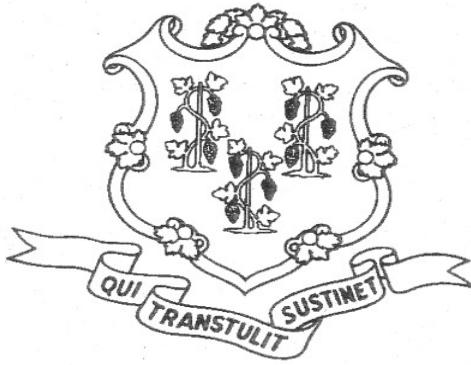


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2018

Name of Facility (as licensed) Massack Memorial Home	
Address (No. & Street, City, State, Zip Code) 30 Davis Ave, Rockville, CT 06066	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input checked="" type="checkbox"/> Residential Care Home	
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018

License Numbers:	CCNH	RHNS	Residential Care Home 1413	Medicare Provider
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Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) Massack Memorial Home	License No. 1413	Report for Year Ended 9/30/2018	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Massack Memorial Home [facility name], for the cost report period beginning October 1, 2017 and ending September 30, 2018, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

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

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Massack Memorial Home		Period Covered:	From 10/1/2017	To 9/30/2018
Address of Facility 30 Davis Ave, Rockville, CT 06066				
Report Prepared By CJLC LLC		Phone Number 860-610-9009	Date 1/21/2019	
Item	Total	CCNH	RHNS	Residential Care Home
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire

Type of Facility - Organization Structure

	Phone No. of Facility 860-875-1011	Report for Year Ended 9/30/2018	Page 2	of 37
Name of Facility (as shown on license) Massack Memorial Home		Address (No. & Street, City, State, Zip) 30 Davis Ave, Rockville, CT 06066		
License Numbers:	CCNH	RHNS	Residential Care Home 1413	Medicare Provider No.
Type of Facility (Check appropriate box(es))				
<input type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> Residential Care Home				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?				
<input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Merrilee McFeaters		Nursing Home Administrator's License No.:	1413	
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 Massack Memorial Home	License No. 1413	Report for Year Ended 9/30/2018	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	
Rhodes Inc. d/b/a Massack Memorial Home	30 Davis Ave Rockville, CT 06066	CT	

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Marie Montpetit	30 Davis Ave Rockville, CT 06066	President	80
Merrilee McFeaters	30 Davis Ave Rockville, CT 06066	Secretary	
Summer Montpetit	30 Davis Ave Rockville, CT 06066	Director	

Names of Stockholders Owning at Least 10% of Shares	Business Address	Title	No. Shares Held by Each
Marie Montpetit	30 Davis Ave Rockville, CT 06066	President	80

General Information and Questionnaire Related Parties*

Name of Facility Massack Memorial Home	License No. 1413	Report for Year Ended 9/30/2018	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Marie Montpetit	30 Davis Ave Rockville, Ct 06066	<input type="radio"/>	<input checked="" type="radio"/>		Rental	22/9	31,000	31,000
Marie Montpetit	30 Davis Ave Rockville, Ct 06066	<input type="radio"/>	<input checked="" type="radio"/>		Interest	27/12D	7,222	7,222
Marie Montpetit	30 Davis Ave Rockville, Ct 06066	<input type="radio"/>	<input checked="" type="radio"/>		Loans to Business	34/B3	90,986	90,986
Marie Montpetit	30 Davis Ave Rockville, Ct 06066	<input type="radio"/>	<input checked="" type="radio"/>		Clerical	10/A4	34,809	34,809
Merrilee McFeaters	30 Davis Ave Rockville, Ct 06066	<input type="radio"/>	<input checked="" type="radio"/>		Person in Charge	10/A2	55,488	55,488
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

* 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 Massack Memorial Home	License No. 1413	Report for Year Ended 9/30/2018	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility Massack Memorial Home			License No. 1413	Report for Year Ended 9/30/2018			Page 6	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
N/A	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input checked="" type="radio"/> 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 Massack Memorial Home	License No. 1413	Report for Year Ended 9/30/2018	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:
 Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm 1 CJLC LLC 2 3 4	Address (No. & Street, City, State, Zip Code) 225 Pitkin St. East Hartford, CT 06108
--	---

Services Provided by This Firm (describe fully)

1 Medicaid Cost Report, Accounting Services, Tax Services	\$	5,250
2	\$	
3	\$	
4	\$	
		Charge for Services Provided
		\$ 5,250

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

Legal Services Information

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

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

Services Provided by This Firm (describe fully)

1 #REF!	\$	
2 #REF!	\$	
3 #REF!	\$	
4 #REF!	\$	
5 #REF!	\$	
		Charge for Services Provided
		\$

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

Schedule of Resident Statistics

Name of Facility Massack Memorial Home			License No. 1413		Report for Year Ended 9/30/2018				Page 8	of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total Residential Care Home	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Residential Care Home	Total	CCNH	RHNS	Residential Care Home
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	19			19	19			19	19			19
B. On last day of THIS report period	19			19	19			19	19			19
2. Number of Residents												
A. As of midnight of PREVIOUS report period	19			19	19			19	19			19
B. As of midnight of THIS report period	19			19	19			19	19			19
3. Total Number of Days Care Provided During Period												
A. Medicare												
B. Medicaid (Conn.)												
C. Medicaid (other states)												
D. Private Pay												
E. State SSI for RCH	6,701			6,701	5,047			5,047	1,654			1,654
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	6,701			6,701	5,047			5,047	1,654			1,654
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	116			116	87			87	29			29
B. Other Bed Reserve Days	17			17	17			17				
5. Total Resident Days (3G + 4A + 4B)	6,834			6,834	5,151			5,151	1,683			1,683

Schedule of Resident Statistics (Cont'd)

Name of Facility Massack Memorial Home			License No. 1413			Report for Year Ended 9/30/2018			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	Residential Care Home	Lost			Gained			CCNH	RHNS	Residential Care Home	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	Residential Care Home		
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	Residential Care Home	R.C.H.	ICF-MR				
No. of Residents									19				
Per Diem Rate													
a. One bed rm.									87.93				
b. Two bed rms.													
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	Residential Care Home	
A. Medicare - Part B													
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other													
D. Total Physical Therapy Treatments													
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B													
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other													
D. Total Speech Therapy Treatments													
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B													
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other													
D. Total Occupational Therapy Treatments													

Report of Expenditures - Salaries & Wages

Name of Facility Massack Memorial Home	License No. 1413	Report for Year Ended 9/30/2018	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)					55,488	2,080
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)					42,905	2,349
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers					51,815	4,001
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers					20,502	1,420
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers						
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers					4,858	375
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses						
b. RN						
1. Direct Care						
2. Administrative**						
c. LPN						
1. Direct Care						
2. Administrative**						
d. Aides and Attendants					105,989	7,856
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers						
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management						
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>					281,557	18,081

* 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	
Massack Memorial Home				1413	9/30/2018			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Residential Care Home							
Section I - Operators/Owners										
Marie Montpetit			34,692		Clerical	1,718	A4			
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
Massack Memorial Home				1413	9/30/2018			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Residential Care Home							
Section III - Administrators***										
Merrilee McFeaters			55,488		Person in charge of running operations of facility	2,080	A2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Massack Memorial Home	1413	9/30/2018	13	37		
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)						
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries						

* 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.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Massack Memorial Home	1413	9/30/2018	15	37
Item	Total	CCNH	RHNS	Residential Care Home
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 16,580			16,580
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 4,062			4,062
4. Social Security (F.I.C.A.)	\$ 21,203			21,203
5. Health Insurance	\$ 28,002			28,002
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 1,084			1,084
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 6,693			6,693
8. Uniform Allowance	\$ 142			142
9. Other (<i>Specify</i>) See Attached Schedule	\$ 4,418			4,418
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$			
d. Accounting and Auditing	\$ 5,250			5,250
e. Legal (<i>Services should be fully described on Page 7</i>)	\$			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 8,027			8,027
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 3,301			3,301
2. Cellular Phones	\$ 1,895			1,895
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ (341)			(341)
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	\$			
Subtotal	\$ 100,316			100,316

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended		Page	of
Massack Memorial Home	1413	9/30/2018		16	37
Item	Total	CCNH	RHNS	Residential Care Home	
Subtotals Brought Forward:	100,316			100,316	
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 369			369	
3. Gifts to Staff and Residents	\$ 725			725	
4. Employee Travel	\$				
5. Education Expenses Related to Seminars and Conventions	\$ 925			925	
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 5,303			5,303	
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 375			375	
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 563			563	
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	\$ 349			349	
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 585			585	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 300			300	
9. Subscriptions	\$ 711			711	
10. Contributions*** See Attached Schedule	\$ 220			220	
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$				
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$ 133			133	
C-14 Total Administrative & General Expenditures	\$ 110,874			110,874	

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

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	Residential Care Home
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	Residential Care Home
Advert.-Pub Relations			\$ 563
Total Other Advertising	\$ -	\$ -	\$ 563

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
CARCH			\$ 500
ALTCFM			\$ 85
Total Dues	\$ -	\$ -	\$ 585

Schedule of Contributions

Description	CCNH	RHNS	Residential Care Home
Contributions			\$ 220
Total Contributions	\$ -	\$ -	\$ 220

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
Bank Fees			\$ 36
Non Reimbursable Expense			\$ 97
Total Other Administrative and General	\$ -	\$ -	\$ 133

Schedule C-1 - Management Services*

Name of Facility Massack Memorial Home	License No. 1413	Report for Year Ended 9/30/2018	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
N/A			

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

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

Name of Facility Massack Memorial Home		License No. 1413	Report for Year Ended 9/30/2018		Page 18	of 37
Item		Total	CCNH	RHNS	Residential Care Home	
2. Dietary						
a. In-House Preparation & Service						
1. Raw Food	\$	44,821				44,821
2. Non-Food Supplies	\$	2,455				2,455
3. Other (Specify) _____	\$					
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$				
c. Other (Specify) _____		\$				
2D. Total Dietary Expenditures (2a + b + c + d)		\$	47,276			47,276
2F. Dietary Questionnaire		Total	CCNH	RHNS	Residential Care Home	
G. Resident Meals:	Total no. of meals served per day:*					
H. Is cost of employee meals included in 2E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No				
I. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.			
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.			
L. Is any revenue collected from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.			
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.			
O. Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.			
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)						

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

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

Name of Facility Massack Memorial Home		License No. 1413	Report for Year Ended 9/30/2018	Page 19	of 37
Item		Total	CCNH	RHNS	Residential Care Home
3.	Laundry				
	a. In-House Processing*	Lbs.			
	1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$			
	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. \$	739		739
	b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$			
	c. Other (Specify)	\$			
3D.	Total Laundry Expenditures (3a + b + c)	\$	739		739
3F. Laundry Questionnaire					
G.	Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
H.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
I.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

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

All allocations should add to total recorded in 3E.

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

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

Name of Facility	License No.	Report for Year Ended	Page	of	
Massack Memorial Home	1413	9/30/2018	20	37	
				Residential Care Home	
Item		Total	CCNH	RHNS	
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care					
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	1,285			1,285
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	Sq. Ft. Serviced by Personnel				
	Amt. \$				
C. Other (<i>Specify</i>)		\$			
4D. Total Housekeeping Expenditures (4a + b + c)		\$ 1,285			1,285
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$				
b. Medicine Cabinet Drugs	\$	13			13
c. Medical and Therapeutic Supplies	\$				
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$				
f. X-rays and Related Radiological Procedures***	\$				
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$				
i. Recreation	\$	1,711			1,711
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (Specify)**** See Attached Schedule	\$				
5M. Total Resident Care Expenditures (5a - 5j)		\$ 1,724			1,724

* 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 Massack Memorial Home			License No. 1413	Report for Year Ended 9/30/2018	Page of 21 37					
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	Residential Care Home	Pg	Line
N/A		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

* 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 Massack Memorial Home	License No. 1413	Report for Year Ended 9/30/2018	Page 22	of 37
Item	Total	CCNH	RHNS	Residential Care Home
6. Maintenance & Operation of Plant				
a. Repairs & Maintenance	\$ 37,435			37,435
b. Heat	\$ 11,590			11,590
c. Light & Power	\$ 13,054			13,054
d. Water	\$ 4,936			4,936
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$			
f. Other (<i>itemize</i>)	\$ 9,319			9,319
See Attached Schedule				
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 76,334			76,334
7. Depreciation (<i>complete schedule page 23*</i>)				
a. Land Improvements	\$			
b. Building & Building Improvements	\$			
c. Non-Movable Equipment	\$			
d. Movable Equipment	\$ 2,131			2,131
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 2,131			2,131
8. Amortization (<i>Complete att. Schedule Page 24*</i>)				
a. Organization Expense	\$			
b. Mortgage Expense	\$			
c. Leasehold Improvements	\$ 22,962			22,962
d. Other (<i>Specify</i>)	\$			
*8e. Total Amortization Costs (8a + b + c + d)	\$ 22,962			22,962
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 31,000			31,000
10. Property Taxes				
a. Real estate taxes paid by owner	\$ 13,904			13,904
b. Real estate taxes paid by lessor	\$			
c. Personal property taxes	\$ 1,065			1,065
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 71,062			71,062

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

Massack Memorial Home
9/30/2018

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

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

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
3/6/2018	Water Heater	\$ 2,945	5	\$ 344
6/18/2018	Stairwell	\$ 5,800	5	\$ 387
9/20/2018	Dining Room Floor	\$ 3,400	5	\$ 57
9/25/2018	Upper Chimney	\$ 6,000	5	\$ 100
Total additions for Leasehold Improvement		\$ 18,145		\$ 887 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Massack Memorial Home			License No. 1413		Report for Year Ended 9/30/2018			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	VAR	VAR	VAR	340,638	283,140	SL	VAR	22,075	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				18,145				887	
C-4. Subtotal									22,962
D. Total Amortization									22,962

* 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 Massack Memorial Home	License No. 1413	Report for Year Ended 9/30/2018	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" 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		05/01/56		
2. Date Structure Completed		05/01/56		
3. If NOT Original Owner, Date of Purchase		04/01/60		
4. Date of Initial Licensure		05/01/56		
5. Total Licensed Bed Capacity		19		
6. Square Footage				
7. Acquisition Cost				
a. Land		200,000		
b. Building				
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)		Fixed 5 yrs		
b. Date Mortgage Obtained		04/01/00		
c. Interest Rate for the Cost Year		630.00%		
d. Term of Mortgage (number of years)		30		
e. Amount of Principal Borrowed		77,908		
f. Principal balance outstanding as of _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
Part C - Arms-Length Leases for Real Property Improvements Only				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility		License No.	Report for Year Ended			Page	of
Massack Memorial Home		1413	9/30/2018			26	37
Item		Total	CCNH	RHNS	Residential Care Home		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
2. Second Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
3. Third Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
4. Fourth Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount		\$					
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expense							
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$					

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page of	
Massack Memorial Home		1413		9/30/2018		27 37	
Item				Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (<i>Specify</i>)				\$			
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 (<i>Specify</i>)				\$	7,222		7,222
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	7,222		7,222
14. Insurance							
a. Insurance on Property (buildings only)				\$	13,803		13,803
b. Insurance on Automobiles				\$	2,296		2,296
c. Insurance other than Property (as specified above)							
1. Umbrella (<i>Blanket Coverage</i>)				\$			
2. Fire and Extended Coverage				\$			
3. Other (<i>Specify</i>)				\$			
14d. Total Insurance Expenditures (14a + b + c)				\$	16,099		16,099
15. Total All Expenditures (A-13 thru C-14)				\$	614,171		614,171

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Massack Memorial Home				1413	9/30/2018	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 1,175			1,175
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m3	Unallowable Advertising *	\$ 563			563
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 653			653
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 2,391			2,391

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
16	m13	Non Reimbursable Expenses			\$ 97
16	m13	Bank Fees			\$ 36
16	m8a	Dues to Chamber of Commerce			\$ 300
16	m10	Contributions			\$ 220
Total Other A&G Adjustments			\$ -	\$ -	\$ 653

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Massack Memorial Home			1413	9/30/2018	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward				\$ 2,391			2,391
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$			
28.			Ambulance/Limousine	\$			
29.			X-rays, etc	\$			
30.			Laboratory	\$			
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$			
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 2,391			2,391

*** 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.

Massack Memorial Home
9/30/2018

Schedule of Other Ancillary Costs

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

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Property Adjustments			\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Adjustments			\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Massack Memorial Home	1413	9/30/2018			30	37
Item	Total	CCNH	RHNS	Residential Care Home		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 612,491			612,491		
b. Medicaid Room and Board Contractual Allowance **	\$					
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$					
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$					
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$					
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$					
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$					
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$					
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$					
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$					
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$					
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$					
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 612,491			612,491		
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$					
V. Total Other Revenue (1 thru 8)	\$					
VI. Total All Revenue (III +V)	\$ 612,491			612,491		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Resident Revenue		\$ -	\$ -	\$ -

Interest Income

		Account			
Page Ref	Account	Balance	CCNH	RHNS	Residential Care Home
Total Interest Income			\$ -	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Revenue		\$ -	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Massack Memorial Home	1413	9/30/2018	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	2,992
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	46,795
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	17,112
a. _____				
b. _____				
c. _____				
d. See Schedule		17,112		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	66,899
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	14,670	\$	
	Accum. Depreciation	14,670		Net
3. Buildings	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		Net
4. Leasehold Improvements	*Historical Cost	358,784	\$	52,681
	Accum. Depreciation	306,102		Net
5. Non-Movable Equipment	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		Net
6. Movable Equipment	*Historical Cost	42,067	\$	6,239
	Accum. Depreciation	35,828		Net
7. Motor Vehicles	*Historical Cost	38,357	\$	
	Accum. Depreciation	38,357		Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	58,920

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Massack Memorial Home	1413	9/30/2018	32	37
Account			Amount	
Total Brought Forward:			\$	125,819
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Non-Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
5. Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
6. Motor Vehicles				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

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

See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	125,819

* 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 Massack Memorial Home		License No. 1413	Report for Year Ended 9/30/2018	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	19,182
2. Notes Payable (<i>itemize</i>)				\$	

See Schedule					
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	4,769
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	4,049
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>)				\$	

See Schedule					
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	28,000

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Massack Memorial Home	License No. 1413	Report for Year Ended 9/30/2018	Page 34	of 37
Account			Amount	
Total Brought Forward:			28,000	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				
				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				
				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				
				\$ 90,986
Name and Address of Lender	Amount	Loan Date		
Marie Montpetit	90,986			
4. Other Long-Term Liabilities (<i>itemize</i>)				
_____				\$
_____				\$
See Schedule				\$
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 90,986
C. Total All Liabilities (Lines A-13 + B-5)				\$ 118,985

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

Name of Facility	License No.	Report for Year Ended	Page	of
Massack Memorial Home	1413	9/30/2018	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	6,015
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	6,015
B. Net Worth				
1. Owner's Capital			\$	(2,070)
2. Capital Stock			\$	8,000
3. Paid-in Surplus			\$	2,000
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(5,431)
6. Gain or Loss for Period	10/1/2017	thru	9/30/2018	\$ align="right">(1,680)
7. Total Net Worth			\$	818
C. Total Reserves and Net Worth			\$	6,833
D. Total Liabilities, Reserves, and Net Worth			\$	125,819

H. Changes in Total Net Worth

Name of Facility Massack Memorial Home	License No. 1413	Report for Year Ended 9/30/2018	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2017			\$	(25,064)
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	612,491
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	614,171
D. Net Income or Deficit			\$	(1,680)
E. Balance			\$	(26,744)
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions				
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount	
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period			\$	(26,744)

I. Preparer's/Reviewer's Certification

Name of Facility Massack Memorial Home	License No. 1413	Report for Year Ended 9/30/2018	Page 37	of 37
<i>Check appropriate category</i>				
<input type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> Residential Care Home		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
CJLC LLC				
Address Address		Phone Number		
225 Pitkin Street, East Hartford, CT 06108		860-610-9009		
Annual Report Contact		Phone Number		
CJLC		860-610-9009		
Annual Report Contact Email Address				
annualreports@cjlc.com				