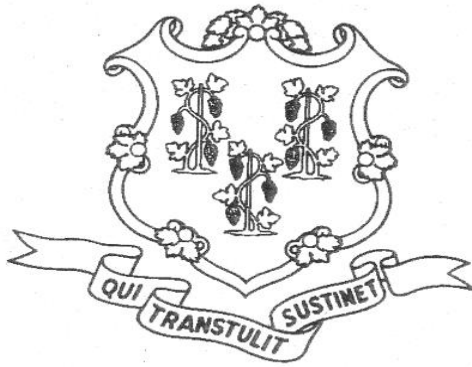


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2017

Name of Facility (as licensed) Southington Care Facility	
Address (No. & Street, City, State, Zip Code) 45 Meriden Avenue, Southington, CT 06489	
Type of Facility Chronic and Convalescent                      Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input type="checkbox"/> Supervision only <input checked="" type="checkbox"/> Other (CCNH)    (RHNS)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH 2060-C	RHNS	Other	Medicare Provider 07-5336
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Medicaid Provider Numbers:	CCNH 2060-2	RHNS	ICF-IID
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**For Department Use Only**

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

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### General Information

Name of Facility (as licensed) Southington Care Facility	License No. 2060-C	Report for Year Ended 9/30/2017	Page 1	of 37
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#### Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Southington Care Facility [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

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

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Southington Care Facility		Period Covered:	From 10/1/2016	To 9/30/2017
Address of Facility 45 Meriden Avenue, Southington, CT 06489				
Report Prepared By Dorothy Robinson		Phone Number 860-378-8022	Date	
Item	Total	CCNH	RHNS	Other
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

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

Phone No. of Facility 860-621-9559		Report for Year Ended 9/30/2017	Page 2	of 37
Name of Facility (as shown on license) Southington Care Facility		Address (No. & Street, City, State, Zip) 45 Meriden Avenue, Southington, CT 06489		
License Numbers:	CCNH 2060-C	RHNS	Other	Medicare Provider No. 07-5336
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> Other				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input checked="" type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?				
<input type="radio"/> Yes <input checked="" type="radio"/> No                   If "Yes," explain fully.				
<b>Administrator</b>				
Name of Administrator William Kowalewski		Nursing Home Administrator's License No.:	001813	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		



**General Information and Questionnaire  
 Corporate Owners**

Name of Facility Southington Care Facility	License No. 2060-C	Report for Year Ended 9/30/2017	Page 3A	of 37
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated	

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
See attached listing			

Names of Stockholders Owning at Least 10% of Shares			

Hartford HealthCare   
Senior Services  
Connect to healthier.™

Hartford HealthCare Senior Services d/b/a  
Southington Care Center  
Board of Directors

As of September 2017

<p>Rocco Orlando, M.D. Secretary and Director 25 Drumlin Road South Glastonbury, CT 06073 <a href="mailto:Rocco.Orlando@hhchealth.org">Rocco.Orlando@hhchealth.org</a> (860) 263-4155</p>	<p>Tracy Church Chair and Director 734 Prospect Avenue Hartford, CT 06105 <a href="mailto:Tracy.Church@hhchealth.org">Tracy.Church@hhchealth.org</a> (860) 263-4148</p>
<p>Charles L. Johnson Director 1314 Town Colony Drive Middletown, CT 06457 <a href="mailto:Charles.Johnson@hhchealth.org">Charles.Johnson@hhchealth.org</a> (860) 263-4100</p>	<p>Rita Parisi Director 15 Benton Drive Bloomfield, CT 06002 <a href="mailto:Rita.Parisi@hhchealth.org">Rita.Parisi@hhchealth.org</a> (860) 696-2550</p>
<p>Sean Rodriguez Director One State Street, 19<sup>th</sup> Floor Hartford, CT 06103 <a href="mailto:Sean.Rodriguez@hhchealth.org">Sean.Rodriguez@hhchealth.org</a> (860) 856-8982</p>	





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

Name of Facility Southington Care Facility	License No. 2060-C	Report for Year Ended 9/30/2017	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?     Yes     No    If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
See attached listing		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					

\* 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 Southington Care Facility	License No. 2060-C	Report for Year Ended 9/30/2017	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

Note: General & Administrative Expenses are allocated based on patient days which is consistent with prior years which have been audited by DSS.

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

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

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

## General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility Southington Care Facility			License No. 2060-C			Report for Year Ended 9/30/2017		Page of 6   37	
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed		
	Yes	No							
short term leases only	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
								<b>Total ***</b>	

Is a Mileage Log Book Maintained for All Leased Vehicles ?  Yes  No **Total \*\*\***

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

**General Information and Questionnaire**  
**Accounting Basis**

Name of Facility Southington Care Facility	License No. 2060-C	Report for Year Ended 9/30/2017	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:  
 Accrual     Cash     Modified Cash

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

**Independent Accounting Firm**

Name of Accounting Firm 1 SGF Accounting 2 Blum Shapiro 3 4	Address (No. & Street, City, State, Zip Code) PO Box 7, Indian Valley, VA 24105 29 S. Main St. #400, West Hartford, CT 06107
---	--

Services Provided by This Firm (*describe fully*)

1 CrossRef Template and Consulting for Medicaid Cost Report	\$ 158
2 Medicare Cost Report preparation	\$ 5,800
3	\$
4	\$
	Charge for Services Provided
	\$ 5,958

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

**Legal Services Information**

Name of Legal Firm or Independent Attorney 1 Michalik, Bauer, Silva & Ciccarillo LLP 2 American Adjustment Bureau 3 4 5	Telephone Number 860-225-8403 203-574-4200
--	--

Address ( <i>No. &amp; Street, City, State, Zip Code</i> ) 1 35 Pearl St. Suite 300, New Britain, CT 06051 2 PO Box 2758, Waterbury, CT 06723 3 4 5
--

Services Provided by This Firm (*describe fully*)

1 Collections - disallowed	\$ 1,473
2 Collections - disallowed	\$ 697
3	\$
4	\$
5	\$
	Charge for Services Provided
	\$ 2,170

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

### Schedule of Resident Statistics

Name of Facility Southington Care Facility			License No. 2060-C			Report for Year Ended 9/30/2017				Page 8		of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total Other	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	Other	Total	CCNH	RHNS	Other	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	130	130			130	130			130	130			
B. On last day of THIS report period	130	130			130	130			130	130			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	130	130			130	130			128	128			
B. As of midnight of THIS report period	124	124			128	128			124	124			
3. Total Number of Days Care Provided During Period													
A. Medicare	7,395	7,395			5,423	5,423			1,972	1,972			
B. Medicaid (Conn.)	26,351	26,351			19,770	19,770			6,581	6,581			
C. Medicaid (other states)													
D. Private Pay	7,898	7,898			5,869	5,869			2,029	2,029			
E. State SSI for RCH													
F. Other (Specify)	4,190	4,190			3,249	3,249			941	941			
G. Total Care Days During Period (3A thru F)	45,834	45,834			34,311	34,311			11,523	11,523			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days	76	76			37	37			39	39			
B. Other Bed Reserve Days	108	108			70	70			38	38			
5. <b>Total Resident Days (3G + 4A + 4B)</b>	46,018	46,018			34,418	34,418			11,600	11,600			

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

Name of Facility Southington Care Facility			License No. 2060-C			Report for Year Ended 9/30/2017			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	Other	Lost			Gained			CCNH	RHNS	Other	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days										CCNH	RHNS	Other	
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare	Medicaid		Self-Pay			Other State Assisted						
	CCNH	CCNH	RHNS	CCNH	RHNS	Other	R.C.H.	ICF-MR					
No. of Residents	18	71		35									
Per Diem Rate													
a. One bed rm.	Rugs	246.64		540.00									
b. Two bed rms.				504.00									
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments										TOTAL	CCNH	RHNS	Other
A. Medicare - Part B										11,576	1,462		10,114
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments										22	22		
C. Other										39,439	39,439		
<b>D. Total Physical Therapy Treatments</b>										51,037	40,923		10,114
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B										274	250		24
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments										462	462		
2. Restorative Treatments													
C. Other										407	343		64
<b>D. Total Speech Therapy Treatments</b>										1,143	1,055		88
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B										1,916	1,486		430
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments										25	25		
C. Other										30,005	29,543		462
<b>D. Total Occupational Therapy Treatments</b>										31,946	31,054		892

### Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Southington Care Facility	2060-C	9/30/2017	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Other	Hours
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	162,227	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	664,825	28,848			13,550	727
5. Dietary Service						
a. Head Dietitian	74,950	1,787				
b. Food Service Supervisor						
c. Dietary Workers	443,576	30,221				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	227,795	19,630			32,118	2,768
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	55,843	1,276			7,873	180
b. Other Maintenance Workers	78,540	3,650			11,074	515
8. Laundry Service						
a. Supervisor	25,884	624				
b. Other Laundry Workers	110,871	7,096				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	206,777	4,160				
b. RN						
1. Direct Care	1,180,255	34,277				
2. Administrative**	341,750	9,160				
c. LPN						
1. Direct Care	1,281,495	43,394				
2. Administrative**						
d. Aides and Attendants	2,418,194	148,177				
e. Physical Therapists	748,621	22,608			185,020	5,588
f. Speech Therapists	38,394	1,359			3,203	113
g. Occupational Therapists	504,001	14,967			14,477	430
h. Recreation Workers	184,399	8,169				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	336,190	9,788				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	97,016	4,283			593,527	25,798
<i>A-13. Total Salary Expenditures</i>	9,181,603	395,554			860,842	36,119

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

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

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





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

Name of Facility				License No.	Report for Year Ended				Page	of
Southington Care Facility				2060-C	9/30/2017				11	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Other							
<b>Section I - Operators/Owners</b>										
<b>Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).</b>										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended				Page	of
Southington Care Facility				2060-C	9/30/2017				12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Other							
<b>Section III - Administrators***</b>										
William Kowalewski	162,227			Non-discriminatory	Administrator - Management of facility	2,080	A2			
<b>Section IV - Assistant Administrators</b>										

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

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

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

**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended	Page	of		
Southington Care Facility	2060-C	9/30/2017	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	Other	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian						
2. Dentist	5,212	96				
3. Pharmacist	13,053	208				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	78,077	1,396			19,297	345
b. Other						
6. Social Worker						
7. Recreation Worker	27,482	1,125				
8. Physicians						
a. Medical Director (entire facility)	51,600	720				
b. Utilization Review (Title 18 and 19 only) monthly meeting	900	9				
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	4,106	21			343	2
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	25,123	785			176,875	3,540
2. Administrative***						
b. LPN						
1. Direct Care	23,074	824				
2. Administrative***						
c. Aides	924	54				
d. Other						
12. Other (Specify) See Attached Schedule	11,128	53			5,687	173
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>240,679</b>	<b>5,291</b>			<b>202,202</b>	<b>4,060</b>

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

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

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

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

Name of Facility Southington Care Facility		License No. 2060-C		Report for Year Ended 9/30/2017		Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship			
		Yes	No				
United Dental Resources	dental consulting	<input type="radio"/>	<input checked="" type="radio"/>				
Omnicare	pharmacy consulting	<input type="radio"/>	<input checked="" type="radio"/>				
Hartford HealthCare Rehab Network	physical therapy	<input checked="" type="radio"/>	<input type="radio"/>	Hartford HealthCare affiliate			
Dr. Joseph Babiarz - Prohealth Physicians	medical director	<input type="radio"/>	<input checked="" type="radio"/>				
Dr. Craig Bogdanski	medical director	<input type="radio"/>	<input checked="" type="radio"/>				
Dr. Curtland Brown III - Giosa and Brown Pulmonary	medical staff	<input type="radio"/>	<input checked="" type="radio"/>				
Dr. Leonard glazer	medical staff	<input type="radio"/>	<input checked="" type="radio"/>				
Dysphagia experts	swallowing testing	<input type="radio"/>	<input checked="" type="radio"/>				
Swallowing Diagnostics	swallowing testing	<input type="radio"/>	<input checked="" type="radio"/>				
Lifebridge Community Service	sign language services	<input type="radio"/>	<input checked="" type="radio"/>				
CT Rehabilitation & Spasticity	physiatrist	<input type="radio"/>	<input checked="" type="radio"/>				
Brian Colbrath	recreation - music program	<input type="radio"/>	<input checked="" type="radio"/>				
Brian Gillie	recreation - music program	<input type="radio"/>	<input checked="" type="radio"/>				
Ann & Frank Difiglia	recreation - music program	<input type="radio"/>	<input checked="" type="radio"/>				
Don Szamier	recreation - music program	<input type="radio"/>	<input checked="" type="radio"/>				
Douglas Mulcahy	recreation - music program	<input type="radio"/>	<input checked="" type="radio"/>				
Gary Andreadis	recreation - music program	<input type="radio"/>	<input checked="" type="radio"/>				
Roger Hart	recreation - slide program	<input type="radio"/>	<input checked="" type="radio"/>				
Janice Scott	recreation - music program	<input type="radio"/>	<input checked="" type="radio"/>				
Wesley Thouin	recreation - music program	<input type="radio"/>	<input checked="" type="radio"/>				
Diane Anelli	recreation - music program	<input type="radio"/>	<input checked="" type="radio"/>				
John Condi	recreation - music program	<input type="radio"/>	<input checked="" type="radio"/>				

\* Use additional sheets if necessary.

\*\* Refer to Page 4 for definition of related.

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

Name of Facility Southington Care Facility		License No. 2060-C	Report for Year Ended 9/30/2017	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Karen Kurowski	recreation - music program	<input type="radio"/>	<input checked="" type="radio"/>		
Tom Calinan	recreation - music program	<input type="radio"/>	<input checked="" type="radio"/>		
Anita Siarkowski	recreation - music program	<input type="radio"/>	<input checked="" type="radio"/>		
Christopher Caton	recreation - pastoral care	<input type="radio"/>	<input checked="" type="radio"/>		
Victoria Triano	recreation - pastoral care	<input type="radio"/>	<input checked="" type="radio"/>		
Hartford Hospital	Physical Therapists	<input checked="" type="radio"/>	<input type="radio"/>	Hartford HealthCare Affiliate	
Midstate Medical Center	RNs	<input checked="" type="radio"/>	<input type="radio"/>	Hartford HealthCare Affiliate	
Hospital of Central Connecticut	LPNs, Resource Coordinator	<input checked="" type="radio"/>	<input type="radio"/>	Hartford HealthCare Affiliate	
Hartford HealthCare Medical Group	LPNs	<input checked="" type="radio"/>	<input type="radio"/>	Hartford HealthCare Affiliate	
Mulberry Gardens	Driver	<input checked="" type="radio"/>	<input type="radio"/>	Hartford HealthCare Affiliate	
Jerome Home	Physical Therapist, Speech Therapist, Good Life Fitness Instructor	<input checked="" type="radio"/>	<input type="radio"/>	Hartford HealthCare Affiliate	
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
Southington Care Facility	2060-C	9/30/2017		15	37
Item	Total	CCNH	RHNS	Other	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 217,128	198,516			18,612
2. Disability Insurance	\$ 44,807	40,966			3,841
3. Unemployment Insurance	\$ 19,232	17,583			1,649
4. Social Security (F.I.C.A.)	\$ 744,394	680,584			63,810
5. Health Insurance	\$ 1,430,155	1,307,562			122,593
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 248,212	226,935			21,277
8. Uniform Allowance	\$				
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 22,588	20,652			1,936
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 46,996	46,996			
d. Accounting and Auditing	\$ 5,958	5,958			
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 2,170	2,170			
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$				
g. Office Supplies	\$ 41,859	32,114			9,745
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 10,580	10,580			
2. Cellular Phones	\$ 663	663			
i. Appraisal ( <i>Specify purpose and         attach copy</i> )*	\$				
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$				
k. Other Taxes ( <i>Not related to property - See Page 22</i> )					
1. Income*	\$				
2. Other ( <i>Specify</i> ) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 745,769	745,769			
<b>Subtotal</b>	\$ 3,580,511	3,337,048			243,463

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

(Carry Subtotals forward to next page)

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

Southington Care Facility  
9/30/2017

Attachment Page 15

**Schedule of Other Employee Benefits**

Description	CCNH	RHNS	Other
		\$ -	
EMP BENEFITS-EMP PHYSICALS -DISALLOWED	\$ 16,939		\$ 1,889
EMP BACKGROUND CHECKS	\$ 4,902		\$ 159
EMP BENEFITS-EMPLOYEE ASSISTANCE PROGRAM - DIS	\$ 138		\$ 13
EMP BENEFITS- WELLNESS	\$ (1,040)		\$ (98)
EMP BENEFITS-OTHER	\$ 30		\$ 3
Other Misc Benefitis reclassd from Empl Relations	\$ (317)		\$ (30)
<b>Total</b>	<b>\$ 20,652</b>	<b>\$ -</b>	<b>\$ 1,936</b>

**Schedule of Other Taxes**

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



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

Name of Facility	License No.	Report for Year Ended	Page	of	
Southington Care Facility	2060-C	9/30/2017	16	37	
Item		Total	CCNH	RHNS	Other
<b>Subtotals Brought Forward:</b>		3,580,511	3,337,048		243,463
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$	210	210		
2. Holiday Parties for Staff	\$	1,536	1,536		
3. Gifts to Staff and Residents	\$	6,227	6,227		
4. Employee Travel	\$	2,461	2,461		
5. Education Expenses Related to Seminars and Conventions	\$	17,274	17,274		
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$	4,404	4,404		
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$	560	560		
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	18,532	15,932		2,600
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$	12,640	12,640		
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	11,997	11,997		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	2,866	2,866		
10. Contributions*** See Attached Schedule	\$	1,521	1,521		
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$	123,220	123,220		
12. Administrative Management Services**	\$	3,484,882	3,484,882		
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	1,386,640	80,072		1,306,568
<b>C-14 Total Administrative &amp; General Expenditures</b>	<b>\$</b>	<b>8,655,481</b>	<b>7,102,850</b>		<b>1,552,631</b>

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

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

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

**Schedule of Other Travel and Entertainment**

Description	CCNH	RHNS	Other
	\$ -	\$ -	\$ -
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

**Schedule of Other Advertising**

Description	CCNH	RHNS	Other
		\$ -	
MANAGEMENT CO - MARKETING - DISALLOWED			\$ 2,600
A & G- BUSINESS PROMOTION-ADVERTISING PROMOTION - DISALLOWED	\$ 15,932		
<b>Total Other Advertising</b>	\$ 15,932	\$ -	\$ 2,600

**Schedule of Dues**

Description	CCNH	RHNS	Other
		\$ -	\$ -
Leading Age	\$ 11,142		
CALTC	\$ 600		
ALTCFM	\$ 255		
<b>Total Dues</b>	\$ 11,997	\$ -	\$ -

**Schedule of Contributions**

Description	CCNH	RHNS	Other
A & G-DONATIONS - DISALLOWED	\$ 1,521	\$ -	\$ -
<b>Total Contributions</b>	\$ 1,521	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	Other
A&G LICENSES	\$ 551		
A&G EQUIPMENT RENTAL	\$ 48,784		
A&G BANK CHARGES - DISALLOWED	\$ -		\$ 57,053
INTERNET RECLASSIFIED FROM TELEPHONE	\$ 4,234		
INTERNET CHARGES ABILITY NETWORK - MEDICARE - DISALLOWED	\$ 11,090		
MANAGEMENT COMPANY DEVELOPMENT COSTS - DISALLOWED			\$ 88
MANAGEMENT COMPANY EXPENSES - DISALLOWED			\$ 121,105
MANAGEMENT COMPANY PURCHASED SERVICES - DISALLOWED			\$ 616,860
A&G RECORD STORAGE	\$ 6,638		
A&G PENALTIES - DISALLOWED	\$ 1,168		
A&G TEMPORARY HELP	\$ 25		
GRANT RELATED EXPENSES - DISALLOWED			\$ 143,507
GRANT RELATED WAGES - DISALLOWED			\$ 356,085
RECREATION - CABLE TELEVISION	\$ 5,214		
RECREATION - VOLUNTEER RELATIONS EXPENSE - DISALLOWED	\$ 1,368		
NON-OPERATING BANK FEES - DISALLOWED			\$ 11,870
RECLASS ROOFING PROJECT APPRAISAL FY 16 - DISALLOWED	\$ (4,000)		
REIMBURSEMENT TO HCC FOR FY16 COMPASS CONTRIBUTION - DISALLOWED	\$ 5,000		
<b>Total Other Administrative and General</b>	<b>\$ 80,072</b>	<b>\$ -</b>	<b>\$ 1,306,568</b>

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

Name of Facility	License No.	Report for Year Ended	Page of
Southington Care Facility	2060-C	9/30/2017	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 #
Hartford HealthCare	3,484,882	Contracting & Management	p. 16 line 1m12
Morrison Community Living	449,076	Dietary Staff Management, Support, Food Purchase, Quantity Discount	p. 18 line 2a1, 2, & 3b
Crothall Healthcare	158,680	Environmental Services Staff Management, Support, Supplies Purchase, Quantity Discount	p. 20 line 4a1 & 4b

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Southington Care Facility	2060-C	9/30/2017	18	37
Item	Total	CCNH	RHNS	Other
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 292,008	292,008		
2. Non-Food Supplies	\$ 60,051	60,051		
3. Other (Specify) _____ In house food for dept meetings - disallowed except for recreation dept amount of \$3472 for SNF residents	\$ 13,073	13,073		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 80,799	80,799		
c. Management Services**	\$			
d. Other (Specify) _____ Equipment Rental	\$ 128	128		
<b>2E. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 446,059</b>	<b>446,059</b>		
2F. Dietary Questionnaire	Total	CCNH	RHNS	Other
G. Resident Meals: Total no. of meals served per day:*	377	377		
H. Is cost of employee meals included in 2E? <input checked="" type="radio"/> Yes <input type="radio"/> No				
I. Did you receive revenue from employees? <input checked="" type="radio"/> Yes <input type="radio"/> No                      If yes, specify amt.				
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)				p 18 2a1
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input checked="" type="radio"/> Yes <input type="radio"/> No                      If yes, specify cost.				
L. Is any revenue collected from these people? <input checked="" type="radio"/> Yes <input type="radio"/> No                      If yes, specify amt.				\$5,328
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)				p 18 2a1
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input checked="" type="radio"/> Yes <input type="radio"/> No                      If yes, specify cost.				\$9,601
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify amt.				
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility		License No.	Report for Year Ended	Page	of
Southington Care Facility		2060-C	9/30/2017	19	37
Item		Total	CCNH	RHNS	Other
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	2,912	2,912		
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. \$				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. \$				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. \$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$				
c. Management Services**	\$				
d. Other (Specify) Laundry Supplies	\$	3,197	3,197		
<b>3E. Total Laundry Expenditures (3a + b + c + d)</b>	<b>\$</b>	<b>6,109</b>	<b>6,109</b>		
<b>3F. Laundry Questionnaire</b>					
G. Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
I. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
L. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

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

All allocations should add to total recorded in 3E.

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

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Southington Care Facility		2060-C	9/30/2017		20	37
Item			Total	CCNH	RHNS	Other
4.	Housekeeping	Sq. Ft. Serviced	67,152	58,854		8,298
a.	In-House Care	by Personnel				
	1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	59,801	52,411		7,390
b.	Purchased Services ( <i>by contract other than through Management Services</i> )	Sq. Ft. Serviced	67,152	58,854		8,298
	( <i>Complete Schedule C-2 att. Page 21</i> )	by Personnel				
		Amt. \$	46,812	41,027		5,785
c.	Management Services*		\$			
d.	Other ( <i>Specify</i> )		\$			
4E.	<b>Total Housekeeping Expenditures</b> (4a + b + c + d)		\$ 106,613	93,438		13,175
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy		\$			
	2. Purchased from		\$ 388,995	388,995		
b.	Medicine Cabinet Drugs		\$ 19,631	19,631		
c.	Medical and Therapeutic Supplies		\$			
d.	Ambulance/Limousine***		\$ 1,241	1,241		
e.	Oxygen					
	1. For Emergency Use		\$			
	2. Other***		\$ 26,660	26,660		
f.	X-rays and Related Radiological Procedures***		\$ 34,349	34,349		
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )		\$			
h.	Laboratory***		\$ 44,911	44,911		
i.	Recreation		\$ 4,498	4,498		
j.	Other ( <i>Specify</i> )**** See Attached Schedule		\$ 257,384	231,358		26,026
5K.	<b>Total Resident Care Expenditures</b> (5a - 5j)		\$ 777,669	751,643		26,026

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

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

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

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





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

Name of Facility Southington Care Facility			License No. 2060-C	Report for Year Ended 9/30/2017	Page of 21   37					
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	Other	Pg	Line
See attached list		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
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		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Southington Care Facility	2060-C	9/30/2017			22	37
Item	Total	CCNH	RHNS	Other		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 101,419	88,886			12,533	
b. Heat	\$ 67,857	59,472			8,385	
c. Light & Power	\$ 82,291	72,122			10,169	
d. Water	\$ 45,406	39,795			5,611	
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$					
f. Other ( <i>itemize</i> )	\$ 90,057	78,929			11,128	
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$ 387,030</b>	<b>339,204</b>			<b>47,826</b>	
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$ 37,086	32,503			4,583	
b. Building & Building Improvements	\$ 262,379	219,040			43,339	
c. Non-Movable Equipment	\$ 3,852	3,376			476	
d. Movable Equipment	\$ 147,381	121,114			26,267	
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$ 450,698</b>	<b>376,033</b>			<b>74,665</b>	
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$ 2,124	1,862			262	
c. Leasehold Improvements	\$ 23,789				23,789	
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$ 25,913</b>	<b>1,862</b>			<b>24,051</b>	
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	\$ 51,213	44,885			6,328	
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$ 23,770	20,833			2,937	
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$ 551,594</b>	<b>443,613</b>			<b>107,981</b>	

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

**Schedule of Other Repairs and Maintenance**

Description	CCNH	RHNS	Other
MAINTENANCE-GROUNDS-CONTRACT SERVICES	\$ 14,955		\$ 2,108
MAINTENANCE-RUBBISH REMOVAL	\$ 19,068		\$ 2,689
MAINTENANCE-EQUIP RENTAL	\$ 5,640		\$ 795
MAINTENANCE-BUILDING-CONTRACT SERVICES	\$ 39,266		\$ 5,536
<b>Total Other Repairs and Maintenance</b>	\$ 78,929	\$ -	\$ 11,128

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## Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
6/14/2017	IN2L System Mulberry Gardens (COM00127)	\$ 5,049	3	\$ 843
7/14/2017	IN2L Southington Care Center (COM00128)	\$ 13,839	3	\$ 2,311
6/27/2017	Water softener for building (FURN01165)	\$ 10,573	10	\$ 530
12/12/2016	Hydrocollator (FURN01166)	\$ 2,508	10	\$ 126
2/17/2017	Lift & Scale (FURN01167)	\$ 3,755	10	\$ 188
9/30/2017	Beverage Server Cart (FURN01168)	\$ 3,515	5	\$ 352
9/30/2017	Kitchen Equipt (FURN00169)	\$ 1,411	3	\$ 235
9/30/2017	Housekeeping Equipt (FURN00170)	\$ 1,971	3	\$ 329
9/30/2017	WB Mason, this amount was added to the asset account in FY2017 but not depreciated. An adjustment will be made in Jan 2018 to credit the asset account and expense it in FY2018	\$ 103		\$ -
<b>Total additions for Movable Equipment</b>		\$ 42,724		\$ 4,914 *
<b>Deletions:</b>				
<b>Total deletions for Movable Equipment</b>		\$ -		\$ - **

\*Ties to Page 23, Line D2c

\*\*Ties to Page 23, Line D2b

## Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
<b>Total additions for Leasehold Improvement</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Amortization Schedule\***

Name of Facility			License No.		Report for Year Ended			Page	of
Southington Care Facility			2060-C		9/30/2017			24	37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1. Series B	9	2011	38 years	70,219	9,666			2,124	
2. Series C				10,290	929				
3.									
B-4. Subtotal									2,124
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period	1	2014	5 years	119,019	55,652			23,789	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									23,789
<b>D. Total Amortization</b>									25,913

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

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

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

Name of Facility Southington Care Facility	License No. 2060-C	Report for Year Ended 9/30/2017	Page 25	of 37																																																																											
<b>11. Property Questionnaire</b>																																																																															
<b>Part A</b>																																																																															
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.																																																																											
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.																																																																															
Description	Total																																																																														
1. Date Land Purchased																																																																															
2. Date Structure Completed																																																																															
3. If <b>NOT</b> Original Owner, Date of Purchase																																																																															
4. Date of Initial Licensure																																																																															
5. Total Licensed Bed Capacity	130																																																																														
6. Square Footage																																																																															
7. Acquisition Cost																																																																															
a. Land		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"><b>Part B - Owner and Related Parties</b></td> <td style="text-align: center;">1st Mortgage</td> <td style="text-align: center;">2nd Mortgage</td> <td style="text-align: center;">3rd Mortgage</td> <td style="text-align: center;">4th Mortgage</td> </tr> <tr> <td>1. Financing</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">a. Type of Financing (e.g., fixed, variable)</td> <td style="text-align: center;">variable</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">b. Date Mortgage Obtained</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">c. Interest Rate for the Cost Year</td> <td style="text-align: center;">variable</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">d. Term of Mortgage (number of years)</td> <td style="text-align: center;">40</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">e. Amount of Principal Borrowed</td> <td style="text-align: right;">7,031,283</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">f. Principal balance outstanding as of 9/30/17</td> <td style="text-align: right;">7,031,283</td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="5" style="text-align: center;"><b>Complete if Mortgage was Refinanced During Current Cost Year</b></td> </tr> <tr> <td style="padding-left: 20px;">g. Type of Financing (e.g., fixed, variable)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">h. Date of Refinancing</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">i. New Interest Rate</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">j. Term of Mortgage (number of years)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">k. Amount of Principal Borrowed</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">l. Principal Outstanding on Note Paid-Off</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>			<b>Part B - Owner and Related Parties</b>	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage	1. Financing					a. Type of Financing (e.g., fixed, variable)	variable				b. Date Mortgage Obtained					c. Interest Rate for the Cost Year	variable				d. Term of Mortgage (number of years)	40				e. Amount of Principal Borrowed	7,031,283				f. Principal balance outstanding as of 9/30/17	7,031,283				<b>Complete if Mortgage was Refinanced During Current Cost Year</b>					g. Type of Financing (e.g., fixed, variable)					h. Date of Refinancing					i. New Interest Rate					j. Term of Mortgage (number of years)					k. Amount of Principal Borrowed					l. Principal Outstanding on Note Paid-Off				
<b>Part B - Owner and Related Parties</b>	1st Mortgage				2nd Mortgage	3rd Mortgage	4th Mortgage																																																																								
1. Financing																																																																															
a. Type of Financing (e.g., fixed, variable)	variable																																																																														
b. Date Mortgage Obtained																																																																															
c. Interest Rate for the Cost Year	variable																																																																														
d. Term of Mortgage (number of years)	40																																																																														
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h. Date of Refinancing																																																																															
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j. Term of Mortgage (number of years)																																																																															
k. Amount of Principal Borrowed																																																																															
l. Principal Outstanding on Note Paid-Off																																																																															
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>																																																																															
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease																																																																											

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



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

Name of Facility		License No.	Report for Year Ended			Page	of
Southington Care Facility		2060-C	9/30/2017			26	37
Item		Total	CCNH	RHNS	Other		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$ 108,825	95,377			13,448	
Name of Lender		Rate					
Address of Lender							
2. Second Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
3. Third Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
4. Fourth Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount		\$					
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expense							
12 B7. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$ 108,825	95,377			13,448	

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended			Page of	
Southington Care Facility		2060-C		9/30/2017			27	37
Item				Total	CCNH	RHNS	Other	
Subtotals Brought Forward:				108,825	95,377		13,448	
12. C. Movable Equipment								
1. Automotive Equipment				\$				
A. Item		Rate	Amount					
Lender								
Address of Lender								
2. Other (Specify)				\$				
A. Item		Rate	Amount					
Lender								
Address of Lender								
B. Item		Rate	Amount					
Lender								
Address of Lender								
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$				
12. D. Other Interest Expense (Specify)				\$				
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>				\$ 108,825	95,377		13,448	
14. Insurance								
a. Insurance on Property (buildings only)				\$ 12,177	10,672		1,505	
b. Insurance on Automobiles				\$ 3,580	3,580			
c. Insurance other than Property (as specified above)								
1. Umbrella (Blanket Coverage)				\$ 67,495	67,495			
2. Fire and Extended Coverage				\$				
3. Other (Specify)				\$				
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$ 83,252	81,747		1,505	
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$ 21,607,958	18,782,322		2,825,636	

### D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Southington Care Facility				2060-C	9/30/2017	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
<b>Page 10 - Salaries and Wages</b>							
1.	10	A12e	Outpatient Service Costs	\$ 188,223			188,223
2.	10	A6,7	Salaries not related to Resident Care	\$ 64,615			64,615
3.	10	A12g	Occupational Therapy	\$ 518,478	504,001		14,477
4.	10	A12o	Other - See attached Schedule	\$ 593,527			593,527
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 300,597	98,395		202,202
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 46,996	46,996		
10.	15	1e	Accounting & Legal	\$ 2,170	2,170		
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.	15	1f	Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	1m3	Unallowable Advertising *	\$ 18,532	15,932		2,600
19.			Income Tax / Corporate Business Tax	\$			
20.	16	1m10	Fund Raising / Contributions	\$ 1,521	1,521		
21.	16	1m12	Unallowable Management Fees	\$ 3,484,882	3,484,882		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 1,855,740	305,709		1,550,031
<b>Page 18 - Dietary Expenditures</b>							
24.	18	2a3	Meals to employees, guests and others who are not residents	\$ 9,601	9,601		
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 7,084,882	4,469,207		2,615,675

\* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

**Schedule of Other Salaries Adjustment**

Page Ref	Line Ref	Description	CCNH	RHNS	Other
10	12o	GOOD LIFE FIT/ SR FIT - WAGES & SALARIES			\$ 10,157
10	12o	MANAGEMENT COMPANY WAGES			\$ 583,370
<b>Total Other Salaries Adjustment</b>			\$ -	\$ -	\$ 593,527

**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	Other
13	b2	DENTAL-PURCHASED SERVICE	\$ 5,212		
13	b5a	PHYSICAL THERAPY - PATIENT CARE - HARTFORD HEALTHCARE REHAB NETWORK	\$ 78,077		\$ 19,297
13	b9a	SPEECH THERAPY PATIENT CARE - DYSPHAGIA EXPERTS & SWALLOWING DIAGNOSTICS	\$ 4,106		\$ 343
13	b11a1	HHC AT HOME RELATED PARTY RNS			\$ 176,875
13	b12	OTHER CONSULTANTS - CT REHAB & SPASTICITY	\$ 11,000		
13	b12	RELATED PARTY RECLASS #4 HOCC RESOURCE COORDINATOR TRANSITIONS OF CARE - DISALLOWED			\$ 3,511
13	b12	RELATED PARTY RECLASS #10 JEROME HOME GOOD LIFE FITNESS - DISALLOWED			\$ 2,176
<b>Total Other Fees Adjustments</b>			\$ 98,395	\$ -	\$ 202,202

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	Other
15	1a1	Benefits related to Outpatient Therapy - Workers Comp			\$ 18,612
15	1a2	Benefits related to Outpatient Therapy - Disability Insurance			\$ 3,841
15	1a3	Benefits related to Outpatient Therapy - Unemployment Insurance			\$ 1,649
15	1a4	Benefits related to Outpatient Therapy - Social Security - FICA			\$ 63,810
15	1a5	Benefits related to Outpatient Therapy - Health Insurance			\$ 93,763
15	1a5	Health Insurance - Management Benefits	\$ 244,360		\$ 22,910
15	1a5	Benefits related to Outpatient Therapy - Dental			\$ 5,765
15	1a5	Benefits related to Outpatient for Related Parties			\$ 155
15	1a7	Benefits related to Outpatient Therapy - Pension			\$ 21,277
15	1a9	Benefits related to Outpatient Therapy - Employee Physicals			\$ 2,048
15	1a9	Employee Physicals - Preplacement Physicals - SNF portion	\$ 16,939		
15	1a9	Benefits related to Outpatient Therapy - Employee Assistance Program	\$ 138		\$ 13
15	1a9	Benefits related to Outpatient Therapy - Other Benefits			\$ (27)

Page Ref	Line Ref	Description	CCNH	RHNS	Other
15	1a9	Benefits related to Outpatient Therapy - Wellness	\$ (1,040)		\$ (98)
15	1G	Management Company Office Supplies			\$ 9,745
16	1L2	Employee Relations - Parties for Staff in excess of 1 party	\$ -		
16	1L3	Employee Relations - Gifts in excess of \$25 or discriminatory in nature	\$ 4,302		
16	1m9	It's Never 2 Late subscription for Oct-Dec 2016 - reversal of disallowance from FY 16 Annual Report	\$ (338)		
16	1m11	A&G Consultant Fees - Celtic Consulting	\$ 26,508		
16	1m13a	A & G- BANK CHARGES - DISALLOWED			\$ 57,053
16	1m13a	INTERNET CHARGES - ABILITY NETWORK - MEDICARE CONNECTION	\$ 11,090		
16	1m13a	MANAGEMENT COMPANY DEVELOPMENT COSTS - DISALLOWED			\$ 88
16	1m13a	MANAGEMENT COMPANY EXPENSES - DISALLOWED			\$ 121,105
16	1m13a	MANAGEMENT CO. PURCHASED SERVICES - DISALLOWED			\$ 616,860
16	1m13a	A & G- PENALTIES - DISALLOWED	\$ 1,168		
16	1m13a	GRANT RELATED EXPENSES- DISALLOWED			\$ 143,507
16	1m13a	GRANT RELATED WAGES - DISALLOWED			\$ 356,085
16	1m13a	RECREATION- VOLUNTEER REL EXP - DISALLOWED	\$ 1,368		
16	1m13a	NON OPERATING-BHC - BANK FEES - DISALLOWED			\$ 11,870
16	1m13a	REVERSAL OF PRIOR YR 16 ROOF GRANT APPRAISAL - DISALLOWED	\$ (4,000)		
16	1m13a	CABLE TV	5,214		
<b>Total Other A&amp;G Adjustments</b>			\$ 305,709	\$ -	\$ 1,550,031

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

Name of Facility				License No.	Report for Year Ended	Page	of
Southington Care Facility				2060-C	9/30/2017	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
Subtotals Brought Forward				\$ 7,084,882	4,469,207		2,615,675
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5a2	Prescription Drugs	\$ 388,995	388,995		
28.	20	5d	Ambulance/Limousine	\$ 1,241	1,241		
29.	20	5f	X-rays, etc	\$ 34,349	34,349		
30.	20	5h	Laboratory	\$ 44,911	44,911		
31.			Medical Supplies	\$			
32.	20	5 e2	Oxygen (non emergency)	\$ 26,660	26,660		
33.			Occupational Therapy	\$			
34.	20	4a,b,s	Other - See Attached Schedule	\$ 74,740	35,539		39,201
<b>Page 22 - Maintenance and Property</b>							
35.	22	7d	Excess Movable Equipment Depreciation See Attached Schedule	\$ 26,267			26,267
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.	22	10a, c	Unallowable Property and Real Estate Taxes	\$ 9,265			9,265
38.			Rental of Building Space or Rooms	\$			
39.	22	6a-8c	Other - See Attached Schedule	\$ 77,965			77,965
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Research or Experimental Activities	\$			
43.	16	1m13	Radio and Television Revenue	\$ 11,685	11,685		
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.	30	IV8	Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$ 3,720,644	158,621		3,562,023
<b>Not For Profit Providers Only</b>							
50.	22, 26	7b,7c	Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$ 57,263			57,263
51.	<b>Total Amount of Decrease (Items 1 - 50)</b>			\$ 11,558,867	5,171,208		6,387,659

\*\*\* 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.

Southington Care Facility  
9/30/2017

**Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	Other
20	5i	A & G-RESIDENT RELATIONS -DISALLOWED - replace lost resident belongings	\$ 494		
20	5j	PLANETREE - DISALLOWED	\$ 2,539		
20	5j	SOCIAL SERVICES-PATIENT PERSONAL - DISALLOWED	\$ 108		
20	5j	PT-SUPPLIES - DISALLOWED	\$ 6,848		\$ 1,692
20	5j	PT-EQUIPMENT RENTAL - DISALLOWED	\$ 337		\$ 83
20	5j	OT-SUPPLIES - DISALLOWED	\$ 3,018		\$ 87
20	5j	NURSING SUPPLIES - KCI WOUND VAC- DISALLOWED	\$ 11,386		
20	5j	NURSING SUPPLIES - MED ESSENTIAL WOUND VAC- DISALLOWED	\$ 1,125		
20	5j	NURSING SUPPLIES - KENSINGTON HEARING SERVICES - HEARING AID FOR RESIDENT	\$ 2,850		
20	5j	NURSING SUPPLIES - MED ESSENTIALS - PRESSURE MATTRESS RENTALS AND LONG BED RENTALS	\$ 2,057		
20	5j	ANCILLARY-PROSTETIC DEVICES - MEDICARE - DISALLOWED	\$ 593		
20	5j	ANCILLARY-OTHER MEDICARE ANCILLARY(MEDICARE A) - DISALLOWED	\$ 4,184		
20	5j	GOOD LIFE FIT/ SR FIT- SUPPLIES - DISALLOWED			\$ 53
20	5j	PT OPTIMA SOFTWARE FEES - DISALLOWED			\$ 3,111
20	5j	HHCRN PT MANAGEMENT FEES - DISALLOWED			\$ 21,000
20	4a	HOUSEKEEPING SUPPLIES - OUTPATIENT			\$ 7,390
20	4b	HOUSEKEEPING PURCHASED SERVICES - OUTPATIENT			\$ 5,785
<b>Total Other Ancillary Costs</b>			\$ 35,539	\$ -	\$ 39,201

**Schedule of Excess Movable Equipment Depreciation**

Page Ref	Line Ref	Description	CCNH	RHNS	Other
22	7d	NON OPER DEPRECIATION-MOVEABLE EQUIPMENT			\$ 2,376
22	7d	DEPRECIATION-FURNITURE/EQUIP			\$ 7,734
22	7d	DEPRECIATION - COMPUTERS			\$ 8,153
22	7d	MNGMNT CO. MOVEABLE EQUIP DEPRECIATION			\$ 269
22	7d	MNGMNT CO. COMPUTER EQUIP DEPRECIATION			\$ 7,735
<b>Total Excess Movable Equipment Depreciation</b>			\$ -	\$ -	\$ 26,267

Page Ref	Line Ref	Description	CCNH	RHNS	Other
22	6a	MAINTENANCE-REPAIRS			\$ 8,755
22	6a	MAINTENANCE-SUPPLIES			\$ 3,739
22	6a	MAINTENANCE-MINOR EQUIPMENT			\$ 58
22	6a	MAINTENANCE-MINOR IMPROV			\$ (19)
22	6b	MAINTENANCE-GAS & PROPANE			\$ 8,262
22	6b	MAINTENANCE-OIL			\$ 123
22	6c	MAINTENANCE-ELECTRICITY			\$ 10,169
22	6d	MAINTENANCE-WATER & SEWER			\$ 5,611
22	6f	MAINTENANCE-GROUNDS-CONTRACT SERVICES			\$ 2,108
22	6f	MAINTENANCE-RUBBISH REMOVAL			\$ 2,689
22	6f	MAINTENANCE-EQUIP RENTAL			\$ 795
22	6f	MAINTENANCE-BUILDING-CONTRACT SERVICES			\$ 5,536
22	7a	DEPRECIATION-LAND IMPROVEMENTS			\$ 4,583
22	8b	AMORTIZATION - SERIES B & C			\$ 262
22	8c	MNGMNT CO. LEASEHOLD IMP DEPRECIATION			\$ 23,789
27	14a	INSURANCE ON PROPERTY			\$ 1,505
<b>Total Other Property Adjustments</b>			\$ -	\$ -	\$ 77,965

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
30	IV8	VAN FEE INCOME	\$ 10,547		
30	IV8	MANAGEMENT FEE REVENUE			\$ 2,347,751
30	IV8	MISCELLANEOUS INCOME	\$ 67,345		
30	IV8	GOOD LIFE FIT - SR FIT REVENUE			\$ 11,800
30	IV8	BHC-OTHER INCOME			\$ 22,800
30	IV8	BHC-INTEREST INCOME			\$ 68,357
30	IV8	TEMP NET ASSET RELEASED FROM RESTRICTION-OPERATION	\$ 80,503		
30	IV8	BHC-REALIZED GAIN ON INVESTMNT			\$ 95,790
30	IV8	BHC-UNREALIZED GAIN ON INVEST			\$ 338,930
30	IV8	GRANT REVENUE RELEASED THROUGH MANAGEMENT CO			\$ 676,595
30	IV8	INTEREST ON ACCOUNTS RECEIVABLE	\$ 226		
<b>Total Other Adjustments</b>			\$ 158,621	\$ -	\$ 3,562,023



## Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Other
22	7b	DEPRECIATON-BUILDING			\$ 14,902
22	7b	NON OPERATING-BHC-DEPRECIATION/ BUILDING			\$ 12,456
22	7b	DEPRECIATON-BUILDING IMPROV			\$ 15,981
22	7c	DEPRECIATON-FIXED EQUIPMENT			\$ 476
<b>Total Unallowable Building Interest</b>			\$ -	\$ -	\$ 43,815

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### F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Southington Care Facility	2060-C	9/30/2017		30	37
Item	Total	CCNH	RHNS	Other	
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 12,991,482	12,991,482			
b. Medicaid Room and Board Contractual Allowance **	\$ (6,481,275)	(6,481,275)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 3,721,207	3,721,207			
b. Medicare Room and Board Contractual Allowance **	\$ 411,713	411,713			
4. a. Private-Pay Residents and Other	\$ 6,239,634	6,239,634			
b. Private-Pay Room and Board Contractual Allowance **	\$ 110,156	110,156			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 263,600	263,600			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (263,600)	(263,600)			
c. Prescription Drugs - Non-Medicare	\$ 122,567	122,567			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (122,410)	(122,410)			
2. a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$ 1,086,393	770,123			316,270
b. Physical Therapy - Medicare Contractual Allowance **	\$ (797,514)	(747,282)			(50,232)
c. Physical Therapy - Non-Medicare	\$ 679,616	400,339			279,277
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (422,893)	(395,840)			(27,053)
4. a. Speech Therapy - Medicare	\$ 54,689	53,271			1,418
b. Speech Therapy - Medicare Contractual Allowance **	\$ (38,915)	(39,451)			536
c. Speech Therapy - Non-Medicare	\$ 32,657	27,997			4,660
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (26,610)	(26,610)			
5. a. Occupational Therapy - Medicare	\$ 800,977	789,395			11,582
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (747,772)	(745,432)			(2,340)
c. Occupational Therapy - Non-Medicare	\$ 429,984	417,978			12,006
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (476,993)	(417,874)			(59,119)
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 7,485	7,485			
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ (157)	(157)			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 17,574,021	17,087,016			487,005
<b>IV. Other Revenue*</b>					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income ( <i>Specify</i> )	\$				
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 3,724,435	162,412			3,562,023
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 3,724,435	162,412			3,562,023
<b>VI. Total All Revenue</b> (III +V)	\$ 21,298,456	17,249,428			4,049,028

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

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

**Schedule of Other Resident Revenue - Medicare**

**Related Exp**

Page Ref	Description	CCNH	RHNS	Other
			\$ -	\$ -
30 II 6a	PHLEBOTOMY - MED B	\$ 7,650		
30 II 6a	CONTR ALLOW - PHLEBOTOMY - MED B	\$ (165)		
<b>Total Other Resident Revenue - Medicare</b>		\$ 7,485	\$ -	\$ -

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

**Related Exp**

Page Ref	Description	CCNH	RHNS	Other
30 II 6b	CONTR.ALLOW - OTHER ANCILLARY	\$ (157)	\$ -	\$ -
<b>Total Other Resident Revenue</b>		\$ (157)	\$ -	\$ -

**Interest Income**

**Account**

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



Southington Care Center  
Misc. Income  
FY 2017  
Acct # 4750-091

Oct-16	Mobilex discount for prompt pay	576.43	
	WB Mason rebate	1,226.26	
Nov-16	badge replacement	10.00	
	medical records	735.80	
	GNYHA rebate from HHC	2,192.72	
Jan-17	medical records	108.95	
Feb-17	GNYHA rebate from HHC	2,358.96	
	Anthem reimb	140.25	
	CALTC	12,000.00	
	Mobilex discount for prompt pay	155.88	
	badge replacement	10.00	
March	Mobilex credit	34,000.00	see June
	medical records	1,106.30	
April	medical records	24.70	
	medical records	35.10	
	medical records	85.50	
	badge replacement	10.00	
May	medical records	13.65	
	medical records	92.30	
	medical records	43.55	
	medical records	120.25	
	badge replacement	10.00	
	GNYHA rebate from HHC	2,008.79	
	Record Journal refund	567.68	
	MobileX refund - the net of these two is what the actual credit was	(1,766.78)	see March
July	medical records	129.35	
	flu shots	3,947.83	
August	HHC Acurity Vendor Rebate	2,001.79	
	CALTC	5,400.00	
		<u>67,345.26</u>	

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Southington Care Facility	2060-C	9/30/2017	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	4,929,800
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,225,709
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	27,698
4. Inventories			\$	42,472
5. Prepaid Expenses			\$	140,314
a. PREPAID ACCOUNTS RECEIVABLE	82,584			
b. PREPAID-TAX	20,365			
c. PREPAID-INSURANCE	22,250			
d. PREPAID-OTHER - see schedule	15,115			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	335,292
Due From Affiliates	335,292			
<b>A-9. Total Current Assets (Lines A1 thru 8)</b>			\$	6,701,285
B. Fixed Assets				
1. Land			\$	810,000
2. Land Improvements	*Historical Cost	366,370	\$	146,636
	Accum. Depreciation	219,734	Net	
3. Buildings	*Historical Cost	4,936,723	\$	3,282,432
	Accum. Depreciation	1,654,291	Net	
4. Leasehold Improvements	*Historical Cost	119,019	\$	39,578
	Accum. Depreciation	79,441	Net	
5. Non-Movable Equipment	*Historical Cost	54,669	\$	12,435
	Accum. Depreciation	42,234	Net	
6. Movable Equipment	*Historical Cost	1,146,923	\$	262,291
	Accum. Depreciation	884,632	Net	
7. Motor Vehicles	*Historical Cost	42,230	\$	4,209
	Accum. Depreciation	38,021	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	214,063
Construction in Progress	214,063			
<b>B-10. Total Fixed Assets (Lines B1 thru 9)</b>			\$	4,771,644

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

(Carry Total forward to next page)

Southington Care Center

	<u>Pharmacy A/R</u>	<u>Due from HHC for overpaid insurance</u>	<u>Due from Heather Hitchcock - payroll</u>	<u>Accrue triple a days</u>	<u>Balance</u>
FY2016 balance	15,000.00	1,909.98			16,909.98
A/R Misc #1014-060		1,382.48	5,100.00	3,042.93	9,525.41
A/R Good Life Fitness #1710-000					1,262.75
<b>Total 1014-060 and 1710-000</b>					<b>27,698.14</b>

SOUTHINGTON CARE CENTER  
PREPAID ANALYSIS  
Prepaid Other  
FYE 9/30/17

2018

DESCRIPTION	October	November	December	January	February	March	April	May	June	Balance	GL	Variance
CT COMPUTER MAINT. AGREEMENT	73.12	73.12	73.12	73.12						292.48		
SBS YEARLY CONTRACT	135.76									135.76		
TAX CUSHION	600.00									600.00		
TAX CUSHION	600.00									600.00		
TAX CUSHION	4,600.00									4,600.00		
TAX CUSHION	600.00									600.00		
TAX CUSHION	600.00									600.00		
LEADING AGE	1,017.91	1,017.91	1,017.91							3,053.73		
GAVLAK WATER MARCH - FEB ONE YEAR	158.33	158.33	158.33	158.33	158.37					791.69		
SBS YEARLY CONTRACT	150.22	150.22	150.22	150.22						600.88		
IN2L YEARLY SUBS	103.13	103.13	103.13	103.13	103.13	103.13	103.13	103.13		825.04		
HH BIOMEDICAL FEES	1,000.00									1,000.00		
IN2L YEARLY SUBS	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	1,800.00		
NATIONAL RESEARCH JULY AUG AND SEPT	(388.62)									(388.62)		
										<u>15,110.96</u>	15,115.57	(4.61)



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

Name of Facility	License No.	Report for Year Ended	Page	of
Southington Care Facility	2060-C	9/30/2017	32	37
Account			Amount	
Total Brought Forward:			\$	11,472,929
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Non-Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
5. Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
6. Motor Vehicles				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
7. Minor Equipment-Not Depreciable			\$	
C-8 <b>Total Leasehold or Like Properties</b> (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	
_____				
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	
Name and Address		Amount	Loan Date	
7. Other Assets ( <i>itemize</i> )			\$	3,620,146
Unrestricted & Permanently Restricted Investment		3,478,188		
Cost of Issuance Series B&C		67,792		
A/R Deposit (Excess WC)		74,166		
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	3,620,146
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$	15,093,075

\* 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 Southington Care Facility		License No. 2060-C	Report for Year Ended 9/30/2017	Page 33	of 37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	131,835
2. Notes Payable ( <i>itemize</i> )				\$	
_____					
_____					
_____					
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$	680,449
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable ( <i>Current Portion</i> )				\$	
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities ( <i>itemize</i> )				\$	2,690,504
Deferred Revenue		102,967	State of CT Provider Tax	181,614	
Accrued Expenses -see sub schedule		447,852	Other - Excess WC	74,166	
Due to Third Parties		76,136	Moveable Lease	6,897	
Due to Affiliates		1,795,167	Life Ins. & Benefits W/H	5,705	
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>				\$	<b>3,502,788</b>

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

(Carry Total forward to next page)

**SOUTHINGTON CARE CENTER  
ACCRUED EXPENSES  
FYE 9/30/17**

**#2103-040**

<b>DESCRIPTION</b>	<b>Account #</b>	<b>Balance</b>
RECLASS HHFF MONEY	4750-092	2,425.00
ACCRUE AT RISK	6010-020	103,468.18
ACCRUE SEWERS	6820-034	463.81
ACCRUE WATER	6820-034	1,655.77
ACCRUE AUDREY V	6010-020	1,545.12
ACCRUE KATIE M	6010-020	1,400.00
ACCRUE SUSAN V	6010-020	1,457.26
ACCRUE MARIE P	6010-020	594.28
ACCRUE NICK G	SEE BACKUP	436.80
ACCRUE PHARMACY	SEE BACKUP	26,518.10
ACCRUE MISC MNMNGT CO PER PAULA	6020-020	500.00
ACCRUE BANK OF AMERICA	SEE BACKUP	3,382.88
ACCRUE MISC MNMNGT CO PER PAULA	6020-020	1,000.00
ACCRUE LAB	SEE BACKUP	17,923.76
ACCRUE UNEMPLOYMENT	6920-036	6,000.00
ACCRUE ELECTRICITY	6820-036	11,000.00
ACCRUE CROTHALL	6720-001	8,562.00
ACCRUE MORRISON	6620-001	47,000.00
ACCRUE PROHEALTH	6320-020	5,000.00
ACCRUE DENTAL	6229-001	495.00
ACCRUE LAB	6227-012	3,000.00
ACCRUE LAB	6227-015	1,000.00
ACCRUE WORKERS COMP	6920-034	198,849.88
CRABAPPLE NEIGHBORHOOD	6420-078	406.19
LILY LANE NEIGHBORHOOD	6420-078	746.12
MAGNOLIA NEIGHBORHOOD	6420-078	900.08
SUNFLOWER NEIGHBORHOOD	6420-078	608.59
NORTH STAR NEIGHBORHOOD	6420-078	253.51
ACCRUE CBS QRTLY	6420-030	420.00
ACCRUE CBS QRTLY	6420-030	420.00
ACCRUE CBS QRTLY	6420-030	420.00
<b>TOTAL SEPT</b>		<b>447,852.33</b>

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

Name of Facility Southington Care Facility		License No. 2060-C	Report for Year Ended 9/30/2017	Page 34	of 37
Account				Amount	
Total Brought Forward:				3,502,788	
<b>Liabilities (cont'd)</b>					
B. Long-Term Liabilities					
1. Loans Payable-Equipment ( <i>itemize</i> )					
\$					
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$ 7,031,283	
Name and Address of Lender	Amount	Loan Date			
Hartford HealthCare	7,031,283				
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$ 230,162	
Workers Compensation		230,162			
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 7,261,445	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 10,764,233	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Southington Care Facility	2060-C	9/30/2017	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	646,606
6. Total Reserves			\$	646,606
<b>B. Net Worth</b>				
1. Owner's Capital			\$	3,991,738
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	
6. Gain or Loss for Period			\$	(309,502)
	10/1/2016	thru 9/30/2017		
7. Total Net Worth			\$	3,682,236
<b>C. Total Reserves and Net Worth</b>			\$	4,328,842
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	15,093,075

### H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of	
Southington Care Facility	2060-C	9/30/2017	36	37	
Account			Amount		
A.	Balance at End of Prior Period as shown on Report of 09/30/2016		\$	4,318,237	
B.	Total Revenue ( <i>From Statement of Revenue Page 30</i> )		\$	21,298,456	
C.	Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )		\$	21,607,958	
D.	Net Income or Deficit		\$	(309,502)	
E.	Balance		\$	4,008,735	
F.	Additions				
	1. Additional Capital Contributed ( <i>itemize</i> )				
	2. Other ( <i>itemize</i> )				
	Temporary Restricted Net Assets	1,077,205			
	Release of Restricted Funds	(757,098)			
F-3.	Total Additions		\$	320,107	
G.	Deductions				
	1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )				
	Name and Address ( <i>No., City, State, Zip</i> )	Title	Amount		
	2. Other Withdrawings ( <i>Specify</i> )				
	Purpose	Amount			
	3. Total Deductions		\$		
H.	<b>Balance at End of Period</b>		\$	4,328,842	
	09/30/17				

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

Name of Facility Southington Care Facility	License No. 2060-C	Report for Year Ended 9/30/2017	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> Other		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
Dorothy Robinson				
Address			Phone Number	
80 Meriden Avenue, Southington, CT 06489			860-378-8022	

Error Check

Level	Item	Reported as	
Other	Page 9 - Total Speech Therapy Treatments	88	is inconsistent with balance of 88