hours	1	I
Item	CCNH	TT	RHNS	*******	(0:6)	TT
*B. Direct care consultants paid on a fee	CCNH	Hours	Krins	Hours	(Specify)	Hours
for service basis in lieu of salary						
(For all such services complete Schedule B1)						
1. Dietitian.	14,716	375				
2. Dentist	1,800	6				
3. Pharmacist	9,534	131				
4. Podiatrist		<del></del>				
5. Physical Therapy						
a. Resident Care	187,219	2,957				
b. Other.						
6. Social Worker						-
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	50,400	274				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**	56					
d. Administrative Services facility  1. Infection Control Committee						
(Quarterly meetings)						
2. Pharmaceutical Committee		······································				***************************************
(Quarterly meetings)						
Staff Development Committee						
(Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	39,148	490	<del></del>			
b. Other						
10. Occupational Therapist						
a. Resident Care	2,659	<del>~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~</del>				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	10 100	20				
2. Administrative*** b. LPN	12,128	32				
1. Direct Care 2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	-					
B-13 Total Fees Paid in Lieu of Salaries  * Do not include in this section management consultants or services which	317,660	4,263				

<sup>\*</sup> 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.

<sup>\*\*</sup> 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.

<sup>\*\*\*</sup> 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.

State of Connecticut

Annual Report of Long-Term Care Facility
CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees (Medical Director Detail)

b. Report of Expenditures 11 oresional rees (Nituateur Director Delan)								
Name of Facility		License No.		Report for Y	port for Year Ended		of	
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care	Center	2182-C 9/30/2016		13 a	37			
				Total Cost and	d Hours			
Item		CCNH	Hours	RHNS	Hours	(Specify)	Hours	
8.	Physicians							
a.	Medical Director Detail	0	274	0	0	0	0	

ProHealth / Dr. Miller \$20,400 108.25 hours Alliance Medical Group Inc (Dr. Elser) \$30,000 165.25 hours

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

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Bro	alr Waalth	License No.		Report for Year Ende		Page	of
Care Center	ок пеани	2182-C		9/30	/2016	14	37
				to Owners,			
Name & Address of Individual	Full Expla	nation of Service		rs, Officers	Expla	nation of R	elationship
Advanced Medical Personnel P.O. Box 392450 Pittsburgh, PA 15251-9450	Physical a	& Speech Therapy	Yes	No 🗹			
Mary Jane Leonetti, 245 Cherry Avenue Unit 21N Watertown, CT 06795		Dietician		Ø			
Robert Badrigian, 5 South Main St, Suite 515 Branford, CT 06405		Dentist		Ø			
Omnicare/Value Health Care Services, Inc 525 Knotter Drive Cheshire, CT 06410		harmacist		Ø			
Access Therapies, P.O.Box 823461, Philadelphia, PA	Phys	sical Therapy		Ø			
Alliance Medical Group Inc (Dr. Elser), 1801 W Olympic Blvd File 2201 Pasadena, CA 91199-		Director, Physician		Ø			
SDX Swallowing Diagnostics, 21 Waterville Rd, Avon, CT 06001	Spe	ech Therapy		Ø			
ProHealth / Dr. Neil Miller, 3 Farm Glen Road Farmington, CT 06032	M	edical Staff		Ø			
Athena Health Care Systems 135 South Road Farmington, CT 06032	M	IDS Fill-in	Ø		Common Owe	nrship	
AMN Healthcare Allied Therapy PO Box 281939 Atlanta, GA 30384		Therapy		Ø			
Malie Guerini Associates 222 Boston Avenue Stratford, CT 06614	Nurse	Placement Fee		Ø			

<sup>\*</sup> Use additional sheets if necessary

<sup>\*\*</sup> Refer to Page 4 for definition of related.

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

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health	icense No.	o. Report for Year Ended		Page	of
	182-C	9/30/2016		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
Workmen's Compensation	\$	449,577	449,577		
2. Disability Insurance	\$				
3. Unemployment Insurance	\$	132,780	132,780		
4. Social Security (F.I.C.A.)	\$	519,560	519,560		
5. Health Insurance	\$	1,108,570	1,108,570		
6. Life Insurance (employees only)					
(not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory)	\$	40,155	40,155		
(not-owners and not-operators)					
8. Uniform Allowance	\$				
9. Other ( <i>Specify</i> )	\$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and	\$			:	
Profit Sharing Plans for Owners and					
Operators (Discriminatory)*					
•		14 H 18 H			
c. Bad Debts*	\$	59,121	59,121		
d. Accounting and Auditing	\$	28,775	28,775		
e. Legal (Services should be fully described on P	age 7) \$	8,281	8,281		
f. Insurance on Lives of Owners and	\$				
Operators (Specify)*			100		
g. Office Supplies	\$	53,914	53,914		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	20,008	20,008		
2. Cellular Phones	\$	2,309	2,309		
i. Appraisal (Specify purpose and	\$				
attach copy)*					
j. Corporation Business Taxes (franchise tax).	\$				
k. Other Taxes (Not related to property - See Page	ge 22)				
1. Income*	\$				The second secon
2. Other (Specify)	\$				
See Attached Schedule					
3. Resident Day User Fee	\$	753,210	753,210		
Subtotal	\$	3,176,260	3,176,260		
				tala familiand	<u> </u>

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

### **Schedule of Other Employee Benefits**

Description	CCNH	RHNS	(Specify)
	100000		
		(2)	
			and the second
			1000
		100	
Total	\$ -	\$ -	\$ -

### **Schedule of Other Taxes**

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

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

Name of Facility	License No.		Report for Year Ended		Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook Health					• •	277
Care Center	2182-C		9/30/2016		16	37
Item			Total	CCNH	RHNS	(Specify)
	ls Brought Forwa	rd:	3,176,260	3,176,260		
l. Travel and Entertainment						
Resident Travel and Entertainment		\$			***************************************	
2. Holiday Parties for Staff		\$	5,055	5,055	***************************************	
3. Gifts to Staff and Residents		\$	9,335	9,335		
4. Employee Travel		\$	1,509	1,509		
5. Education Expenses Related to Seminars ar		\$	4,667	4,667		
6. Automobile Expense (not purchase or depr		\$				
7. Other ( <i>Specify</i> )	•••••	\$				
See Attached Schedule						
m. Other Administrative and General Expenses			an de la company			
1. Advertising Help Wanted (all such expense		\$	14,546	14,546		
2. Advertising Telephone Directory (all such e		\$	1,230	1,230		
3. Advertising Other (Specify)***	•••••	\$	16,302	16,302		
See Attached Schedule						
4. Fund-Raising***		\$				
5. Medical Records		\$				
6. Barber and Beauty Supplies (if this service		\$				
directly and not by contract or fee for service						
7. Postage		\$	7,982	7,982		
* 8. Dues and Membership Fees to Professional		\$	8,586	8,586		
Associations (Specify)						
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other Non-A		\$				
9. Subscriptions		\$	650	650		
10. Contributions***		\$				
See Attached Schedule						
11. Services Provided by Contract (Specify and		\$				
Schedule C-2, Page 21 for each firm or ind						
12. Administrative Management Services**		\$	155,467	155,467	······································	
13. Other (Specify)		\$	114,650	114,650		
See Attached Schedule						
C-14 Total Administrative & General Expenditures		\$	3,516,239	3,516,239		

<sup>\*</sup> Do not include Subscriptions, which should go in item 9.

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

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

### Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
	200		
Total Other Travel and Entertainment	S -	S -	\$ -

### Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	\$ 16,302		
		100	
Total Other Advertising	\$ 16,302	\$ -	\$ -

### Schedule of Dues

Description	CCNH	RHNS	(Specify)
Description CHACF	\$ 8,586		
	220 2.00		
Total Dues	\$ 8,586	S -	S -

### **Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
	10.00		
		100	
Total Contributions	\$ -	\$ -	\$ -

### Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Lobbying Fees	\$ 4,220		
Licenses	\$ 1,070		
Bank Charges	\$ 8,903		
Payroll Processing Fees	\$ 22,772		
Employee Physicals & Background Checks	\$ 19,703		
Data Processing Fees	\$ 47,265		
Compliance Consulting	\$ 10,297		
Energy Audit	\$ 420	100	
The state of the s			
Total Other Administrative and General	\$ 114,650	\$ -	\$ -

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

Name of Facility Naugatuck Health Care LLC d/b/a Beacon	License No.	Report for Year Ended	Page of
Brook Health Care Center	2182-C	9/30/2016	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 #
Athena Health Care Assoc., Inc			
135 South Road	\$180,792	Contract Attached to a	
Farmington, CT 06032		Prior Year	See Below
Allocation of the Above	\$119,323	Admin/Gen 66%	Pg 16, Line 12
	\$28,927	Indirect 16%	Pg 18, Line 2C
	\$32,543	Direct 18%	Pg 20, Line 5J
Athena Health Care Assoc., Inc 135 South Road	\$36,144	Admin/Gen - Other Exp	Pg 16, Line 12
Farmington, CT 06032			

<sup>\*</sup> 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.

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

CSP-18 Rev. 9/2002

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

		<del>,</del>		i age 3	<del>,                                    </del>		1 1	7	
Name	e of Facility atuck Health Care LLC d/b/a Beacon Brook	License	No.		Repo	rt for Y	ear Ended	Page	of
-	h Care Center		2182-0	C .		9/30	/2016	18	37
	Item	<u> </u>		otal	C	CNH	RHNS	(Sp	ecify)
2.	Dietary	•							3,
	a. In-House Preparation & Service						10 (10 m) (10 m)		
	1. Raw Food	\$		275,362	2	275,362	AND AND TOWNS AND THE STORY STORY ASSESSMENT AND		
	2. Non-Food Supplies	\$		27,771		27,771			
	3. Other (Specify)	\$		5,216		5,216			
	Dishes = \$5,216								
	b. Purchased Services (by contract other	\$							
	than through Management Services)								
	(Complete Schedule C-2 att. Page 21)								
	c. Management Services**	\$		28,927		28,927			
	d. Other (Specify)	\$							
2E.	Total Dietary Expenditures $(2a + b + c + d)$	\$		337,276		337,276			
2F.	Dietary Questionnaire		П	otal	C	CNH	RHNS	(Sp	ecify)
G.	Resident Meals: Total no. of meals served per	r day:*		363		363			
H.	Is cost of employee meals included in 2E?		7	Yes		No			
	Did you receive revenue from employees?			Yes	\(\overline{1}\)	No	If yes, speci	fy amount	•
J.	Where is the revenue received reported in the	Cost Re	eport?	(Page/L	ine It	em)			
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	n	Ø	Yes		No	If yes, specia	fy cost. =	\$180
L.	Is any revenue collected from these people?			Yes	Į.	No	If yes, specif	fy amount	
M.	Where is the revenue received reported in the	Cost Re	eport?	(Page/L	ine It	em)			
N.	Is cost of food (other than meals, e.g., snacks monthly staff meetings, board meetings) provemployees included in 2E?			Yes	Ø	No	If yes, speci	fy cost.	
O.	Is any revenue collected from employees?			Yes	Image: section of the content of the	No	If yes, specif	fy amount	•
	Where is the revenue received reported in the							· <del></del>	~~~

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

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

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

LLTHING	atuck Health Care LLC d/b/a Beacon Brook Health	License	NO.		Kepc	ort for Y	Year Ended	Page	of
Care	Center	2	182-0			9/30	/2016	19	37
	Item		Т	otal	C	CNH RHNS (Sp		pecify)	
1	Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies,	Lbs.							
	gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$							
	<ol><li>Employee items including uniforms, gowns, etc. washed, ironed and/or</li></ol>	Lbs.							
	processed.***	Amt. \$							
	3. Personal clothing of residents	Lbs.							
	washed, ironed, and/or processed.***	Amt. \$							
	4. Repair and/or purchase of linens.***	Lbs.							
		Amt. \$		10,848		10,848			
	b. Purchased Services (by contract other	\$	olasiiantinteleksistensi.			Vinteren anylokopi ir iskil			
	than through Management Services)								
	(Complete Schedule C-2 att. Page 21)								
	c. Management Services**	\$							
1	d. Other (Specify)	\$		8,981		8,981			
	Supplies = \$8,981						n n		
3E.	Total Laundry Expenditures $(3a + b + c + d)$	\$		19,829		19,829			
3F.	Laundry Questionnaire								
G.	Is cost of employee laundry included in 3E?			Yes	\( \overline{1} \)	No	If yes, specif	y cost.	
H.	Did you receive revenue from employees?	. ,		Yes	V	No	If yes, specif	y amoun	t.
I.	Where is the revenue received reported in the Co	st Repor	t?		(Pag	ge/Line	Item)		
1.7.	Is Cost of laundry provided to persons other than employees or residents included in 3E?			Yes	Ø	No	If yes, specif	y cost.	
K.	Did you receive revenue from these people?			Yes	IJ	No	If yes, specif	ỳ amoun	t.
L.	Where is the revenue received reported in the Co	st Repor	t?		(Pag	ge/Line	Item)		

<sup>\*</sup> 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.

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

<sup>\*\*\*</sup> 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)

	ne of Facility	License No.	Repo	ort for Year E	nded	Page	of
	gatuck Health Care LLC d/b/a Beacon Brook th Care Center	2182-C		9/30/2	2016	20	37
	Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping a. In-House Care	Sq. Ft. Serviced					
	1. Supplies - Cleaning (Mops, pails, brooms, etc.)	by Personnel Amt.	\$	34,473	34,473		
	b. Purchased Services (by contract other than through Management Services)	Sq. Ft. Serviced by Personnel					
	(Complete Schedule C-2 att. Page 21)	Amt.	\$				
	c. Management Services*		\$				
	d. Other (Specify)		\$				
4E.	Total Housekeeping Expenditures (4a +	b+c+d)	\$	34,473	34,473		
5.	Resident Care (Supplies)**						
	a. Prescription Drugs***						
	1. Own Pharmacy		\$				
	2. Purchased from		\$	506,338	506,338		
	Omni Care			en en en en en en			7
	b. Medicine Cabinet Drugs		\$	5,682	5,682		
	c. Medical and Therapeutic Supplies			281,172	281,172		·
	d. Ambulance/Limousine***		\$	10,004	10,004		
	e. Oxygen						
	1. For Emergency Use		\$				
	2. Other***		\$	49,715	49,715		
	f. X-rays and Related Radiological		\$	51,510	51,510		
	Procedures***						
	g. Dental (Not dentists who should be inc		\$				
	salaries or fees)						
<u></u>	h. Laboratory***		\$	48,143	48,143		
<u></u>	i. Recreation		\$	22,522	22,522		
	j. Other (Specify)****		\$	198,311	198,311		
	See Attached Schedule						
5K.	Total Resident Care Expenditures (5a - 5	5j)	\$	1,173,397	1,173,397		

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

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

<sup>\*\*\*</sup> Facility should self-disallow the expense on Page 29 of the Cost Report.

<sup>\*\*\*\*</sup> ICFMR's should provide a detailed schedule of all Day Program Costs.

### Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center 9/30/2016

Attachment Page 20

### **Schedule of Other Resident Care**

Description	(	CCNH	RHNS	(Specify)
Management Fee Direct	\$	32,543		
Medical Equip Rentals-Medicaid	\$	57,426		
Physical Therapy Supplies	\$	38,152		
Occupational Therapy Supplies	\$	11,220		
Oxygen Concentrator Rentals	\$	6,566		
Cable Television	\$	13,597		
Speech Therapy Supplies	\$	117		
Medical Equip Rentals-Other	\$	38,690	100	
				0.00
				100
		100		
				100
				a constant
Total Other Resident Care	\$	198,311	\$ -	\$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 10/2001

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

Name of Facility				License No.	Report for Year Ended	-			Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	a Beacon Brook Health C	are Center		2182-C	9/30/	9/30/2016			21	37
		Related ** to	d ** to							
		Owners, Operators,	Operators,			•	( ) ( )	÷	***	
		Oilicers	cers				I otal Cost	I otal Cost/Fage Kel.		
Name of Individual or Company	Address	Yes	Z	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	(Specify)	ρφ	Line
	100 Corporate Drive, Windsor, CT 06095		Image: control of the		Payroll Processing	19,079			91	m13
CT Waste Processing	P.O. Box 415 Plainville, CT 06062		2		Rubbish Removal	23,771			22	J9
Harmony Health Care International Inc.	7		5		Compliance Consulting	10,298			16/ 16A	1m13
Omnicare	525 Knotter Dr, Cheshire, CT		2		Pharmacy Services	498,147			20	12, 2C, 5J
										lm13
									11.75311.1	
									1 10 201 11 20 10 10	
									1-801-0-1-0-0-0	
	•									

<sup>\*</sup> List all contracted services over \$10,000. Use additional sheets if necessary.

<sup>\*\*</sup> Refer to Page 4 for definition of related.

<sup>\*\*\*</sup> 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 Y	ear Ended		Page	of
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	2182-C		9/30/2016		22	37
Item	7 2102 C	Total	CCNH	RHNS		ecify)
6. Maintenance & Operation of Plant			001111		(5)	••••
a. Repairs & Maintenance	\$	78,441	78,441			
b. Heat.		51,529	51,529			
c. Light & Power	\$	156,191	156,191			
d. Water	<del></del>	48,626	48,626			
e. Equipment Lease (Provide detail on p		46,579	46,579			·····
f. Other (itemize)		61,288	61,288			
See Attached Schedule			and the second			
6g. Total Maint. & Operating Expense (6a	- 6f)\$	442,654	442,654			
7. Depreciation (complete schedule page 23	3*)					
a. Land Improvements	\$	1,770	1,770			
b. Building & Building Improvements	\$	292,921	292,921			
c. Non-Movable Equipment	\$	15,559	15,559			
d. Movable Equipment	\$	72,822	72,822			
*7e. Total Depreciation Costs $(7a + b + c + c)$	d)\$	383,072	383,072			
8. Amortization (Complete att. Schedule Po	age 24*)					
a. Organization Expense	\$					
b. Mortgage Expense	\$	17,144	17,144			
c. Leasehold Improvements	\$					
d. Other (Specify)	\$	332	332			
*8e. Total Amortization Costs (8a + b + c + c	d)\$	17,476	17,476		<u> </u>	
9. Rental payments on leased real property	less					
real estate taxes included in item 10b	\$					
10. Property Taxes						
a. Real estate taxes paid by owner	\$	212,981	212,981			
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes		21,603	21,603			
11. Total Property Expenses (7e + 8e + 9 +	10)\$	635,132	635,132			

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

### Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center 9/30/2016

Attachment Page 22

### Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Groundskeeping	\$ 9,448		
Rubbish Removal	\$ 23,771		
Snow Removal	\$ 4,998		
Supplies	\$ 23,071		
Total Other Repairs and Maintenance	\$ 61,288	\$ -	\$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-23 Rev. 10/2006

License No.   Report for Year En			Depreciation Schedule	tion Sc	hedule					
Historical Cost   Less   Cost to Be   Beginning of Land   Value   Depreciation to S2,076   S2,0775   S2	Name of Facility		License No.			Report for Year E	nded,		Page	Jo
Historical   Less   Cost to Be   Beginning of Land   Salvage   Cost to Be   Beginning of Land   Value   Depreciation to Depreciation to	Vaugatuck Health Care L.L.C d/b/a Beacon Brook Health Car	e Center		2182-C		76	30/2016		23	37
Land Improvements   Property Item   Land   Value   Depreciated   Value   Depreciated   Pergimming of Enginemy			Historical	Less		Accumulated Depreciation to	Method of	1 0		
Land Improvements	Property Item		Exclusive of Land	Salvage	Cost to Be Depreciated	Beginning of Year's Operations	Computing Depreciation	Useful Life	Deprectation for This Year	Totals
1. Acquired during this report period (attach schedule)	Land Improvements		201 (21		160 405	152 005	1/3	Various	1 770	
Subtotal   Subtotal during this report period (attach schedule)   Subtotal during this report period (attach schedule)   Subtotal   Subtotal during this report period (attach schedule)   Subtotal   Subtotal during this report period (attach schedule)   Subtotal Depreciation   Subtotal Subto	Acquired prior to this report period     Disposals (attach schedule)		102,473		104,422	134,703	3 0	choire v	277,	
Subtotal   Subtotal	3. Acquired during this report period (attach schedule	(4					S/L	Various		
1. Acquired prior to this report period (attach schedule)	A-4. Subtotal									1,770
1. Acquired during this report period (attach schedule)			0 371 702		9 321 702	4 890 970	S/I	Varions	290.264	
Subtotal	2 Disnosals (attach schedule)		77,427,0		-0.6.					
Non-Movable Equipment	3 Acquired during this report period (attach schedule	(6)	52.076		52.076		S/L	Various	2,657	
1. Acquired prior to this report period   2. Disposals (attach schedule)   3. Acquired during this report period   4. Acquired during this report period	S				,					292,921
State   Schedule   State   S										
ls (attach schedule)  d during this report period (attach schedule)  ls a mileage logbook maintained?  Accumulated Cost to Be Exclusive of Salvage rof each vehicle)  e Equipment chiefe S(Specify name, model rof each vehicle)  inced prior to this report period uired during this report period chiefe during this report period chief	<ol> <li>Acquired prior to this report period</li> </ol>		321,793		321,793	235,742	SF	Various	15,559	
d during this report period (attach schedule)           Is a mileage logbook maintained? Acquisition         Date of logbook alignment         Historical cost         Less         Accumulated Depreciation to Depreciation and Depreciation and Depreciation to Depreciation and Depreciation and Depreciation to Depreciation and Dep	2. Disposals (attach schedule)									
Is a mileage   Is a mileage   Iogbook   Date of maintained?   Acquisition   Acquisition   Acquisition   Cost   Less   Depreciation to   Depreciation   Depreciation   Depreciation   Accumulated   Acquisition   A	<ol> <li>Acquired during this report period (attach schedule</li> </ol>	(6)					SF	Various		
Samileage	C-4. Subtotal.									15,559
Movable Equipment         Yes         No         Month         Year         Land         Value         Depreciated         Year's Operations           1. Motor Vehicles (Specify name, model and year of each vehicle)         a.         Image: Cost to Be and propertion of each vehicle)         <	Is a mil logbo maintai		Historical Cost	Less		Accumulated Depreciation to	Method of			
Movable Equipment	Yes	Month		Salvage Value	Cost to Be Depreciated	Beginning of Year's Operations	Computing Depreciation	Useful Life	Depreciation for This Year	Totals
and year of each Vehicle)  a. b.  c. d.  d.  2. Movable Equipment a. Acquired prior to this report period b. Disposals (attach schedule) c. Acquired during this report period (attach schedule) 3. Subtotal										
b. c. Movable Equipment a. Acquired prior to this report period b. Disposals (attach schedule) c. Acquired during this report period (attach schedule) 3. Subtotal	and year of each vehicle) a.									
c. Movable Equipment a. Acquired prior to this report period b. Disposals (attach schedule) c. Acquired during this report period (attach schedule) 3. Subtotal	b,									
2. Movable Equipment       9       2015       950,792       641,658         a. Acquired prior to this report period       9       2015       950,792       641,658         b. Disposals (attach schedule)       c. Acquired during this report period (attach schedule)       9       2016       28,893       28,893       28,893         3. Subtotal       Total Deprectation	C.									
a. Acquired prior to this report period b. Disposals (attach schedule) c. Acquired during this report period										
b. Disposals (attach schedule)  c. Acquired during this report period		一			950,792	641,658	S/L	Various	70,911	
c. Acquired during this report period         9         2016         28,893         28,893         28,893           3. Subtotal	b. Disposals (attach schedule)									
3. Subtotal	c. Acquired during this report period (attach schedule)				28,893		S/L	Various	116,1	
	D-3. Subtotal					7				72,822
	E. Total Depreciation									383,072

Useful

### Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
Total additions for Land Imp	rovements	\$ -		\$ -
Deletions:				
		100		
- 100 PM				
Total deletions for Land Imp	rovements	\$ -		S -

<sup>\*</sup>Ties to Page 23, Line A3

### Schedule of Building Improvements Acquired during this report period

S	Description of Item	Cost	Useful Life	Depreciation
Acquisition Date Additions:	Description of Item			Depreciation
Additions.				
Various	See Attached List	\$ 2,042	5	\$ 204
Various	See Attached List	\$ 1,255	7	\$ 90
Various	See Attached List	\$ 5,800	8	\$ 363
Various	See Attached List	\$ 34,986	10	\$ 1,749
Various	See Attached List	\$ 6,238	15	\$ 208
Various	See Attached List	<b>S</b> 1,755	20	\$ 44
		2.00		
		9.00		
Total additions for Bu	ilding Improvements	\$ 52,076		\$ 2,657
Deletions:				
	The second of th			
Total deletions for Bu	Ilding Improvements	\$ -		\$ -

<sup>\*</sup>Ties to Page 23, Line B3

### Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
				-
				+
	The state of the s			
Total additions for Non-Mova	ble Fauinment	s -		S -
Deletions:	Die Equipment	9		
Deletions.				
				100
	and the second s			
	100			
				0.00
Total deletions for Non-Mova	ble Equipment	\$ -		\$ -

<sup>\*</sup>Ties to Page 23, Line C3

<sup>\*\*</sup>Ties to Page 23, Line A2

<sup>\*\*</sup>Ties to Page 23, Line B2

<sup>\*\*</sup>Ties to Page 23, Line C2

	BEACON BROOK HEALTH CARE CENTER BUILDING IMPROVEMENTS 9/30/2016	ACCT:#	1922
DATE VENDOR	DESCRIPTION	IIEE	AMOUNT\$
BALANCE 9/30/15			\$3,547,885.27
10/31/2015 KTL Trucking & Backhoe    KTL Trucking & Backhoe    Emerald Resources 1/31/2016 Fire Control Service Co. 3/31/2016 Fire Service Group    Modern Mechanical    Inpro 6/30/2016 All Trade Industries, LLC    Write Way Signs & Designs 7/31/2016 Emcor Services    Emcor Services    West Hartford Fence Company    TNT Refrigeration    TNT Refrigeration 8/31/2016 Mechanical & Pump Services    Emcor Services	Removed 20x 20 Asphalt patch & regrade with 4" new asphalt Remove 700' of Asphalt curbing and Replace Secure Care System Key Pads & Power Supply Wiring for Horns for the Fire Panel Kitchen Sprinkler Heads B & G Circulator Pump Wallcovering Trap Installation Sign and Awning recover Water Source Heat Pump Qty 1 Water Source Heat Pump Qty 2 Vinyl Fence Water Source Heat Pump Thermostatic Expansion Valve Water Source Heat Pump Replace Pumps in Interior Sewer Ejector Pit Water Source Heat Pump Qty 2 TOTAL ACQUSITIONS FOR FYE 2016 BALANCE 9/30/16	8 8 7 10 10 10 5 20 10 10 10 10 10 5 15	\$1,600.00 \$4,200.00 \$1,254.93 \$1,233.66 \$1,210.95 \$2,711.12 \$1,378.80 \$1,754.78 \$6,088.01 \$2,968.23 \$5,723.76 \$3,477.65 \$5,849.25 \$663.62 \$6,237.83 \$5,723.76 \$52,076.35

### Schedule of Movable Equipment Acquired during this report period

Acquisition Date Additions:	Description of Item	Cost	Useful Life Depreciati
Various	See Attached	\$ 10,587	5 \$ 1,05
Various	See Attached	\$ 12,619	10 \$ 63
Various	See Attached	\$ 3,772	12 \$ 15
Various	See Attached	\$ 1,915	15 \$ 6
v ar ious	See Attached	3 1,312	10 9 0
A Committee of the Comm			
Total additions for Mov	able Equipment	\$ 28,893	\$ 1,91
Deletions:			
ocicions.			
Total deletions for Mov		\$ -	\$ -

<sup>\*</sup>Ties to Page 23, Line D2c

<sup>\*\*</sup>Ties to Page 23, Line D2b

# BEACON BROOK HEALTH CARE CENTER FURNITURE & EQUIPMENT

9/30/2016

اتات		
		COLUMN ST

DATE	DESCRIPTION	LIFE	AMOUNT \$
<u>.                                    </u>	BALANCE AT 9/30/15		\$937,133.52
Dec-15	McKesson PLTFRM MAT BARI ELECT	12	\$3,772.44
	Hill Rom Bariatric Bed, SAE Mattress, & Blowe	5	\$9,930.87
Mar-16	Kittredge	10	\$3,891.51
	Kittredge	10	\$5,840.41
	McKesson Bariatric Parallel Bar	15	\$1,915.37
1/31/2015	Daniels Equipment Washer	15	\$13,658.53
6/30/2016	Grainger	5	\$655.65
9/30/2016	Kittredge	10	\$2,887.40
	TOTAL ACQUISITIONS FOR Y/E 2016		\$42,552.18
	BALANCE 9/30/16		\$979,685.70

Daniels Wisher 13659 Moved from Non Moveder

Per Steete request

Perior year cost report

### Schedule of Leasehold Improvements Acquired during this report period

Description of Item	Cont	Usetui	Dammaiatian
Description of Rem	Cost	The	Depreciation
20 (1993) (1994)			
			1
			-
		-	-
		-	
		1	1
			1000
Improvements	\$ -		\$ -
	-		
Charles The Charles and Charles and Charles			
Improvements	S -		\$ -
		Improvements \$ -	Description of Item  Cost Life  Improvements  S -

<sup>\*</sup>Ties to Page 24, Line C3
\*\*Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility CSP-24 Rev. 10/2006 State of Connecticut

# Amortization Schedule\*

Nan	Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health Care	ealth Care		License No.		Report for Year Ended	r Ended		Page	Jo
Center	ter			2182-C	-с		9/30/2016		24	37
						Accumulated				
		Date of		NACE AND ADDRESS OF THE PARTY O		Amort. to				*********
		Acquisition	ion			Beginning of	Basis for			
······································				Length of	Cost to Be	Year's	Computing	Rate	Amortization	
	Item	Month Y	Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
A.	Organization Expense									
	1.									
	2.									
	3.									
A-4	A-4. Subtotal									
B.	Mortgage Expense									
	1. Finance Fees - Santander	9 2(	2016 6	6 yrs	91,342		SL	0	17,144	
	2.									
	3.									
B-4	B-4. Subtotal									17,144
ن	Leasehold Improvements and									
	Other (Specify)				. Har Harder war					
	1. Acquired prior to this report period	7(	2015 V	Various	1,128,829	150,746		Var	332	
	2. Disposals (attach schedule)									
	3. Acquired during this report period									
	(attach schedule)	20	2016 V	Various				Var		
C-4.	C-4. Subtotal									332
<u>.</u>	Total Amortization									17,476

\* 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.

State of Connecticut Annual Report of Long-Term Care Facility

Amortization Schedule - Detail of Leasehold Improvements & Other

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook Health Care	Health Care	License No.	No.		Report for Year Ended	ır Ended		Page	Jo
Center			2182-C			9/30/2016		24A	37
C. Leasehold Improvements									10 To
(Specify)		······································	***********						
1. Acquired prior to this report period	2015	15	<del></del>						
2. Disposals (attach schedule)									
3. Acquired during this report period	2016	91							
C-4. Subtotal									
C. Other (Specify)									
1 Dod I Someo Dimeters	1001			107 500	77000		; ; pd		
1. Ded Licelise rurgiase	7 17	97 113 yrs		1,127,300	150,746   None	None	None		
2. Wound Vac Warranty	7 2014	14		1,329		None	None	332	
C-4. Subtotal					0				332
Total Acquired prior to this report period	2015	15 Various		1,128,829	150,746		Var	332	
Total Disposals									e de la companya de l
Total Acquired during this report period	2016	16 Various					Var		14 AB

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

Reath Care Center   2182-C   9/30/2016   2.5   37	· · · · · · · · · · · · · · · · · · ·	License No.	Report for Year En	ded		Page of
11. Property Questionnaire  Part A  Is the property either owned by the Facility or leased from a Related Party*?  *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  2. Date Structure Completed  3. If NOT Original Owner, Date of Purchase  4. Date of Initial Licensure  11/01/93  5. Total Licensed Bed Capacity  6. Square Footage  7. Acquisition Cost  a. Land  546,300  b. Building  5,739,513  Part B - Owner and Related Parties  1. Financing  a. Type of Financing (e.g., fixed, variable)  b. Date Mortgage Obtained  10/16/06  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 9/30/2016  Complete if Mortgage was Refinanced  During Current Cost Year  g. Type of Financing (e.g., fixed, variable)  h. Date of Refinancing  g. Type of Financing (e.g., fixed, variable)  h. Date of Refinancing  g. Type of Financing (e.g., fixed, variable)  h. Date of Refinancing  g. Type of Financing (e.g., fixed, variable)  h. Date of Refinancing  g. Type of Financing (e.g., fixed, variable)  h. Date of Refinancing  g. Type of Financing (e.g., fixed, variable)  h. Date of Refinancing  g. Type of Financing (e.g., fixed, variable)  h. Date of Refinancing  g. Type of Financing (e.g., fixed, variable)  h. Date of Refinancing  g. Type of Financing (e.g., fixed, variable)  h. Date of Refinancing  g. Type of Financing (e.g., fixed, variable)  y. Type of Financing (e.g., fixed, variable)  y. Variable  y.	Naugatuck Health Care LLC d/b/a Beacon Brook	2192.0		0/20/0016		05 1 25
Part A  Is the property either owned by the Facility or leased from a Related Party*?  Is the property either owned by the Facility or leased from a Related Party*?  If "No," complete Part for No, " complete Part for No," complet	Heatti Care Center	2182-C		9/30/2016		1 25   37
Is the property either owned by the Facility or leased from a Related Party*?  If "Yes," complete Part *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  Date Land Purchased  2. Date Structure Completed  3. If NOT Original Owner, Date of Purchase  4. Date of Initial Licensure  5. Total Licensed Bed Capacity  6. Square Footage  7. Acquisition Cost  a. Land  S46,300  b. Building  5.739,513  Part B - Owner and Related Parties  1st 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 9/30/2016  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  3. 31%  j. Term of Mortgage (number of years)  6 Interest Rate  3. 31%  j. Term of Mortgage (number of years)  6 Interest Rate  3. 31%  John Mortgage  No If "Yes," complete Part If "No," complete Part If If "No," complete Part If If "No," complete Part It If "No," complete Part It If If "No," complete Part It It If	11. Property Questionnaire					
Is the property either owned by the Facility or leased from a Related Party*?  *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  Desc	Part A					
*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  Date Land Purchased  Date Structure Completed  In Date Land Purchased  Date of Initial Licensure  Licensure  Licensure  Linding  Total Licensed Bed Capacity  Square Footage  Acquisition Cost  Land  Building  Square Footage  Ist Mortgage  Ist Mortgage  Ist Mortgage  The Owner and Related Parties  Ist Mortgage  Lifensuring  Total Licensure  Litensure  L				[7] Vec	П Мо	If "Yes," complete Part B.
business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.  Description Total  Description Total  Not Current Completed Total  Not Original Owner, Date of Purchase Licensure Completed Total Licensure Completed Square Footage Total Licensed Bed Capacity Square Footage That Acquisition Cost Land Suilding States Completed Titlot/93  Land States Completed Titlot/93  Land States Completed Square Footage That B - Owner and Related Parties Titlot/93  Part B - Owner and Related Parties Titlot/93  Land States Complete Cost Year Variable Date Mortgage Obtained Total  Variable Total  Variable Total  Variable Total  Variable Total  Variable Total  Tota		-	•		□ 140	If "No," complete Part C.
Description Description Total Date Land Purchased Date Structure Completed Total Date of Initial Licensure Total Licensed Bed Capacity Square Footage Taken and Related Parties Term of Mortgage Obtained Total Mortgage was Refinanced During Current Cost Year Type of Financing (e.g., fixed, variable) Total Licensed Balance outstanding as of 9/30/2016  Complete if Mortgage was Refinanced During Current Cost Year Type of Fefinancing (e.g., fixed, variable) Type of Financing (e.g., fixed, variable) Total	*If any owner or operator of this fac	ility is related by family	, marriage, ownership, abil	ity to control or		
Description 1. Date Land Purchased 2. Date Structure Completed 3. If NOT Original Owner, Date of Purchase 4. Date of Initial Licensure 5. Total Licensed Bed Capacity 6. Square Footage 7. Acquisition Cost a. Land b. Building 5,739,513  Part B - Owner and Related Parties 1st 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 9/30/2016  Complete if Mortgage was Refinanced During Current Cost Year g. Type of Financing (e.g., fixed, variable) b. Date of Refinancing i. New Interest Rate 3,31% j. Term of Mortgage (number of years) 6		r organization from who	om buildings are leased, the	n it is considered		
1. Date Land Purchased 2. Date Structure Completed 3. If NOT Original Owner, Date of Purchase 4. Date of Initial Licensure 5. Total Licensed Bed Capacity 6. Square Footage 7. Acquisition Cost a. Land b. Building 5,739,513  Part B - Owner and Related Parties 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 9/30/2016  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) 6 08/15/16 i. New Interest Rate 3.3.1% j. Term of Mortgage (number of years) 6			Total			
2. Date Structure Completed 3. If NOT Original Owner, Date of Purchase 4. Date of Initial Licensure 5. Total Licensed Bed Capacity 126 6. Square Footage 7. Acquisition Cost a. Land 546,300 b. Building 5,739,513  Part B - Owner and Related Parties 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 9/30/2016  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) 6  08/15/16 i. New Interest Rate 3.3.1% j. Term of Mortgage (number of years) 6			Iotal			
3. If NOT Original Owner, Date of Purchase 4. Date of Initial Licensure 5. Total Licensed Bed Capacity 6. Square Footage 7. Acquisition Cost a. Land b. Building 5,739,513  Part B - Owner and Related Parties 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 9/30/2016  Complete if Mortgage was Refinanced During Current Cost Year g. Type of Financing (e.g., fixed, variable) b. Date of Refinancing c.g., fixed, variable d. Term of Mortgage (number of years) f. Principal balance outstanding as of 9/30/2016  Complete of Mortgage was Refinanced During Current Cost Year g. Type of Financing (e.g., fixed, variable) b. Date of Refinancing c.g., fixed, variable c.g., fixed, variable b. Date of Refinancing c.g., fixed, variable						
4. Date of Initial Licensure 11/01/93 5. Total Licensed Bed Capacity 126 6. Square Footage 7. Acquisition Cost a. Land 546,300 b. Building 5,739,513  Part B - Owner and Related Parties 1st Mortgage 2nd Mortgage 3rd Mortgage 4th Mortgage 1. Financing a. Type of Financing (e.g., fixed, variable) Variable b. Date Mortgage Obtained 10/16/06 c. Interest Rate for the Cost Year Variable d. Term of Mortgage (number of years) 5 e. Amount of Principal Borrowed 12,750,000 f. Principal balance outstanding as of 9/30/2016  Complete if Mortgage was Refinanced During Current Cost Year g. Type of Financing (e.g., fixed, variable) Variable h. Date of Refinancing 08/15/16 i. New Interest Rate 3.31% j. Term of Mortgage (number of years) 6		of Purchase				
5. Total Licensed Bed Capacity 6. Square Footage 7. Acquisition Cost a. Land 546,300 b. Building 5,739,513  Part B - Owner and Related Parties 1 st 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 9/30/2016  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) 6 6			11/01/93			
6. Square Footage 7. Acquisition Cost a. Land b. Building 5,739,513  Part B - Owner and Related Parties 1 st 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 9/30/2016  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) 6 6					100	
7. Acquisition Cost a. Land 546,300 b. Building 5,739,513  Part B - Owner and Related Parties 1 st Mortgage 2 nd Mortgage 3 rd Mortgage 4 th Mortgage 1. Financing a. Type of Financing (e.g., fixed, variable) 4 b. Date Mortgage Obtained 5 c. Interest Rate for the Cost Year 5 d. Term of Mortgage (number of years) 6 e. Amount of Principal Borrowed 7 d. Principal balance outstanding as of 9/30/2016  Complete if Mortgage was Refinanced During Current Cost Year  g. Type of Financing (e.g., fixed, variable) 4 b. Date of Refinancing 6 complete if Mortgage (number of years) 7 d. Variable 8 complete if Mortgage was Refinanced During Current Cost Year 9 d. Type of Financing (e.g., fixed, variable) 10/16/06						
b. Building 5,739,513  Part B - Owner and Related Parties 1st Mortgage 2nd Mortgage 4th Mortgage  1. Financing a. Type of Financing (e.g., fixed, variable) Variable b. Date Mortgage Obtained 10/16/06 c. Interest Rate for the Cost Year Variable d. Term of Mortgage (number of years) 5 e. Amount of Principal Borrowed 12,750,000 f. Principal balance outstanding as of 9/30/2016  Complete if Mortgage was Refinanced During Current Cost Year g. Type of Financing (e.g., fixed, variable) Variable h. Date of Refinancing 08/15/16 i. New Interest Rate 3.31% j. Term of Mortgage (number of years) 6						
Part B - Owner and Related Parties  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) c. Amount of Principal Borrowed f. Principal balance outstanding as of 9/30/2016  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) 6  1st Mortgage Variable Variable Variable Variable Variable Variable  Variable  Variable  Variable  Variable  Variable  Variable  Variable  Variable  Variable  Variable  Abut of Refinancing  New Interest Rate  3.31% j. Term of Mortgage (number of years)	a. Land		546,300			
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 9/30/2016  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)  6	b. Building		5,739,513			
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 9/30/2016  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)  6	Part B - Owner and Related Par	rties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
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 9/30/2016  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)  10/16/06  Variable  Variable  08/15/16  3.31%  j. Term of Mortgage (number of years)  6	1. Financing					
c. Interest Rate for the Cost Year Variable d. Term of Mortgage (number of years)  e. Amount of Principal Borrowed f. Principal balance outstanding as of 9/30/2016  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)	a. Type of Financing (e.g., fix	xed, variable)	Variable			
d. Term of Mortgage (number of years)  e. Amount of Principal Borrowed  f. Principal balance outstanding as of 9/30/2016  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)  5  08/15/16  08/15/16	b. Date Mortgage Obtained		10/16/06			
e. Amount of Principal Borrowed f. Principal balance outstanding as of 9/30/2016  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)  12,750,000 12,7	c. Interest Rate for the Cost	Year	Variable			
f. Principal balance outstanding as of 9/30/2016  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)  Variable  3.31%			5			
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)  Variable  08/15/16  3.31%  6						
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)  Variable  Variable  3.31%						
g. Type of Financing (e.g., fixed, variable)  h. Date of Refinancing  i. New Interest Rate  j. Term of Mortgage (number of years)  Variable  08/15/16  3.31%  6						
h. Date of Refinancing         08/15/16           i. New Interest Rate         3.31%           j. Term of Mortgage (number of years)         6						
i. New Interest Rate 3.31% j. Term of Mortgage (number of years) 6		xed, variable)	Variable			
j. Term of Mortgage (number of years) 6			08/15/16			
			3.31%			
			10,300,000			
1. Principal Outstanding on Note Paid-Off 10,049,390						
Part C - Arms-Length Leases for Real Property Improvements Only	Part C - Arms-Length Lease	s for Real Property	y Improvements Only	7		
Name and Address of Lessor Property Leased Date of Lease Term of Lease Annual Amount of Lea	Name and Address of Le	essor P	roperty 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 Naugatuck Health Care LLC d/b/a	License No.		Report for Yea	ar Ended		Page of
Beacon Brook Health Care Center	2182-C			9/30/2016		26   37
Item			Total	CCNH	RHNS	(Specify)
12. Interest				***************************************		
A. Building, Land Improve	ment & Non-Movable	е				
Equipment					:	
First Mortgage  Name of Lender	***************************************		354,367	354,367		
Sovereign Bank		Rate Variable				
Address of Lender		variable				
Reading, PA						
2. Second Mortgage		\$				
Name of Lender		Rate		70 min		
Address of Lender	**************************************					
3. Third Mortgage\$						
Name of Lender		Rate				
Address of Lender		<u> </u>				
4. Fourth Mortgage		\$				
Name of Lender		Rate				
Address of Lender	A SECTION OF THE SECT	<u> </u>				
B. CHEFA Loan Information	on			$\frac{1}{2}$		
1. Original Loan Amour	nt	\$				
2. Loan Origination Dat						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expe						
12 B7. Total Building Interest Expe		\$	354,367	354,367		
12 D Louis Danning Line Col Lape	(IXI IXT   DJ)	Φ.		334,307	<del></del>	

(Carry Subtotals forward to next page)

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

Item	Name of Facility	License No.	<del></del>	Report for Year Ended			Page	of
Item								
Subtotals Brought Forward: 354,367 354,367	Beacon Brook Health Care Center	2182-C			9/30/2016		27	37
12. C. Movable Equipment	Item	<del></del>		<del></del>	CCNH	RHNS	(Speci	fy)
1. Automotive Equipment		Subtotals Brough	t Forward:	354,367	354,367			
A. Item	1 1							
Lender   Address of Lender   S			<del></del>	Management of the Control of the Con				
Address of Lender  2. Other (Specify)	A. Item	Rate	Amount		14.10 			
2. Other (Specify)	Lender	***************************************						
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)	Address of Lender							
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)	2. Other (Specify)		\$					e se como de la como d
Address of Lender  B. Item Rate Amount  Lender  Address of Lender  12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		····	<del></del>			705 St.		
B. Item   Rate   Amount   Lender	Lender	<u> </u>						
Lender   L	Address of Lender							
Address of Lender  12. C. 3. Total Movable Equipment Interest	B. Item							
12. C. 3. Total Movable Equipment Interest	Lender							
Expense (C1 + 2)	Address of Lender							
12. D. Other Interest Expense (Specify)       \$ 13,478         Vender Interest = \$13,478       13,478         13. Total All Interest Expense (12B7 + 12C3 + 12D)       367,845         14. Insurance       a. Insurance on Property (buildings only)       \$ 80,377         b. Insurance on Automobiles       \$         c. Insurance other than Property (as specified above)       1. Umbrella (Blanket Coverage)       \$         2. Fire and Extended Coverage       \$         3. Other (Specify)       \$			. \$					
Vender Interest = \$13,478	12. D. Other Interest Expense (	Specify )	. \$	<del></del>	13,478			
14. Insurance  a. Insurance on Property (buildings only)\$  b. Insurance on Automobiles\$  c. Insurance other than Property (as specified above)  1. Umbrella (Blanket Coverage)\$  2. Fire and Extended Coverage\$  3. Other (Specify)\$								
14. Insurance  a. Insurance on Property (buildings only)\$  b. Insurance on Automobiles\$  c. Insurance other than Property (as specified above)  1. Umbrella (Blanket Coverage)\$  2. Fire and Extended Coverage\$  3. Other (Specify)\$	13. Total All Interest Expense (	12B7 + 12C3 + 12I	D)\$	367,845	367,845			
a. Insurance on Property (buildings only)\$ 80,377 b. Insurance on Automobiles\$ c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage)\$ 2. Fire and Extended Coverage\$ 3. Other (Specify)\$		· · · · · · · · · · · · · · · · · · ·						
b. Insurance on Automobiles\$  c. Insurance other than Property (as specified above)  1. Umbrella (Blanket Coverage)\$  2. Fire and Extended Coverage\$  3. Other (Specify)\$	[	ouildings only)	\$	80,377	80,377			
c. Insurance other than Property (as specified above)  1. Umbrella (Blanket Coverage)\$  2. Fire and Extended Coverage\$  3. Other (Specify)\$								
2. Fire and Extended Coverage\$ 3. Other (Specify)\$								
3. Other (Specify)\$								
14d. Total Insurance Expenditures (14a + b + c) \$ 80 377 80 377	3. Other (Specify)		\$					
14d. <i>Total Insurance Expenditures</i> (14a + b + c) \$ 80 377 80 377								
	14d. Total Insurance Expenditur	res (14a + b + c)	<u> </u>	80,377	80,377			
15. Total All Expenditures (A-13 thru C-14)\$ 13,884,768 13,884,768	<u> </u>		-					

# D. Adjustments to Statement of Expenditures

	e of Fa			Li	cense No.	Report for Ye	ar Ended	Page	of
Nauga Cente		teaitn	Care LLC d/b/a Beacon Brook Health Care		2182-C	9/30	/2016	28	37
					Total				
Item	Page	Line			Amount of				
No.		1	Item Description		Decrease	CCNH	RHNS	(S	pecify)
Page	10 - 5	alari	es and Wages					(-	, , , , ,
1.			Outpatient Service Costs	\$					
2.			Salaries not related to Resident Care	\$			·		***************************************
3.	10	A12g	Occupational Therapy	\$	436,116	436,116			
4.	Var		Other - See attached Schedule	\$	<del></del>	50,658			
Page	13 - I	Profes	sional Fees						
5.	13	B8c	Resident Care Physicians **	\$	56	56			
6.	13.	B10a	Occupational Therapy	\$	2,659	2,659			
7.			Other - See attached Schedule	\$					
Page.	s 15 &	16 -	Administrative and General			60.55			
8.		1a9	Discriminatory Benefits	\$					
9.	15	1c	Bad Debts	\$		59,121			***************************************
10.	15		Accounting & Legal	\$		7,414			
11.			Telephone	\$					
12.	15	1h2	Cellular Telephone	\$	1,029	1,029			
13.			Life insurance premiums on the life						
			of Owners, Partners, Operators	\$					
14.	16	13	Gifts, flowers and coffee shops	\$	9,335	9,335			·····
15.			Education expenditures to colleges or						
			universities for tuition and related costs				and the second second		
			for owners and employees	\$					*
16.			Travel for purposes of attending		1				
			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	m2&3	Unallowable Advertising *	\$	17,532	17,532			
19.			Income Tax / Corporate Business Tax	\$					
20.			Fund Raising / Contributions						
21.	16	m12	Unallowable Management Fees		(10,821)	(10,821)			
	18	2e	<u>-</u>	\$	(2,623)	(2,623)			
	20	5j		\$	(2,951)	(2,951)			
22.			Barber and Beauty	\$					
23.	Var	Var	Other - See attached Schedule	\$	24,932	24,932			
Page	18 - L	)ietar	y Expenditures						
24.	18	2a1	Meals to employees, guests and others						
			who are not residents	\$	180	180			nent ti sine ti tili sine ti
Page	19 - L	aund	ry Expenditures						
25.			Laundry services to employees, guests						
			and others who are not residents	\$	3000 a para a				
Page	20 - E	Iouse	keeping Expenditures						
26.			Housekeeping services to employees						
			and others who are not residents	\$					
			Subtotal (Items 1 - 26)		592,637	592,637		••••	
*			Wanted".				orward to next		

<sup>\*</sup> All except "Help Wanted".

<sup>(</sup>Carry Subtotal forward to next page)

<sup>\*\*</sup> 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)
		Section 2011 and 12 Things			
10	A12m	Community Coordinator Salaries & Benefits	50,658		
Total Othe	r Salaries	l Adjustment	\$ 50,658	\$ -	S -

### Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
				100	
				100	
					100
			141.4	100	
Total Othe	r Fees Adj	ustments	s -	\$ -	\$ -

### Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M13	Bank Charges	8,903		1000
16	M13	Lobbying Fees	4,220		
16	M13	Compliance Consulting	10,297		
16		Software Settlement	1,512		
			No.		
			100		
ntal Othe	r A&G Ad	iustments	\$ 24,932	<u>s</u> -	S -

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

CSP-29 Rev. 10/2006

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

Name	Name of Facility  License No.   Report for Year Ended   Page   Of									
Nauga	tuck F	Iealth	Care LLC d/b/a Beacon Brook Health Care	icclise 140.	report for Year Ended		rage	01		
Cente				2182-C	9/30/2	2016	29	37		
				Total						
Item	Page	Line		Amount of						
No.	No.	No.	Item Description	Decrease	CCNH	RHNS	(Spe	cify)		
			Subtotals Brought Forward S	592,637	592,637					
Page	20 - I		nt Care Supplies***							
27.	20	5a1&2		506,338	506,338					
28.	20	5d		10,004	10,004					
29.	20	5f	X-rays, etc		51,510					
30.	20	5h	Laboratory		48,143					
31.	20	5c	Medical Supplies		15,681					
32.	20	5e2	Oxygen (non emergency)		49,715					
33.	20	5j	Occupational Therapy 9		11,220					
34.	Var	Var	Other - See Attached Schedule	38,690	38,690					
Page	22 - N	1ainte	enance and Property				9.0			
35.			Excess Movable Equipment Depreciation							
	Var	Var	See Attached Schedule	732	732					
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 - I	nsura	nce							
40.			Mortgage Insurance							
41.			Property Insurance \$	,			***************************************			
Other	- Mis	cella	neous							
42.			Research or Experimental Activities \$							
43.	20	5	Radio and Television Revenue \$	<del></del>	9,997		***************************************			
44.			Vending Machine Revenue \$				***************************************			
45.			Purchase Discounts and Allowances \$							
46.			Duplications of functions or services \$							
47.			Expenditures made for the protection,		P.					
ļ			enhancement or promotion of the							
l			providers interest\$							
48.	30	IV5	Interest Income on Accounts Rec \$	8	8					
49.			Other (include personnel and other		-					
			costs unrelated to resident care) - See							
			Attached Schedule\$							
Not F	or Pr	ofit P	roviders Only							
50.	Var		Building/Non Movable Eq. Depreciation							
			Unallowable Building Interest -		P 5 2 3 5 5 1 1					
			See Attached Schedule\$							
51.	Total	Amoi	unt of Decrease (Items 1 - 50) \$	1,334,675	1,334,675					
			- , , , , , , , , , , , , , , , , , , ,	1,00,,075	1,00 1,070					

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

### Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Medical Equipment Rental	38,690		
	100				
					T
Fotal Othe	r Ancillary	Costs	\$ 38,690	S -	S -

### Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Carryforward Equipment AJE	732		
-					
Total Exce	ss Movable	Equipment Depreciation	732		

### Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other	r Property	Adjustments			

### Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
		Grant Company			
				1000	
Total Othe	r Adjustme	ents	\$ -	S -	S -

### Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
					T
Total Unall	owable Bu	ilding Interest	S -	S -	\$ -

Cost Year	Amount	Beacon Amount	Brook Move Amount	eable Equip Amount		nt Carry Imount		vard Sch Amount	le Amount	Ar	nount	Totals
	Excess Over CON Adj #1	Excess Over CON Adj #2	Dryer Reclass	Dryer Reclass		000 Bed dition Adj #1		000 Bed dition Adj #2	14 Joerns d Credit		15 cost rts - tv's	
Cost Term	\$ 26,458 \$ 5	\$ 10	\$ (1,583) \$ 10 ADD BACK	\$ 1,583 \$ 10	\$ \$		\$ \$	55,977 15	8,907 15	\$ \$	691 5	\$ 125,910
1995 Deprec 1996 Book Value 1996 Book Value 1997 Book Value 1997 Book Value 1998 Book Value 1998 Book Value 1999 Deprec 1999 Book Value 1999 Book Value 2000 Deprec 2001 Book Value 2001 Deprec 2002 Book Value 2002 Deprec 2002 Book Value 2003 Deprec 2004 Book Value 2004 Deprec 2004 Book Value 2005 Deprec 2006 Book Value 2006 Deprec 2006 Book Value 2007 Deprec 2006 Book Value 2007 Deprec 2008 Book Value 2009 Deprec 2010 Book Value 2010 Deprec 2011 Book Value 2011 Deprec 2011 Book Value 2011 Deprec 2011 Book Value 2011 Deprec 2012 Deprec 2013 Book Value 2014 Book Value 2015 Deprec 2015 Book Value 2016 Deprec 2017 Zour 2018 Book Value 2019 Deprec 2019 Deprec 2010 Deprec 2011 Book Value 2011 Deprec 2011 Book Value 2011 Deprec 2012 Deprec 2013 Book Value 2014 Book Value 2015 Zour 2016 Zour 2017 Zour 2018 Zour 2019 Zour 2020 Zour 2020 Zour 2021 Zour 2022 Zour 2023 Zour 2024 Zour 2025 Zour 2026 Zour 2027 Zour 2028 Zou	\$ 2,646 \$ 23,812 \$ 5,292 \$ 18,520 \$ 5,292 \$ 7,936 \$ 5,292 \$ 2,644 \$ 2,644	\$ 612 \$ 11,633 \$ 11,224 \$ 10,409 \$ 1,224 \$ 9,185 \$ 9,185 \$ 1,224 \$ 7,961 \$ 1,224 \$ 6,737 \$ 1,224 \$ 5,513 \$ 1,224 \$ 3,065 \$ 1,224 \$ 1,2	\$ (79) \$ (1,504) \$ (158) \$ (1,346) \$ (158) \$ (1,346) \$ (158) \$ (1,029) \$ (158) \$ (713) \$ (158) \$ (713) \$ (158) \$ (158) \$ (158) \$ (158) \$ (238) \$ (238) \$ (238) \$ (79) \$ (79)	\$ 1,504 \$ 158 \$ 1,346 \$ 1,188 \$ 1,188 \$ 1,188 \$ 1,58 \$ 158 \$ 158 \$ 171 \$ 158 \$ 773 \$ 158 \$ 554 \$ 158 \$ 158 \$ 158 \$ 548 \$ 158 \$ 73 \$ 158 \$ 73 \$ 158 \$ 773 \$ 158 \$ 158		19,469 2,163 17,306 2,163 15,143 2,163 12,980 2,163 10,817 2,163 8,654 2,163 4,328 2,165 2,165 2,165		•	594 8,313 594 7,779 594 7,125 594 6,531 594 5,937 594 4,749 594 4,155 594 2,967 594 2,373 594 1,185 594 1,185 591 591	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	69 622 138 484 138 208 138 70 70 (0)	\$ 3,258 \$ 35,445 \$ 6,437 \$ 22,771 \$ 6,516 \$ 16,055 \$ 16,055 \$ 9,763 \$ 77,385 \$ 77,385 \$ 77,119 \$ 56,286 \$ 7,119 \$ 56,028 \$ 7,119 \$ 56,028 \$ 7,119 \$ 48,909 \$ 6,512 \$ 42,388 \$ 5,974 \$ 30,449 \$ 5,5974 \$ 30,449 \$ 5,585 \$ 24,554 \$ 5,885 \$ 24,554 \$ 5,885 \$ 3,732 \$ 11,193 \$ 3,732 \$ 14,925 \$ 3,732 \$ 3,

### CSP-30 Rev.10/2005

## F. Statement of Revenue

Name of Facility Naugatuck Health Care LLC d/b/a Beacon		Report for Y	ear Ended		Page	of
Brook Health Care Center 2182-C			30	37		
Item		Total	CCNH	RHNS	(Sp	ecify)
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (CT only)	\$	16,618,863	16,618,863			
b. Medicaid Room and Board Contractual Allo	wance **\$	(8,825,934)	(8,825,934)			
2. a. Medicaid (All other states)	\$					
b. Other States Room and Board Contractual A	llowance ** \$					
3. a. Medicare Residents (all inclusive)	\$	2,749,263	2,749,263			
b. Medicare Room and Board Contractual Allo		718,785	718,785			
4. a. Private-Pay Residents and Other	\$	2,648,305	2,648,305			
b. Private-Pay Room and Board Contractual Al		(314,434)	(314,434)			
II. Other Resident Revenue						
a. Prescription Drugs - Medicare	<u></u> \$	364,481	364,481			
b. Prescription Drugs - Medicare Contractual A	.Ilowance **\$	(364,481)	(364,481)			
c. Prescription Drugs - Non-Medicare	\$	243,256	243,256			
d. Prescription Drugs - Non-Medicare Contract		(243,256)	(243,256)			
2. a. Medical Supplies - Medicare	\$	3,081	3,081			•
b. Medical Supplies - Medicare Contractual Al						
c. Medical Supplies - Non-Medicare						
d. Medical Supplies - Non-Medicare Contractu						
3. a. Physical Therapy - Medicare	\$	1,239,437	1,239,437			
b. Physical Therapy - Medicare Contractual All	owance **\$	(970,487)	(970,487)			
c. Physical Therapy - Non-Medicare	\$	510,575	510,575			
d. Physical Therapy - Non-Medicare Contractus	al Allowance **\$	(510,575)	(510,575)			
4. a. Speech Therapy - Medicare	\$	337,845	337,845			
b. Speech Therapy - Medicare Contractual Allo	wance **\$	(260,227)	(260,227)			
c. Speech Therapy - Non-Medicare		121,150	121,150			
d. Speech Therapy - Non-Medicare Contractual		(121,150)	(121,150)			
5. a. Occupational Therapy - Medicare	\$	1,064,105	1,064,105			
b. Occupational Therapy - Medicare Contractua		(895,147)	(895,147)			
c. Occupational Therapy - Non-Medicare	\$	463,375	463,375			
d. Occupational Therapy - Non-Medicare Contr		(463,375)	(463,375)			
6. a. Other (Specify) - Medicare						
b. Other (Specify) - Non-Medicare			1,028			
III Total Resident Revenue (Section I.thru Section II.)	)\$	14,114,483	14,114,483			
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
Rental of rooms to non-residents		l				
3. Telephone		L				
Rental of Television and Cable Services						
5. Interest Income (Specify)			8			
6. Private Duty Nurses' Fees						
7. Barber, Coffee, Beauty and Gift shops						
8. Other (Specify)	\$		1,025			
V. Total Other Revenue (1 thru 8)			1,033			
VI, Total All Revenue (III + V)	\$	14,115,516	14,115,516			

<sup>\*</sup> Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

<sup>\*\*</sup> Facility should report all contractual allowances and/or payer discounts..

### Schedule of Other Resident Revenue - Medicare

n.	1.4		Exp
n.	1211	*11	F. X 13

Page Ref	Description	CCNH	RHNS	(Specify)
Total Oth	er Resident Revenue - Medicare	S -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

### Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
N/A	Retroactives	\$ 1,028		
Total Oth	er Resident Revenue	\$ 1,028	\$ -	\$ -

### **Interest Income**

A	cc	ดม	nt

Account	Balance	CCNH	RHNS	(Specify)
Interest on A/R	N/A	\$ 8		
rest Income		\$ 8	\$ -	S -
	Interest on A/R	Interest on A/R N/A	Interest on A/R N/A \$ 8	Interest on A/R N/A \$ 8

### Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
				,
		100		
X14	D. J. D. L. D.	6 1505		
NA	Bad Debt Recoveries	<b>\$</b> 1,025		
			_	
Total Othe	r Revenue	<b>\$</b> 1,025	\$ -	\$

# G. Balance Sheet

Name of Facility Naugatuck Health Care LI	C d/b/a Reacon	License No.	Report for Year Ended		Page	(
Brook Health Care Center	C U/D/A DEACON	2182-C	9/30/2016		31	3
		Account				nount
Assets					2 11	ilouiit
A. Current Assets						
1. Cash (on hand	and in banks)		• • • • • • • • • • • • • • • • • • • •	\$		88,0
2. Resident Acco	unts Receivabl	e (Less Allowance for	Bad Debts)	\$		1,046,5
			Related Parties)			
						18,1
						192,5
a. Prepaid Inst			169,039			
b. Prepaid Exp	ense		15,693			
c.						
d. A/R Related	l Parties		7,856			
7. Medicare Fina	l Settlement Re	eceivable		\$		
8. Other Current	Assets (itemize	?)		\$		39,8
Mortgage Res	owio Franci		31,249			
Mongage Res	erve runa		8,622			
A-9. Total Current Ass	ets (Lines A1	thru 8)		\$		1,385,1
B. Fixed Assets						
1. Land	••••••	•••••	***************************************	\$		546,30
<ol><li>Land Improver</li></ol>		*Historical Cost	162,495	\$		7,82
		Accum. Depreciation	(154,675) Net			
3. Buildings		*Historical Cost	9,373,781	\$	***************************************	4,189,8
		Accum. Depreciation	(5,183,894) Net			
<ol><li>Leasehold Imp</li></ol>	rovements	*Historical Cost		\$		
		Accum. Depreciation	Net			
5. Non-Movable	Equipment	*Historical Cost	321,794	\$		70,49
		Accum. Depreciation	(251,302) Net			
<ol><li>Movable Equip</li></ol>	ment	*Historical Cost	972,077	\$		257,59
		Accum. Depreciation	(714,481) Net			
7. Motor Vehicles	3	*Historical Cost		\$		
		Accum. Depreciation	Net			
8. Minor Equipme	ent-Not Depred	ciable	• • • • • • • • • • • • • • • • • • • •	\$		
9. Other Fixed As	Other Fixed Assets (itemize)			\$		7,60
	d Equipment A		7,609	ľ		.,00
<del></del>	* *		-	_		
3-10. Total Fixed As	sets (Lines B1	thru 9)		\$		5,079,70
						-,-,,,

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

# BEACON BROOK HEALTH CARE CENTER PREPAID EXPENSES September 30, 2016

	ACCT. # 1580
CLIA Laboratory User Fees	\$150.00
7/31/2016 Recol	\$1,090.23
8/31/2016 The CBORD Group	\$1,267.76
9/30/2016 Schindler Elevator Corp	\$983.59
Frontier Communications	\$411.82
Connecticut Water	\$1,711.64
Eversource	\$9,902.40
Concentra	\$176.00
BALANCE PER GENERAL LEDGER 9/30/16	<u>\$15,693.44</u>

# G. Balance Sheet (cont'd)

Name of Facility Naugatuck Health Care LLC d/b/a Beacon			License No.	Report for Year Ended		Page		of
	Brook Health Care Center		2182-C	2182-C 9/30/2016			1	37
			Account		Ī	32 Am	ount	
				Total Brought Forward:	\$		6,464	,877
C.	Le	asehold or like property recorde	ed for Equity Purpose					
	1.	Land			\$			
	2.	Land Improvements	*Historical Cost					
			Accum. Depreciation	Net	\$		•	
	3.	Buildings	*Historical Cost					
			Accum. Depreciation		\$			
	4.	Non-Movable Equipment	*Historical Cost					
			Accum. Depreciation		\$			
	5.	Movable Equipment	*Historical Cost					
			Accum. Depreciation	Net	\$			
	6.	Motor Vehicles	*Historical Cost					
			Accum. Depreciation		\$			
		Minor Equipment-Not Deprec			\$	~~~	~~~	
C-8		tal Leasehold or Like Properti	es (C1 thru 7)		\$			
D.		restment and Other Assets						
	1.	Deferred Deposits			\$			
		Escrow Deposits		***************************************	\$			
	3.	Organization Expense	*Historical Cost	***************************************				
			Accum. Depreciation		\$			
	4.	Goodwill (Purchased Only)		• • • • • • • • • • • • • • • • • • • •	\$			
	5.	Investments Related to Reside	nt Care (itemize)	***************************************	\$			
					-			
ļ	6.	Loans to Owners or Related P	, ————————————————————————————————————		\$			-
		Name and Address	Amount	Loan Date				
		·				E		
	7.	Other Assets (itemize)	• • • • • • • • • • • • • • • • • • • •	***************************************	\$		2,586	,382
		Unamortized Bed License		2,497,302				
		Deferred Finance Fees		89,080				
<u></u>								
<u></u>		tal Investments and Other Ass	` '		\$		2,586	
D-9.	To	tal All Assets (Lines A9 + B10	+ C8 + D8)	• • • • • • • • • • • • • • • • • • • •	\$		9,051	<u>,259</u>

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

# G. Balance Sheet (cont'd)

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook		License No.	Report for Year	Ended	Page	of	
Health Care C			2182-C	9/30/20	16	33	37
			Account				nount
Liabilities				· · · · · · · · · · · · · · · · · · ·			
A.	Cu	rrent Liabilities					
	1.	Trade Accounts Payable		• • • • • • • • • • • • • • • • • • • •		5	901,878
	2.	Notes Payable (itemize)				5	175,000
		Due from Related Party		175,000	)		
							1.00
[ 							
	3.	Loans Payable for Equipme		n ) (itemize )		5	
		Name of Lender	Purpose	Amount	Date Due		
¥							
	4.	Accrued Payroll (Exclusive					351,019
	5.	Accrued Payroll (Owners of					
***************************************	6.	Accrued Payroll Taxes Pay	rable				15,414
	<u>7.</u>	Medicare Final Settlement	Payable				
	8.	Medicare Current Financin	g Payable			5	
	9.	Mortgage Payable (Curren					
	10.	Interest Payable (Exclusive				)	11,532
	11.	Accrued Income Taxes*			\$	)	***************************************
		Other Current Liabilities (i			\$	<u> </u>	230,706
		Acc'd Operating Expenses		66,806	5		
		Acc'd Expense - CT Sales Tax		1,456	5		D. C.
		Provider Taxes Due		201,876	5		
		Acc'd Property Taxes		115,077	7		
		Swap offset		(154,509	))		
A-13.	To	tal Current Liabilities (Line	es A1 thru 12)		\$		1,685,549

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

# G. Balance Sheet (cont'd)

Name of Facility Naugatuck Health Care LLC d/b/a Beacon	License No.	Report for Year	r Ended	Page	of
Brook Health Care Center	2182-C	9/30/20	016	34	37
	Account		1		ount
		Total Broug	tht Forward:	***************************************	1,685,549
Liabilities (cont'd)					
B. Long-Term Liabilities					
<ol> <li>Loans Payable-Equipmen</li> </ol>	t ( <i>itemize</i> )	• • • • • • • • • • • • • • • • • • • •	\$		
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable	*****	• • • • • • • • • • • • • • • • • • • •	\$		10,278,575
3. Loans from Owners or Re					· · · · · · · · · · · · · · · · · · ·
Name and Address of Lender	Amount	Loan D			
4. Other Long-Term Liabilit	ies (itemize)		\$		154,509
Santander Swap	(1101111120 )	154,509	the same of the sa		137,307
Santanuci Swap		107,007			
***************************************					
B-5. Total Long-Term Liabilities	(Lines R1 thru 1)		\$		10 422 004
C. Total All Liabilities (Lines A	$\frac{(Lines D)}{-13 + R-5}$		<u>э</u>		10,433,084
C. Total Milliantities (Lines A	10   <b>D</b> -0]		·····\$		12,118,633

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

	ne of Facility	License No.	Report for Y	ear Ended	Page		of
	gatuck Health Care LLC d/b/a con Brook Health Care Center	2182-C	9/3	30/2016	35		37
		Account		1	A	mount	
A.	Reserves						
	1. Reserve for value of leased	land	• • • • • • • • • • • • • • • • • • • •		8		
	2. Reserve for depreciation val	lue of leased buildi	ngs and appurter	nances			
	to be amortized				5		
	3. Reserve for depreciation val	lue of leased person	nal property ( $Eqa$	uity)	3		
	4. Reserve for leasehold real p	roperties on which	fair rental value	is based	S		
	5. Reserve for funds set aside a	as donor restricted.			}		······································
	6. Total Reserves			9	)		
B.	Net Worth						
	1. Owner's Capital		*****		5		
	2. Capital Stock		****	9	)		
	3. Paid-in Surplus				)	(897	,623)
	4. Treasury Stock			s	)		
	5. Cumulated Earnings			s	)	(2,400	,499)
	6. Gain or Loss for Period	10/1/20	15 thru	9/30/2016		230	,748
	7. Total Net Worth			s		(3,067	,374)
C.	Total Reserves and Net Worth		• • • • • • • • • • • • • • • • • • • •	\$		(3,067	,374)
D.	Total Liabilities, Reserves, and	Net Worth	•••••	s		9,051	,259

# H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year	Ended	Page	of		
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	2182-C	9/30/201	16	36	37		
	Account			Aı	nount		
A. Balance at End of Prior Period as s	A. Balance at End of Prior Period as shown on Report of 09/30/2015						
	Total Revenue (From Statement of Revenue Page 30)						
C. Total Expenditures (From Stateme					13,884,768		
D. Net Income or Deficit			\$		230,748		
E. Balance			\$		(2,642,169)		
F. Additions 1. Additional Capital Contributed	l (itemize )						
		(425,204)					
rounding		(1)					
2. Other ( <i>itemize</i> )							
					(425,205)		
F-3. Total Additions				) 	(423,203)		
G. Deductions 1. Drawings of Owners/Operator	c/Dortners (Specify)		•	!			
Name and Address (No., City,		Title	Amount				
2. Other Withdrawings (Specify)	2. Other Withdrawings (Specify)						
Purpose		Amou	nt				
3. Total Deductions			\$	····			
H. Balance at End of Period	09/30/1	6	\$	}	(3,067,374)		

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-37 Rev. 9/2002

Farmington, CT 06032

# I. Preparer's/Reviewer's Certification

DI CD W							
Name of Facility Naugatuck Health Care LLC d/b/a	License No.	Report for Year Ended	Page	of			
Beacon Brook Health Care Center							
Bedeon Brook Hearth Care Center	2182-C	9/30/2016	37	37			
	Check appropriate categ	ory					
CCNH	RHNS	Other (Spec	cify)				
V							
P	reparer/Reviewer Cert	tification					
have inquired of appropriate per not reimbursable under the appropriate per (except those expenses known to result of reading reports, inquirely report on Pages 28 and 29 (adjusted)	ost recent Federal and State issue ersonnel as to the possible inclus oplicable regulations. All non-reisto be automatically removed in the ry or other services performed by ustments to statement of expenditionals books and records, as provided to	tion in this report of expenses mbursable expenses of which he State rate computation sys me are properly reported as itures). Further, the data cont	s which a n I am aw stem) as a such in t	re vare t his			
Signature of Preparer	Title	Date Signed					
Sul Pell	Mar 18-17						
Printed Name of Preparer			7,000,000,000,000				
Athena Health Care Associates, Inc							
Address		Phone Number					
135 South Road		i none number					

Cost report forms generated by Athena Health Care Associates, Inc as approved in letter dated 12/11/13.

(860) 751-3900

Name of Facility Naugatuck Health Care LLC d/b/a Beacon Brook	License No.	Report for Year Ended	Page
Health Care Center	2198-C/2198-C	9/30/2016	ERROR REPORT

### INCOME/EXPENSE STATEMENT

ERROR CHECK LIST

\*\*\*RED CELLS INDICATE POSSIBLE ERROR\*\*\*

\*\*\* REVIEW THE FOLLOWING FOR POSSIBLE ERRORS \*\*\*

RECONCILIATION OF COST REPORT PAGES TO INTERFACE:

(NUMBERS FROM INTERFACE MUST	EQUAL (	COST REPORT PA	AGES)		
•		TOTAL	CCNH	RHNS	OTHER: (Specify)
PG 1A PER INTERFACE PG 1A PER COST REPORT DIFFERENCE	N/A N/A		L		
PG 10 PER INTERFACE PG 10 PER COST REPORT DIFFERENCE		6,959,886 6,959,886	6,959,886 6,959,886		
PG 1A PER COST REPORT PG 10 PER COST REPORT DIFFERENCE	N/A N/A				
PG 13 PER INTERFACE PG 13 PER COST REPORT DIFFERENCE		317,660 317,660	317,660 317,660		
PG 15 & 16 PER INTERFACE PG 15 & 16 PER COST REPORT DIFFERENCE		3,516,239 3,516,239	3,516,239 3,516,239		
PG 18 PER INTERFACE PG 18 PER COST REPORT DIFFERENCE		337,276 337,276	337,276 337,276		
PG 19 PER INTERFACE PG 19 PER COST REPORT DIFFERENCE		19,829 19,829	19,829 19,829		
PG 20 PER INTERFACE PG 20 PER COST REPORT DIFFERENCE		1,207,870 1,207,870	1,207,870 1,207,870		
PG 22 PER INTERFACE PG 22 PER COST REPORT DIFFERENCE		1,077,786 1,077,786	1,077,786 1,077,786		
PG 26 & 27 PER INTERFACE PG 26 & 27 PER COST REPORT DIFFERENCE		448,222 448,222	448,222 448,222		
TOTAL EXPENSES PER INTERFACE TOTAL EXPENSES PER COST REPORT DIFFERENCE		13,884,768 13,884,768	13,884,768 13,884,768		
TOTAL REVENUES PER INTERFACE TOTAL REVENUES PER COST REPORT DIFFERENCE		14,115,516 14,115,516	14,115,516 14,115,516		
EQUIPMENT LEASES PER PAGE 6 EQUIPMENT LEASES PER PAGE 22,LINE DIFFERENCE	6e	46,579 46,579			

Name of Facility	License No.	Report for Year	Ended	Page
Naugatuck Health Care LLC d/b/a Beacon Brook Health Care Center	2198-C/2198-C	9/30/2016		ERROR REPORT
BALANCE SHEET ERROR CHECK LIST		1		1
*** REVIEW THE FOLLOWING FOR PORT I	PAGES TO INTERFACE		TOTAL	
(NUMBERS FROM INTERFACE MUST I ***RED CELLS INDICATE POSSIBLE ERR		PAGES)		
RED CIELS INDICATE 1 030IDEL ERR				
PG 31 CURRENT ASSETS PER INTERFACE PG 31 CURRENT ASSETS PER COST REPO DIFFERENCE		-	1,385,173 1,385,173	
PG 31 FIXED ASSETS PER INTERFACE PG 31 FIXED ASSETS PER COST REPORT DIFFERENCE			5,079,704 5,079,704	
PG 32 LEASED ASSETS PER INTERFACE PG 32 LEASED ASSETS PER COST REPOR DIFFERENCE	XT	-		
PG 32 OTHER ASSETS PER INTERFACE PG 32 OTHER ASSETS PER COST REPORT DIFFERENCE	г	-	2,586,382 2,586,382	
PG 32 TOTAL ASSETS PER INTERFACE PG 32 TOTAL ASSETS PER COST REPORT DIFFERENCE	Γ	-	9,051,259 9,051,259	
PG 33 CURRENT LIABS PER INTERFACE PG 33 CURRENT LIABS PER COST REPOR DIFFERENCE	RT	-	1,685,549 1,685,549	
PG 34 LONG TERM LIABS PER INTERFACE PG 34 LONG TERM LIABS PER COST REPORTEDIFFERENCE	<del>-</del>	-	10,433,084 10,433,084	
PG 34 TOTAL LIABS PER INTERFACE PG 34 TOTAL LIABS PER COST REPORT DIFFERENCE		-	12,118,633 12,118,633	
PG 35 RESERVES PER INTERFACE PG 35 RESERVES PER COST REPORT DIFFERENCE		· -		
PG 35 NET WORTH PER INTERFACE PG 35 NET WORTH PER COST REPORT DIFFERENCE		-	(3,067,374) (3,067,374)	
PG 35 TOTAL LIAB & WORTH PER INTER PG 35 TOTAL LIAB & WORTH PER COST I DIFFERENCE		-	9,051,259 9,051,259	
PG 32 TOTAL ASSETS PER COST REPORT PG 35 TOTAL LIAB & WORTH PER COST DIFFERENCE		-	9,051,259 9,051,259	
NET INCOME PER BALANCE SHEET NET INCOME PER INCOME STATEMENT DIFFERENCE		-	230,748 230,748	
PG 35 NET WORTH PER COST REPORT TOTAL NET WORTH PER PG 36 DIFFERENCE		-	(3,067,374) (3,067,374)	

Name of Facility	License No.	Report for Year Ended	Page
Naugatuck Health Care LLC d/b/a Beacon Brook		•	-
Health Care Center	2198-C/2198-C	9/30/2016	ERROR REPORT

# INFORMATIONAL PAGES ERROR CHECK LIST

### \*\*\*RED CELLS INDICATE POSSIBLE ERROR\*\*\*

### \*\*\* REVIEW THE FOLLOWING FOR POSSIBLE ERRORS \*\*\*

RECONCILIATION OF COST REPORT PAGES TO INTERFACE INPUT: (NUMBERS FROM INTERFACE MUST EQUAL COST REPORT PAGES)

(NUMBERS FROM INTERFACE MUST EQUAL CO	OST REPORT PA	AGES)		
	TOTAL	CCNH	RHNS	OTHER: (Specify)
PG 7 TOTAL LEGAL FEES DETAIL	8,281	NOT APPLIC	ABLE	1
PG 15, LINE 1e LEGAL FEES PER COST REPORT	8,281	NOT APPLIC		
DIFFERENCE		NOT APPLIC		
PG 7 TOTAL ACCOUNTING FEES DETAIL	28,775	NOT APPLIC	ABLE	
PG 15, LINE 1d ACCOUNTING FEES PER C/RPT	28,775	NOT APPLIC	ABLE	
DIFFERENCE		NOT APPLIC	ABLE	
PG 11 OWNER'S SALARY PER COST REPORT	-			
PG 10 OWNER'S SALARY PER COST REPORT	-			
DIFFERENCE				
PG 12 ADMINISTRATOR'S SALARY PER C/RPT	122,516	122,516		
PG 10 ADMINISTRATOR'S SALARY PER C/RPT	122,516	122,516		
DIFFERENCE	122,310	122,510		
-				
PG 12 ASST ADMIN'S SALARY PER COST REPORT	-			
PG 10 ASST ADMIN'S SALARY PER COST REPORT	-			
DIFFERENCE				
PT TREATMENTS CROSSFOOT CHECK:(PG 9)				
VERTICAL TOTALS	33,444	NOT APPLIC	ABLE	
HORIZONTAL TOTALS	33,444	NOT APPLIC	ABLE	
DIFFERENCE		NOT APPLIC	ABLE	
ST TREATMENTS CROSSFOOT CHECK:(PG 9)				
VERTICAL TOTALS	4,309	NOT APPLIC	ARLE	
HORIZONTAL TOTALS	4,309	NOT APPLIC		
DIFFERENCE	3,5 3,5	NOT APPLIC		
OT TREATMENTS CROSSFOOT CHECK:(PG 9)				
VERTICAL TOTALS	28,174	NOT APPLIC		
HORIZONTAL TOTALS_	28,174	NOT APPLIC		
DIFFERENCE		NOT APPLIC	ABLE	
NO. OF CERTIFIED BEDS RECONCILATION:				
NUMBER OF BEDS-BEG OF REPORT PERIOD(PG 8	126	126		
ADDITIONS/DELETIONS DURING PERIOD(PG 9)	-			
CALCULATED CERT. BEDS AT END OF PERIOD	126	126		
ACTUAL CERT. BEDS END OF PERIOD(PG 8)	126	126		
DIFFERENCE				

### COMPARISON OF ACTUAL PATIENT DAYS TO MAXIMUM POSSIBLE PATIENT DAYS:

AVERAGE CERTIFIED BEDS	126.00000	126.00000	
MAXIMUM PATIENT DAYS	46,116	46,116	
ACTUAL PATIENT DAYS	44,519	44,519	
PERCENT OCCUPIED(NOT TO EXCEED 100%)	96.5370%	96.5370%	

Name of Facility	License No.	Report for Year Ended	Page
Naugatuck Health Care LLC d/b/a Beacon Brook			_
Health Care Center	2198-C/2198-C	9/30/2016	ERROR REPORT

# DEPRECIATION TIE-IN ERROR CHECK LIST

### \*\*\*RED CELLS INDICATE POSSIBLE ERROR\*\*\*

# RECONCILIATION OF COST REPORT BALANCE SHEET TO DEPRECIATION PAGES: (BOOK VALUE NUMBERS FROM EACH COLUMN BELOW MUST EQUAL)

FIXED ASSET CATEGORY	BOOK VALUE	BOOK VALUE	Difference
	PG 23 OR 24	PG 31 OR 32	
LAND IMPROVEMENTS	7,820	7,820	_
BUILDING AND BUILDING IMPROVEMENTS	4,189,887	4,189,887	-
LEASEHOLD IMPROVEMENTS		-	_
NON-MOVEABLE EQUIPMENT	70,492	70,492	-
MOTOR VEHICLES	-	-	-
MOVEABLE EQUIPMNT(NET OF LEASED EQUIP)	265,205	257,596	7.00
LEASED MOVEABLE EQUIPMENT	-	-	-
ORGANIZATION/START-UP	•	-	-
OTHER-PG 24	977,751	N/A **	
FIXED ASSET CATEGORY	EXPENSE	EXPENSE	
	PG 23 OR 24	PG 22	Difference
LAND IMPROVEMENTS	1,770	1 770	
		1.770	
BUILDING AND BUILDING IMPROVEMENTS	292,921	1,770 292,921	-
BUILDING AND BUILDING IMPROVEMENTS	*	292,921	-
NON-MOVEABLE EQUIPMENT	*		-
	292,921	292,921	•
NON-MOVEABLE EQUIPMENT	292,921	292,921	
NON-MOVEABLE EQUIPMENT MOVEABLE EQUIPMENT(NET OF LEASED EQUIP) &	292,921 15,559	292,921 15,559	-
NON-MOVEABLE EQUIPMENT MOVEABLE EQUIPMENT(NET OF LEASED EQUIP) & MOTOR VEHICLES	292,921 15,559	292,921 15,559 72,822	-
NON-MOVEABLE EQUIPMENT MOVEABLE EQUIPMENT(NET OF LEASED EQUIP) & MOTOR VEHICLES LEASED MOVEABLE EQUIPMENT	292,921 15,559	292,921 15,559 72,822	· ·
NON-MOVEABLE EQUIPMENT MOVEABLE EQUIPMENT(NET OF LEASED EQUIP) & MOTOR VEHICLES LEASED MOVEABLE EQUIPMENT ORGANIZATION/START-UP	292,921 15,559 72,822	292,921 15,559 72,822 N/A *	-
NON-MOVEABLE EQUIPMENT MOVEABLE EQUIPMENT(NET OF LEASED EQUIP) & MOTOR VEHICLES LEASED MOVEABLE EQUIPMENT ORGANIZATION/START-UP FINANCE FEES	292,921 15,559 72,822	292,921 15,559 72,822 N/A *	- - - - - -

<sup>\*</sup> NOT APPLICABLE BECAUSE THERE IS NO CORRESPONDING LINE ON PAGE 22.

<sup>\*\*</sup>NOT APPLICABLE BECAUSE THERE IS NO CORRESPONDING LINE ON PAGES 31 OR 32.

FIXED ASSET CATEGORY		PG 23a/24a	PG 23/24	Difference
COMPARE DETAIL ADDITIONS TO PA	AGES 23 & 24			
LAND IMPROVEMENTS	ADDITIONS	•	-	-
	DEPREC	<u> </u>	-	-
BUILDING IMPROVEMENTS	ADDITIONS	52,076	52,076	
	DEPREC	2,657	2,657	
NON-MOVEABLE EQUIPMENT	ADDITIONS	-	-	-
	DEPREC	-	-	-
MOVE EQUIP(NET OF LEASED EQUIP&	VEHICLES ADDITIONS	28,893	28,893	
	DEPREC	1,911	1,911	
LEASEHOLD IMPROVES	ADDITIONS	-	<b>-</b>	-
	DEPREC	-	-	=.

<sup>\*\*\*</sup> REVIEW THE FOLLOWING FOR POSSIBLE ERRORS \*\*\*