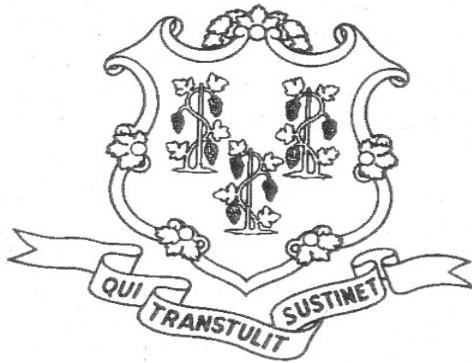


# State of Connecticut



# Annual Report of Long-Term Care Facility

## Cost Year 2022

Name of Facility (as licensed) Mystic Healthcare & Rehabilitation, LLC		
Address (No. & Street, City, State, Zip Code) 475 High Street, Mystic, CT 06355		
Type of Facility		
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS)	<input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2021	Report for Year Ending 9/30/2022	

License Numbers:	CCNH 839-C	RHNS	(Specify)	Medicare Provider 07-5271
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Medicaid Provider Numbers:	CCNH 8391	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) Mystic Healthcare & Rehabilitation, LLC	License No. 839-C	Report for Year Ended 9/30/2022	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 Mystic Healthcare & Rehabilitation, LLC [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, 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) Kenneth Kopchik		Printed Name (Owner) Martin Sbriglio		
Subscribed and Sworn to before me:	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

<b>Data Required for Real Wage Adjustment</b>		Page 1A	of 37
Name of Facility Mystic Healthcare & Rehabilitation, LLC	Period Covered:	From 10/1/2021	To 9/30/2022
Address of Facility 475 High Street, Mystic, CT 06355			
Report Prepared By Ryders Health Management	Phone Number 203-381-1327	Date 1/17/2023	
Item	Total	CCNH	RHNS (Specify)
1. Dietary wages paid	\$		
2. Laundry wages paid	\$		
3. Housekeeping wages paid	\$		
4. Nursing wages paid	\$		
5. All other wages paid	\$		
<b>6. Total Wages Paid</b>	\$		
7. Total salaries paid	\$		
<b>8. 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	Report for Year Ended	Page	of
203-318-1327	9/30/2022	2	37

Name of Facility (as shown on license) Mystic Healthcare & Rehabilitation, LLC		Address (No. & Street, City, State, Zip) 475 High Street, Mystic, CT 06355		
License Numbers:	CCNH 839-C	RHNS	(Specify)	Medicare Provider No. 07-5271
Type of Facility (Check appropriate box(es))				
<input checked="" 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 type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," explain fully.

**Administrator**

Name of Administrator Kenneth Kopchik	Nursing Home Administrator's License No.:	001904
--	---	--------

Other Operators/Owners who are assistant administrators (full or part time) of this facility.		
Name N/A	License No.:	N/A

## **General Information and Questionnaire Partners/Members**

**General Information and Questionnaire**  
**Corporate Owners**

Name of Facility Mystic Healthcare & Rehabilitation, LLC	License No. 839-C	Report for Year Ended 9/30/2022	Page of 3A   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	
N/A			
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
N/A			
Names of Stockholders Owning at Least 10% of Shares			
N/A			

State of Connecticut

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

CSP-3B Rev. 10/2005

**General Information and Questionnaire**  
**Individual Proprietorship**

Name of Facility	License No.	Report for Year Ended	Page	of
Mystic Healthcare & Rehabilitation, LLC	839-C	9/30/2022	3B	37

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

Owner(s) of Facility

N/A

## **General Information and Questionnaire**

### **Related Parties\***

Name of Facility Mythic Healthcare & Rehabilitation, LLC	License No. 839-C	Report for Year Ended 9/30/2022	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?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input checked="" type="radio"/> Yes	<input type="radio"/> 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		<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"/>					

\* Use additional sheets if necessary.

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

**Mystic Healthcare**  
**Cost Report 9/30/2022**  
**List of Related Parties**  
**Page 4 Attachment**

Name of Related Individual or Company	Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Services Provided	Indicate Where Costs are Included in Annual Report Page #/Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%				
Ryders Health Management (RHM)	88 Ryders Lane, Suite 208, Stratford, CT 06614	X			Financial and Managerial Support	16/m12	381,480	
Due from Ryders Health Management	88 Ryders Lane, Suite 208, Stratford, CT 06614	X			Loan to Facility	32/D7	31,469	
Due from Bel-Air Realty	88 Ryders Lane, Suite 208, Stratford, CT 06614	X			Loan to Facility	32/D7	189,205	
Due from Lighthouse	88 Ryders Lane, Stratford, CT 06614	X			Loan to Facility	32/D7	304,875	
ValueRx	54 Tuttle Place, Middletown, CT	X			Pharmacy Expenses	20/5a2	173,441	Disallowed
Due to Aaron Manor	3 South Wig Hill Road, Chester, CT 06412	X			Loan from Facility	34/B4	40,589	
Due to Chamberlain Manor	7003 Main St., Stratford, CT 06614	X			Loan from Facility	34/B4	1,079,267	
Due to Cheshire House	3396 East Main St., Waterbury, CT 06705	X			Loan from Facility	34/B4	101,626	
Due to Greentree Manorr	4 Greentree Drive, Waterford, CT 06385	X			Loan from Facility	34/B4	3,696	
Due to Lord Chamberlain	7003 Main St., Stratford, CT 06614	X			Loan from Facility	34/B4	360,289	
Due to GT Realty	3396 East Main St., Waterbury, CT 06705	X			Loan from Facility	34/B4	640,000	

## **General Information and Questionnaire**

### **Basis for Allocation of Costs**

Name of Facility Mystic Healthcare & Rehabilitation, LLC	License No. 839-C	Report for Year Ended 9/30/2022	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?	<input checked="" type="radio"/> Yes <input type="radio"/> 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.)		
<input checked="" type="radio"/> Yes <input type="radio"/> 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.

### Is a Mileage Log Book Maintained for All Leased Vehicles?

Yes

⊕ No

Total \*\*\*

8,545

\* 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	License No.	Report for Year Ended	Page	of
Mystic Healthcare & Rehabilitation	839-C	9/30/2022	7	37

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      If "No," explain.  
Ⓑ No

### **Independent Accounting Firm**

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 CJLC Consulting, LLC	225 Pitkin Street, East Hartford, CT 06108
2 Marcum LLP	555 Long Wharf, New Haven, CT 06511
3	
4	

**Services Provided by This Firm (*describe fully*)**

1	Tax Returns, Year end financial statement review, consulting	\$	6,656
2	Financial Statements	\$	2,389
3		\$	
4		\$	
		Charge for Services Provided	
		\$	9,044

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	Telephone Number
1 See Attached	
2	
3	
4	
5	

Address (No. & Street, City, State, Zip Code)

**Services Provided by This Firm (*describe fully*)**

1	\$
2	\$
3	\$
4	\$
5	\$

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

Line 15, Line 1e

**Mystic Healthcare**  
**Legal Fees**  
**9/30/2022**

Vendor	Description	Amount	Allowable	
			Yes	No
Litigation Services	Employee Matter	735.08	-	735.08
Lemieux & Associates	Employee Matter	1,397.97	-	1,397.97
The Law Offices of Meehan, DiPalma, Rob	Employee Matter	7,866.95	-	7,866.95
Cicchiello & Cicchiello LLP	Employee Matter	5,000.00	-	5,000.00
Joe D'Agostino	Various Matter	9,629.62	4,814.81	4,814.81
Kainen , Escalera & McHale	Employee Matter	10,270.13	-	10,270.13
Murtha Cullina	General Matters	6,362.00	6,362.00	-
<b>Total</b>		<b>\$ 41,261.75</b>	<b>\$ 11,176.81</b>	<b>\$ 30,084.94</b>

## Schedule of Resident Statistics

Name of Facility Mystic Healthcare & Rehabilitation, LLC			License No. 839-C			Report for Year Ended 9/30/2022				Page 8 of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity					100	100						
A. On last day of PREVIOUS report period	100	100										
B. On last day of THIS report period	100	100							100	100		
2. Number of Residents					76	76						
A. As of midnight of PREVIOUS report period	76	76										
B. As of midnight of THIS report period	83	83							83	83		
3. Total Number of Days Care Provided During Period					2,161	2,161						
A. Medicare	2,693	2,693							532	532		
B. Medicaid (Conn.)	18,895	18,895			13,858	13,858			5,037	5,037		
C. Medicaid (other states)												
D. Private Pay	4,234	4,234			3,011	3,011			1,223	1,223		
E. State SSI for RCH												
F. Other (Specify) Managed Care	3,298	3,298			2,408	2,408			890	890		
G. Total Care Days During Period (3A thru F)	29,120	29,120			21,438	21,438			7,682	7,682		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	331	331			235	235			96	96		
B. Other Bed Reserve Days	46	46			42	42			4	4		
<b>5. Total Resident Days (3G + 4A + 4B)</b>	<b>29,497</b>	<b>29,497</b>			<b>21,715</b>	<b>21,715</b>			<b>7,782</b>	<b>7,782</b>		

## Schedule of Resident Statistics (Cont'd)

Name of Facility Mystic Healthcare & Rehabilitation, LLC	License No. 839-C	Report for Year Ended 9/30/2022	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?  Yes  No  
If "YES", provide the following information:

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	6	55		22				
Per Diem Rate								
a. One bed rm.	Various	265.18		\$456/\$479				
b. Two bed rms.				\$460/\$406				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B		TOTAL	CCNH	RHNS	(Specify)
		5,134	5,134		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other		12,630	12,630		
D. <b>Total Physical Therapy Treatments</b>		17,764	17,764		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		425	425		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other		772	772		
D. <b>Total Speech Therapy Treatments</b>		1,197	1,197		

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		1,838	1,838		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other		11,856	11,856		
D. <b>Total Occupational Therapy Treatments</b>		13,694	13,694		

## Report of Expenditures - Salaries &amp; Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		839-C	9/30/2022		10
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
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	123,925	2,072			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	221,974	11,974			
5. Dietary Service					
a. Head Dietitian	-681				
b. Food Service Supervisor	61,981	2,140			
c. Dietary Workers	329,888	20,464			
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers	209,780	13,137			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	51,782	1,988			
b. Other Maintenance Workers	56,939	1,942			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers	62,805	3,364			
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	131,721	2,137			
b. RN					
1. Direct Care	1,086,653	20,219			
2. Administrative**					
c. LPN					
1. Direct Care	660,303	16,597			
2. Administrative**					
d. Aides and Attendants	1,290,830	57,816			
e. Physical Therapists	387,329	8,909			
f. Speech Therapists	61,844	961			
g. Occupational Therapists	201,496	4,759			
h. Recreation Workers	78,020	3,516			
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	128,140	4,185			
n. Marketing					
o. Other (Specify)					
See Attached Schedule					
A-13. Total Salary Expenditures	5,144,728	176,179			

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

\*\* Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and

Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

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

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

**Schedule of Other Fees (Page 13)**

State of Connecticut

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

CSP-11 Rev. 10/2005

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

Name of Facility Mystic Healthcare & Rehabilitation, LLC			License No. 839-C		Report for Year Ended 9/30/2022			Page 11	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section I - Operators/Owners</b>										
Martin Sbriglio								Ryders Health Management, 88 Ryders Lane, Stratford, CT 06614	3,652	245,192
<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.

State of Connecticut

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

CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
Mystic Healthcare & Rehabilitation, LLC				839-C		9/30/2022			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section III - Administrators***</b>										
Kenneth Kopchik	123,925			Non Discriminatory	Administrative	2,072	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
	839-C	9/30/2022		13	37
	Total Cost and Hours				
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary</b> (For all such services complete Schedule B1)					
1. Dietitian	35,525				
2. Dentist	4,800				
3. Pharmacist	2,538				
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	93,613				
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	126,618	576			
2. Administrative***					
b. LPN					
1. Direct Care	514,904	5,477			
2. Administrative***					
c. Aides	386,015	17,287			
d. Other					
12. Other (Specify)					
See Attached Schedule					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	1,164,013	23,340			

\* 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 Mystic Healthcare & Rehabilitation, LLC		License No. 839-C	Report for Year Ended 9/30/2022		Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
LTC Management	Dental Consultant	<input type="radio"/>	<input checked="" type="radio"/>			
IPC Hospitalist of New England, PC 819 Worchester Street, Springfield, MA	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
ValueRx	Pharmacy Consultant	<input checked="" type="radio"/>	<input type="radio"/>	Common Owenership		
Dr. Douglas Cooper, 365 Mantauk Ave., New London, CT 06320	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>			
Dr. Neer Zeevi, 365 Mantauk Ave., New London, CT 06320	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>			
Kathleen S Labella, 12 Wadsworth Lane, Waterford, CT 06385	Dietician	<input type="radio"/>	<input checked="" type="radio"/>			
Joseph Alessandro MD	Medical Director/Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>			
Northeast Medical Group	Medical Director/Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>			
The Nurse Network	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
All American Healthcare Services, Inc	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Norton and Assoc	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Fastaff, LLC	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Dedicated Nursing Assoc., Inc	Nurse Pool	<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"/>			

\* 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
		9/30/2022		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 244,959	244,959			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$				
4. Social Security (F.I.C.A.)	\$ 461,745	461,745			
5. Health Insurance	\$ 275,107	275,107			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 3,269	3,269			
8. Uniform Allowance	\$ 14,407	14,407			
9. Other ( <i>Specify</i> ) See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 109,662	109,662			
d. Accounting and Auditing	\$ 9,044	9,044			
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 41,262	41,262			
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$ 1,071	1,071			
g. Office Supplies	\$ 21,939	21,939			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 10,552	10,552			
2. Cellular Phones	\$ 3,841	3,841			
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	\$ 503,680	503,680			
<b>Subtotal</b>	\$ 1,700,538	1,700,538			

\* 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**

Attachment Page 15

**Schedule of Other Employee Benefits**

Description	CCNH	RHNS	(Specify)
<b>Total</b>	\$ -	\$ -	\$ -

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**Schedule of Other Taxes**

Description	CCNH	RHNS	(Specify)
<b>Total</b>	\$ -	\$ -	\$ -

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

Name of Facility Mystic Healthcare & Rehabilitation, LLC	License No. 839-C	Report for Year Ended 9/30/2022	Page 16	of 37
Item	Total	CCNH	RHNS	(Specify)
<b><i>Subtotals Brought Forward:</i></b>	1,700,538	1,700,538		
I. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$	6,207	6,207	
3. Gifts to Staff and Residents	\$			
4. Employee Travel	\$	637	637	
5. Education Expenses Related to Seminars and Conventions	\$	26,454	26,454	
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$			
7. Other ( <i>Specify</i> ) See Attached Schedule	\$	3,043	3,043	
m. Other Administrative and General Expenses				
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$	31,374	31,374	
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$			
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	15,002	15,002	
4. Fund-Raising***	\$			
5. Medical Records	\$	38,515	38,515	
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$			
7. Postage	\$	5,710	5,710	
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	7,912	7,912	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	290	290	
9. Subscriptions	\$			
10. Contributions*** See Attached Schedule	\$			
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$	100,235	100,235	
12. Administrative Management Services**	\$	381,480	381,480	
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	75,194	75,194	
<b><i>C-14 Total Administrative &amp; General Expenditures</i></b>	\$	2,392,591	2,392,591	

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

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

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

**Schedule of Other Travel and Entertainment**

Description	CCNH	RHNS	(Specify)
Meals & Entertainment	\$ 3,043		
<b>Total Other Travel and Entertainment</b>	<b>\$ 3,043</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
Adv & Pub Rel Donations	\$ 15,002		
<b>Total Other Advertising</b>	<b>\$ 15,002</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 6,912		
AHCA	\$ 1,000		
<b>Total Dues</b>	<b>\$ 7,912</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
<b>Total Contributions</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
CLIA	\$ 180		
Physician Care Employee	\$ 23,543		
Bank Charges	\$ 21,702		
Bank Charges - Lease	\$ 484		
Fines & Penalties	\$ 10,163		
Bookkeeping Services	\$ 2,035		
HR Consultant	\$ 13,089		
Unemployment Tax Management	\$ 1,518		
LLHD	\$ 380		
Bureau of Boilers	\$ 400		
American Express Renewal	\$ 50		
Facility License	\$ 1,020		
CMS	\$ 631		
<b>Total Other Administrative and General</b>	<b>\$ 75,194</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility Mystic Healthcare & Rehabilitation, LLC	License No. 839-C	Report for Year Ended 9/30/2022	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 #
Ryders Health Management, 88 Ryders Lane, Stratford, CT 06614	381,480	Financial and Managerial	Page 16, Line m12

\* 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
	839-C	9/30/2022		18   37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 197,716	197,716		
2. Non-Food Supplies	\$ 14,766	14,766		
3. Other (Specify) _____	\$			
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	\$			
c. Other (Specify) _____	\$			
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 212,482</b>	<b>212,482</b>		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				
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 meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
K. Is any revenue collected 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)				
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
O. 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 Mystic Healthcare & Rehabilitation, LLC	License No. 839-C	Report for Year Ended 9/30/2022	Page 19	of 37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$			
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. \$	6,057	6,057	
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$			
c. Other ( <i>Specify</i> ) Laundry Supplies	\$	6,554	6,554	
<b>3D. Total Laundry Expenditures (3a + b + c )</b>	<b>\$</b>	<b>12,611</b>	<b>12,611</b>	
3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
H. Where is the revenue received reported in the Cost Report?			(Page/Line Item)	
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
K. 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 3D.

\*\*\* 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 Mystic Healthcare & Rehabilitation, LLC	License No. 839-C	Report for Year Ended 9/30/2022		Page 20	of 37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 26,565	26,565		
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )					
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> )	\$				
<b>4D. Total Housekeeping Expenditures (4a + b + c )</b>	\$	<b>26,565</b>	<b>26,565</b>		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from ValueRx	\$	173,441	173,441		
b. Medicine Cabinet Drugs	\$	54,301	54,301		
c. Medical and Therapeutic Supplies	\$				
d. Ambulance/Limousine***	\$	23,556	23,556		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	14,100	14,100		
f. X-rays and Related Radiological Procedures***	\$	10,443	10,443		
g. Dental ( <i>Not dentists who should be included under             salaries or fees</i> )	\$				
h. Laboratory***	\$	34,848	34,848		
i. Recreation	\$	21,560	21,560		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other ( <i>Specify</i> )**** See Attached Schedule	\$	256,469	256,469		
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	<b>588,716</b>	<b>588,716</b>		

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

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

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

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

## **Schedule of Other Resident Care**

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

\* 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 Mystic Healthcare & Rehabilitation, LLC	License No. 839-C	Report for Year Ended 9/30/2022			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 120,942	120,942				
b. Heat	\$ 83,115	83,115				
c. Light & Power	\$ 67,560	67,560				
d. Water	\$ 30,188	30,188				
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 8,545	8,545				
f. Other ( <i>itemize</i> )	\$					
See Attached Schedule						
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$ 310,350	310,350				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$					
b. Building & Building Improvements	\$ 111,996	111,996				
c. Non-Movable Equipment	\$ 27,480	27,480				
d. Movable Equipment	\$ 19,764	19,764				
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$ 159,240	159,240				
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other ( <i>Specify</i> )	\$					
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 600,000	600,000				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 310,550	310,550				
c. Personal property taxes	\$ 6,091	6,091				
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$ 1,075,881	1,075,881				

\* 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**

## Depreciation Schedule

Name of Facility Mystic Healthcare & Rehabilitation, LLC				License No. 839-C			Report for Year Ended 9/30/2022			Page 23	of 37		
Property Item				Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals		
A. Land Improvements 1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule)													
A-4. Subtotal													
B. Building and Building Improvements 1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule)				2,813,626		2,813,626	1,762,370	S/L	Various				
B-4. Subtotal										2,557			
C. Non-Movable Equipment 1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule)				461,247		461,247	315,411	S/L	Various				
C-4. Subtotal										8,283			
				Is a mileage logbook maintained?	Date of Acquisition	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
D. Movable Equipment 1. Motor Vehicles (Specify name, model and year of each vehicle) a. b. c. d.				Yes	No	Month	Year						
2. Movable Equipment a. Acquired prior to this report period b. Disposals (attach schedule) Acquired during this report period (attach schedule): c. Administrative d. Standard Resident e. Specialized Resident Total Acquired during this report period						389,489	389,489	348,877	S/L	Various		3,064	
D-3. Subtotal						13,946						3,064	
E. Total Depreciation						13,946						13,905	

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

\*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
<b>Additions:</b>				
10/1/2021	Metal Door & Frame	\$ 2,346	5	\$ 469
10/1/2021	Fire Sprinkler Repair	\$ 5,678	5	\$ 1,136
11/1/2021	Metal Door & Frame	\$ 2,346	5	\$ 430
1/1/2022	Breaker/Circuit Replacement	\$ 2,908	5	\$ 436
7/1/2022	Spot Lights/Outlet	\$ 1,133	5	\$ 57
9/1/2022	Rear Entry Door Glass Replacement	\$ 1,776	5	\$ 30
<b>Total additions for Building Improvements</b>		\$ 16,188	<u>5</u>	\$ 2,557
<b>Deletions:</b>				*
<b>Total deletions for Building Improvements</b>		\$ -		\$ -

\*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
<b>Additions:</b>				
11/29/2021	Replacement of Boiler	\$ 3,425	5	\$ 571
12/14/2021	Replacement of Boiler	\$ 4,180	5	\$ 697
12/3/2021	Replacement of Boiler	\$ 3,425	5	\$ 571
12/10/2021	Mixing Valve	\$ 1,375	5	\$ 229
12/14/2021	Replacement of Boiler	\$ 4,180	5	\$ 697
1/17/2022	Gas Convection Oven	\$ 8,900	5	\$ 1,335
2/11/2022	Generator	\$ 1,223	5	\$ 163
10/1/2021	Fire Doors	\$ 7,169	5	\$ 1,434
3/14/2022	Generator	\$ 408	5	\$ 48
12/17/2021	Mixing Valve	\$ 1,375	5	\$ 229
7/19/2022	Wiring for AC/Heating Units	\$ 4,785	5	\$ 239
7/25/2022	2 Condensor Ductless Systems	\$ 25,418	5	\$ 1,271
7/4/2022	D-Wing AC Capacitor	\$ 1,082	5	\$ 54
7/27/2022	Wiring for AC/Heating Units	\$ 4,785	5	\$ 239
7/25/2022	2 Condensor Ductless Systems	\$ 1,518	5	\$ 76
6/15/2022	Heater & Burner	\$ 5,434	5	\$ 362

8/9/2022	Bock 32E Water Heater	\$ 2,063	5	\$ 69	23 24
<b>Total additions for Non-Movable Equipment</b>		\$ 80,746		\$ 8,283	*
<b>Deletions:</b>					
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ -	**

\*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	Pick One	Cost	Useful Life		Depreciation
		Movable Category		3	3	
<b>Additions:</b>						
10/1/2021	Electric Beds	Standard Resident	\$ 4,599	3	\$ 1,533	
2/1/2022	Adjustable Bed	Standard Resident	\$ 2,079	3	\$ 462	
2/1/2022	Adjustable Bed	Standard Resident	\$ 2,079	3	\$ 462	
5/1/2022	Adjustable Bed	Standard Resident	\$ 4,167	3	\$ 579	
9/1/2022	Laptops	Standard Resident	\$ 1,023	3	\$ 28	
		PICK A CATEGORY				
<b>Total additions for Movable Equipment</b>			\$ 13,946		\$ 3,064	*
<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
			3	3	
<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 Mystic Healthcare & Rehabilitation, LLC			License No. 839-C		Report for Year Ended 9/30/2022			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. <b>Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
B. <b>Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
C. <b>Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. <b>Total Amortization</b>									

\* 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 Mystic Healthcare & Rehabilitation, L	License No. 839-C	Report for Year Ended 9/30/2022	Page 25	of 37
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#### 11. Property Questionnaire

##### Part A

Is the property either owned by the Facility  
or leased from a Related Party?\*

Yes

No

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

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

Description	Total			
1. Date Land Purchased				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase	08/11/06			
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	100			
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building				

##### Part B - Owner and Related Parties

1st Mortgage 2nd Mortgage 3rd Mortgage 4th Mortgage

1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained	05/01/18			
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)	10			
e. Amount of Principal Borrowed	4,700,000			
f. Principal balance outstanding as of 9/30/2022				

##### 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 9/30/2022			Page 26	of 37
Item		Total	CCNH	RHNS	(Specify)	
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
2. Second Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
3. Third Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
4. Fourth Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount	\$					
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
<b>12 B7. Total Building Interest Expense (A1 - A4 + B5)</b>	\$					

(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 9/30/2022			Page 27	of 37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment			\$			
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)			\$			
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item						
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)			\$			
12. D. Other Interest Expense (Specify) Interest Expense			\$	12,213	12,213	
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)			\$	12,213	12,213	
14. Insurance						
a. Insurance on Property (buildings only)			\$	15,094	15,094	
b. Insurance on Automobiles			\$	3,053	3,053	
c. Insurance other than Property (as specified above)						
1. Umbrella ( <i>Blanket Coverage</i> )			\$	100,058	100,058	
2. Fire and Extended Coverage			\$			
3. Other (Specify)			\$			
14d. <b>Total Insurance Expenditures</b> (14a + b + c)			\$	118,206	118,206	
15. <b>Total All Expenditures</b> (A-13 thru C-14)			\$	11,058,356	11,058,356	

## **D. Adjustments to Statement of Expenditures**

Name of Facility Mystic Healthcare & Rehabilitation, LLC			License No. 839-C	Report for Year Ended 9/30/2022		Page of 28   37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS (Specify)
<b><i>Page 10 - Salaries and Wages</i></b>						
1.			Outpatient Service Costs	\$		
2.			Salaries not related to Resident Care	\$		
3.	10	12g	Occupational Therapy	\$ 201,496	201,496	
4.			Other - See attached Schedule	\$ 13,496	13,496	
<b><i>Page 13 - Professional Fees</i></b>						
5.			Resident Care Physicians **	\$		
6.			Occupational Therapy	\$		
7.			Other - See attached Schedule	\$		
<b><i>Pages 15 &amp; 16 - Administrative and General</i></b>						
8.			Discriminatory Benefits	\$		
9.	15	1c	Bad Debts	\$ 109,662	109,662	
10.			Accounting	\$		
10a.			Legal	\$ 30,085	30,085	
11.			Telephone	\$		
12.			Cellular Telephone	\$		
13.	15	1f	Life insurance premiums on the life of Owners, Partners, Operators	\$ 1,071	1,071	
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 *	\$ 15,002	15,002	
19.			Income Tax / Corporate Business Tax	\$		
20.			Fund Raising / Contributions	\$		
21.			Unallowable Management Fees	\$		
22.			Barber and Beauty	\$		
23.			Other - See attached Schedule	\$		
<b><i>Page 18 - Dietary Expenditures</i></b>						
24.			Meals to employees, guests and others who are not residents	\$		
<b><i>Page 19 - Laundry Expenditures</i></b>						
25.			Laundry services to employees, guests and others who are not residents	\$		
<b><i>Page 20 - Housekeeping Expenditures</i></b>						
26.			Housekeeping services to employees, guests and others who are not residents	\$		
Subtotal (Items 1 - 26)			\$ 370,812	370,812		

\* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

**Schedule of Other Salaries Adjustment**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	l7	Meals & Entertainment	\$ 3,043		
16	m8a	Chamber of Commerce	\$ 290		
16	m13	Fines & Penalties	\$ 10,163		
<b>Total Other Salaries Adjustment</b>			\$ 13,496	\$ -	\$ -

**Schedule of Fees Adjustments**

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

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other A&amp;G Adjustments</b>			\$ -	\$ -	\$ -

State of Connecticut

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

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

Name of Facility Mystic Healthcare & Rehabilitation, LLC				License No. 839-C	Report for Year Ended 9/30/2022		Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)	
Subtotals Brought Forward				\$ 370,812	370,812			
<b>Page 20 - Resident Care Supplies***</b>								
27.	20	5a2	Prescription Drugs	\$ 173,441	173,441			
28.	20	5d	Ambulance/Limousine	\$ 23,556	23,556			
29.	20	5f	X-rays, etc	\$ 10,443	10,443			
30.	20	5h	Laboratory	\$ 21,560	21,560			
31.			Medical Supplies	\$				
32.	20	500	Oxygen (non emergency)	\$ 14,100	14,100			
33.			Occupational Therapy	\$				
34.			Other - See Attached Schedule	\$ 35,289	35,289			
<b>Page 22 - Maintenance and Property</b>								
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	\$				
<b>Page 27 - Insurance</b>								
40.			Mortgage Insurance	\$				
41.			Property Insurance	\$				
<b>Other - Miscellaneous</b>								
42.			Other - Indirect	\$				
43.			Interest Income on Account Rec.	\$				
44.			Other - Miscellaneous Administrative	\$				
45.			Management Fees Direct	\$				
46.			Management Fees Indirect	\$				
47.			Other - Direct	\$				
<b>Not For Profit Providers Only</b>								
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$				
49.	<b>Total Amount of Decrease (Items 1 - 48)</b>			\$ 649,201	649,201			

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

### **Schedule of Other Ancillary Costs**

## Schedule of Excess Movable Equipment Depreciation

### **Schedule of Other Property Adjustments**

## **Schedule of Other - Indirect Adjustments**

Attachment Page 29

### **Schedule of Other - Miscellaneous Administrative Adjustments**

### **Schedule of Other - Direct Adjustments**

## **Schedule of Unallowable Building Interest**

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page 30	of 37
		Item	Total	CCNH	RHNS	(Specify)
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$	6,801,779	6,801,779			
b. Medicaid Room and Board Contractual Allowance **	\$	(1,867,995)	(1,867,995)			
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$	1,207,709	1,207,709			
b. Medicare Room and Board Contractual Allowance **	\$	492,094	492,094			
4. a. Private-Pay Residents and Other	\$	3,247,023	3,247,023			
b. Private-Pay Room and Board Contractual Allowance **	\$	(598,119)	(598,119)			
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$	174,216	174,216			
b. Prescription Drugs - Medicare Contractual Allowance **	\$	(174,216)	(174,216)			
c. Prescription Drugs - Non-Medicare	\$	56,869	56,869			
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	\$	201,384	201,384			
b. Physical Therapy - Medicare Contractual Allowance **	\$	(201,384)	(201,384)			
c. Physical Therapy - Non-Medicare	\$	462,232	462,232			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$	25,362	25,362			
b. Speech Therapy - Medicare Contractual Allowance **	\$	(25,362)	(25,362)			
c. Speech Therapy - Non-Medicare	\$	71,475	71,475			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$	194,449	194,449			
b. Occupational Therapy - Medicare Contractual Allowance **	\$	(194,449)	(194,449)			
c. Occupational Therapy - Non-Medicare	\$	329,895	329,895			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other ( <i>Specify</i> ) - Medicare	\$	0	0			
b. Other ( <i>Specify</i> ) - Non-Medicare	\$	1,703	1,703			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)		\$ 10,204,665	10,204,665			
<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> )	\$	623	623			
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$					
<b>V. Total Other Revenue</b> (1 thru 8)		\$ 623	623			
<b>VI. Total All Revenue</b> (III +V)		\$ 10,205,287	10,205,287			

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

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

**Schedule of Other Resident Revenue - Medicare****Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
	Oxygen	\$ 2,356		
	X-Ray	\$ 8,907		
	Lab	\$ 19,085		
	Contractuals	\$ (30,348)		
	<b>Total Other Resident Revenue - Medicare</b>	<b>\$ 0</b>	<b>\$ -</b>	<b>\$ -</b>

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

Page Ref	Description	CCNH	RHNS	(Specify)
	Oxygen - Managed Care	\$ 45		
	X-Ray - Managed Care	\$ 340		
	Lab - Managed Care	\$ 1,318		
	<b>Total Other Resident Revenue</b>	<b>\$ 1,703</b>	<b>\$ -</b>	<b>\$ -</b>

**Interest Income****Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Income	\$ 623			
	<b>Total Interest Income</b>	<b>\$ 623</b>	<b>\$ -</b>	<b>\$ -</b>	

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
	<b>Total Other Revenue</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**G. Balance Sheet**

Name of Facility Mystic Healthcare & Rehabilitation, LL	License No. 839-C	Report for Year Ended 9/30/2022	Page 31	of 37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$ 370,142	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 2,083,116	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$ (392,213)	
a. Loans & Exchanges		(397,268)		
b. Prepaid Expenses		2,029		
c. Prepaid Insurance		3,026		
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$ 16,777	
See Schedule		16,777		
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$ 2,077,823	
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	Accum. Depreciation	Net	\$
3. Buildings	*Historical Cost	2,829,793		\$ 955,428
	Accum. Depreciation	1,874,365	Net	
4. Leasehold Improvements	*Historical Cost	Accum. Depreciation	Net	\$
5. Non-Movable Equipment	*Historical Cost	541,993		\$ 183,153
	Accum. Depreciation	358,840	Net	
6. Movable Equipment	*Historical Cost	403,436		\$ 50,745
	Accum. Depreciation	352,691	Net	
7. Motor Vehicles	*Historical Cost	8,158		\$
	Accum. Depreciation	8,158	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
See Schedule				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$ 1,189,326	

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

(Carry Total forward to next page)

**Schedule of Prepaid Expenses Page 31 Line A5**

Page Ref	Line Ref	Description	
<b>Total Prepaid Expenses</b>			\$ -

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

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

Page Ref	Line Ref	Description	
		<b>Total Other Other Fixed Assets (Itemize)</b>	\$ -

**Schedule of Other Assets Page 32 Line D7**

**Schedule of Notes Payable (Itemize) Page 33 Line A2**

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

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			\$ -

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

Page Ref	Line Ref	Description	
		Cheshire House	\$ 101,626
		Due to Greentree Manor	\$ 3,696
		Due to Lord Chamberlain	\$ 360,289
		Due to GT Realty	\$ 640,000
		Due to MM Realty	\$ 2,017,120
<b>Total Other Current Liabilities (Itemize)</b>			\$ 3,122,730

## G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Mystic Healthcare & Rehabilitation, LLC	839-C	9/30/2022	32   37
Account			Amount
Total Brought Forward:			\$ 3,267,149
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> )			\$ 525,549
Due from Bel-Air Manor		189,205	
Due from Ryders Health Management		31,469	
See Schedule		304,875	
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$ 525,549
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$ 3,792,698

\* 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	License No.	Report for Year Ended	Page	of
	839-C	9/30/2022	33	37
Account			Amount	
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable			\$ 1,483,056	
2. Notes Payable ( <i>itemize</i> )			\$ 968	
Dish Machine Lease			968	
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> )			\$ 76,211	
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> )			\$ 1,276,646	
Patient Fund	45,055	Accrued User Fee	888,713	
Accrued Expenses	219,532			
Aflac - Individual	7,410			
Accrued PTO	115,936	See Schedule		
<b>A-13. Total Current Liabilities</b> (Lines A1 thru 12)			\$ 2,836,881	

\* 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 Mystic Healthcare & Rehabilitation, LLC	License No. 839-C	Report for Year Ended 9/30/2022	Page 34	of 37
Account				Amount
Total Brought Forward:				2,836,881
<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> )				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$ 4,589,785
Due to Martin Sbriglio				347,200
Due to Aaron Manor				40,589
Due to Chamberlain Manor				1,079,267
See Schedule				3,122,730
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 4,589,785
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 7,426,666

## G. Balance Sheet (cont'd)

### Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Mystic Healthcare & Rehabilitation, L	839-C	9/30/2022	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				\$
6. Total Reserves				\$
<b>B. Net Worth</b>				
1. Owner's Capital				\$
2. Capital Stock				\$ 100,000
3. Paid-in Surplus				\$
4. Treasury Stock				\$
5. Cumulated Earnings				\$ (2,880,900)
6. Gain or Loss for Period 10/1/2021 thru 9/30/2022				\$ (853,068)
7. Total Net Worth				\$ (3,633,968)
<b>C. Total Reserves and Net Worth</b>				\$ (3,633,968)
<b>D. Total Liabilities, Reserves, and Net Worth</b>				\$ 3,792,698

## H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Mystic Healthcare & Rehabilitation, LLC	839-C	9/30/2022	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2021				\$		
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )				\$		
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )				\$		
D. Net Income or Deficit				\$		
E. Balance				\$		
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 (No., City, State, Zip)		Title	Amount			
2. Other Withdrawings ( <i>Specify</i> )				\$		
Purpose		Amount				
3. Total Deductions				\$		
H. <b>Balance at End of Period</b>				\$		

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

Name of Facility Mystic Healthcare & Rehabilitation, LLC	License No. 839-C	Report for Year Ended 9/30/2022	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 type="checkbox"/> (Specify)		

### Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed
Printed Name of Preparer		
Ryders Health Management		
Address Address 88 Ryders Lane, Stratford, CT 06614		Phone Number 203-381-1327
Contacted Person Regarding Additional Information Needed Regarding This Report Elizabeth Maglio		Phone Number 203-381-1327
Contact Email Address emaglio@rydershealth.com		