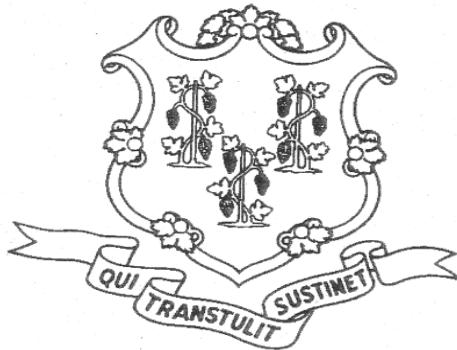


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2021

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 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 10/1/2020	Report for Year Ending 9/30/2021

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 9/30/2021	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, 2020 and ending September 30, 2021, 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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Mystic Healthcare & Rehabilitation, LLC	Period Covered:		From 10/1/2020	To 9/30/2021
Address of Facility 475 High Street, Mystic, CT 06355				
Report Prepared By Ryders Health Management	Phone Number 203-381-1327	Date 2/10/2022		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

	Phone No. of Facility 203-381-1327	Report for Year Ended 9/30/2021	Page 2
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)
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.:	

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 9/30/2021	Page of 3A 37
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			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility Mystic Healthcare & Rehabilitation, LLC	License No. 839-C	Report for Year Ended 9/30/2021	Page 3B	of 37
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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 Mystic Healthcare & Rehabilitation, LLC	License No. 839-C	Report for Year Ended 9/30/2021			Page 4	of 37	
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			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"/>				
		<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 Mystic Healthcare & Rehabilitation, LLC	License No. 839-C	Report for Year Ended 9/30/2021	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.

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Annual Report of Long-Term Care Facility

CSP-6 Rev. 9/2002

**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		License No.		Report for Year Ended			Page of
Mystic Healthcare & Rehabilitation, LLC		839-C		9/30/2021			6 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
BBI Technologies	<input type="radio"/>	<input checked="" type="radio"/>	Copier Machines				8,501
	<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 ***	8,501

* 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 Mystic Healthcare & Rehabilitation	License No. 839-C	Report for Year Ended 9/30/2021	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 Yes If "No," explain.
previous period? No

Independent Accounting Firm

Name of Accounting Firm 1 Marcum, LLP 2 3 4	Address (No. & Street, City, State, Zip Code) 555 Long Wharf Drive, New Haven, CT
------------------------------------------------------------	--------------------------------------------------------------------------------------

Services Provided by This Firm (*describe fully*)

1 Financial Statements & Tax Returns	\$ 409
2	\$
3	\$
4	\$
	Charge for Services Provided \$ 409

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

Yes No |Page 15, Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney 1 See Attached 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 2 3 4 5	\$
	\$
	\$
	\$
	\$
	Charge for Services Provided \$

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

Yes No |Page 15, Line 1e

Schedule of Resident Statistics

Name of Facility Mystic Healthcare & Rehabilitation, LLC			License No. 839-C				Report for Year Ended 9/30/2021				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					67	67						
A. As of midnight of PREVIOUS report period	67	67										
B. As of midnight of THIS report period	76	76							76	76		
3. Total Number of Days Care Provided During Period					2,668	2,668			868	868		
A. Medicare	3,536	3,536										
B. Medicaid (Conn.)	17,493	17,493			13,153	13,153			4,340	4,340		
C. Medicaid (other states)												
D. Private Pay	4,010	4,010			2,628	2,628			1,382	1,382		
E. State SSI for RCH												
F. Other (Specify) Managed Care	2,665	2,665			1,850	1,850			815	815		
G. Total Care Days During Period (3A thru F)	27,704	27,704			20,299	20,299			7,405	7,405		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	405	405			368	368			37	37		
B. Other Bed Reserve Days	114	114			69	69			45	45		
5. Total Resident Days (3G + 4A + 4B)	28,223	28,223			20,736	20,736			7,487	7,487		

Schedule of Resident Statistics (Cont'd)

Name of Facility Mystic Healthcare & Rehabilitation, LLC	License No. 839-C	Report for Year Ended 9/30/2021	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	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)		
				(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)
	CCNH	RHNS	(Specify)	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	8	51		17				
Per Diem Rate								
a. One bed rm.	Various	270.07		446 - 469				
b. Two bed rms.				450 - 396				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B		TOTAL	CCNH	RHNS	(Specify)
		3,661	3,661		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other		11,711	11,711		
D. Total Physical Therapy Treatments		15,372	15,372		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		558	558		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other		765	765		
D. Total Speech Therapy Treatments		1,323	1,323		

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		1,506	1,506		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other		10,521	10,521		
D. Total Occupational Therapy Treatments		12,027	12,027		

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		839-C	9/30/2021	10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes		<input type="radio"/> No	
		Total Cost and Hours			
Item		CCNH	Hours	RHNS	Hours
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	129,008	2,154			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	213,062	10,045			
5. Dietary Service					
a. Head Dietitian	29,906	1,387			
b. Food Service Supervisor	59,061	2,089			
c. Dietary Workers	306,808	19,999			
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers	191,299	12,164			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	50,939	1,976			
b. Other Maintenance Workers	58,236	2,114			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers	58,642	3,358			
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	117,904	2,489			
b. RN					
1. Direct Care	945,376	22,168			
2. Administrative**					
c. LPN					
1. Direct Care	600,584	18,151			
2. Administrative**					
d. Aides and Attendants	1,112,717	54,304			
e. Physical Therapists	306,916	7,275			
f. Speech Therapists	57,600	921			
g. Occupational Therapists	143,564	3,581			
h. Recreation Workers	85,638	3,971			
i. Physicians					
1. Medical Director					
2. Utilization Review					
3. Resident Care***					
j. Dentists					
k. Pharmacists					
l. Podiatrists					
m. Social Workers/Case Management	154,060	4,779			
n. Marketing					
o. Other (Specify)					
See Attached Schedule	38,877	2,109			
<i>A-13. Total Salary Expenditures</i>	4,660,198	175,032			

* 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 9/30/2021			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)							
Section I - Operators/Owners										
Martin Sbriglio								Ryders Health Management, 88 Ryders Lane, Stratford, CT 06614	3,721	145,922
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.

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		9/30/2021			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)							
Section III - Administrators***										
Kenneth Kopchik	129,008			Non Discriminatory	Administrative	2,154	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
	839-C	9/30/2021		13	37
	Total Cost and Hours				
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)					
1. Dietitian	1,265				
2. Dentist	6,000				
3. Pharmacist	9,101				
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	87,300				
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	104,664				
2. Administrative***					
b. LPN					
1. Direct Care	189,618				
2. Administrative***					
c. Aides	365,033				
d. Other					
12. Other (Specify)					
See Attached Schedule	14,538				
B-13 Total Fees Paid in Lieu of Salaries	777,519				

* 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 9/30/2021		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 Ownership	
Dr Douglas Cooper, 365 Montauk Ave., New London, CT 06320	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Neer Zeevi, 365 Montauk Ave., New London, CT 06320	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
Kathleen S Labelia, 12 Wadsworth Lane, Waterford, CT 06385	Dietician	<input type="radio"/>	<input checked="" type="radio"/>		
HealthPro, 307 International Circle, Suite 100, Hunt Valley, MD 21030	Therapy Management Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Joseph Alessandro	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"/>		
Celtic Consulting	PDPM Consulting	<input type="radio"/>	<input checked="" type="radio"/>		
Taylor Healthcare Assoc	Infection Control Consulting	<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
		9/30/2021		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 193,890	193,890			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$				
4. Social Security (F.I.C.A.)	\$ 411,993	411,993			
5. Health Insurance	\$ 385,791	385,791			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 4,516	4,516			
8. Uniform Allowance	\$ 15,660	15,660			
9. Other (Specify) See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 205,982	205,982			
d. Accounting and Auditing	\$ 409	409			
e. Legal (Services should be fully described on Page 7)	\$ 10,879	10,879			
f. Insurance on Lives of Owners and Operators (Specify)*	\$ 1,071	1,071			
g. Office Supplies	\$ 22,735	22,735			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 10,664	10,664			
2. Cellular Phones	\$ 3,626	3,626			
i. Appraisal (Specify purpose and attach copy)*	\$				
j. Corporation Business Taxes (franchise tax)	\$				
k. Other Taxes (Not related to property - See Page 22)					
1. Income*	\$				
2. Other (Specify) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 465,572	465,572			
Subtotal	\$ 1,732,788	1,732,788			

* 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

Schedule of Other Taxes

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

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 9/30/2021		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
<i>Subtotals Brought Forward:</i>		1,732,788	1,732,788		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	9,077	9,077		
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	1,227	1,227		
5. Education Expenses Related to Seminars and Conventions	\$	16,538	16,538		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	20	20		
7. Other (<i>Specify</i>) See Attached Schedule	\$	2,389	2,389		
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	15,272	15,272		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	(4,674)	(4,674)		
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	\$	5,731	5,731		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	7,395	7,395		
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>)	\$	87,222	87,222		
12. Administrative Management Services**	\$	380,511	380,511		
13. Other (<i>Specify</i>) See Attached Schedule	\$	37,993	37,993		
<i>C-14 Total Administrative & General Expenditures</i>	\$	2,291,779	2,291,779		

* 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	\$ 2,389		
Total Other Travel and Entertainment	\$ 2,389	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Adv & Pub Rel Donations	\$ (4,674)		
Total Other Advertising	\$ (4,674)	\$ -	\$ -

Schedule of Dues

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Fees & License	\$ 470		
Physician Care - Employees	\$ 22,192		
Bank Charges	\$ 5,990		
Bank Charges - Lease	\$ 484		
Unemployment Tax Management	\$ 1,518		
A/R Support - Not Collections	\$ 7,289		
American Express Fee	\$ 50		
Total Other Administrative and General	\$ 37,993	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Mystic Healthcare & Rehabilitation, LLC	License No. 839-C	Report for Year Ended 9/30/2021	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	380,511	Financial and Managerial Support	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	9/30/2021		18 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 156,930	156,930		
2. Non-Food Supplies	\$ 16,273	16,273		
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) _____ Dietary Equipment	\$ 1,536	1,536		
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 174,739	174,739		
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 9/30/2021		Page of 19 37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	4,824	4,824	
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.			
	Amt. \$			
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.			
	Amt. \$			
4. Repair and/or purchase of linens.***	Lbs.			
	Amt. \$			
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$			
c. Other (Specify) Laundry Supplies	\$	6,059	6,059	
3D. Total Laundry Expenditures (3a + b + c)	\$	10,883	10,883	
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	License No.	Report for Year Ended		Page	of
		9/30/2021		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced				
a. In-House Care	by Personnel				
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	30,309	30,309		
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)	\$	30,309	30,309		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from ValueRx	\$	193,170	193,170		
b. Medicine Cabinet Drugs	\$	75,741	75,741		
c. Medical and Therapeutic Supplies	\$				
d. Ambulance/Limousine***	\$	21,115	21,115		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	20,093	20,093		
f. X-rays and Related Radiological Procedures***	\$	11,455	11,455		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	43,888	43,888		
i. Recreation	\$	22,257	22,257		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	260,983	260,983		
5M. Total Resident Care Expenditures (5a - 5j)	\$	648,701	648,701		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Physician Care - Patients	\$ 1,700		
Medical Supplies	\$ 203,952		
Medical Supplements	\$ 12,849		
Medical Waste	\$ 315		
Medical Equipment Rental	\$ 24,488		
PT Supplies	\$ 17,680		
Total Other Resident Care	\$ 260,983	\$ -	\$ -

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 9/30/2021			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	153,660	153,660			
b. Heat	\$	56,271	56,271			
c. Light & Power	\$	56,404	56,404			
d. Water	\$	38,448	38,448			
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$	8,501	8,501			
f. Other <i>(itemize)</i>	\$					
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	313,284	313,284			
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$					
b. Building & Building Improvements	\$	112,007	112,007			
c. Non-Movable Equipment	\$	27,487	27,487			
d. Movable Equipment	\$	19,770	19,770			
*7e. Total Depreciation Costs (7a + b + c + d)	\$	159,263	159,263			
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other <i>(Specify)</i>	\$					
*8e. Total Amortization Costs (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	\$	97,027	97,027			
c. Personal property taxes	\$	4,548	4,548			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	860,838	860,838			

* 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 9/30/2021				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				2,785,323		2,785,323	1,650,363	S/L	Various	110,999			
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)				28,303		28,303		S/L	Various	1,008			
B-4. Subtotal											112,007		
C. Non-Movable Equipment				388,948		388,948	287,924	S/L	Various	22,596			
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)				72,299		72,299		S/L	Various	4,891			
C-4. Subtotal											27,487		
	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals	
	Yes	No	Month	Year									
D. Movable Equipment													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a.													
b.													
c.													
d.													
2. Movable Equipment					372,565		372,565	329,107	S/L	Various	17,896		
a. Acquired prior to this report period													
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)					16,924		16,924		S/L	Various	1,874		
D-3. Subtotal												19,770	
E. Total Depreciation												159,263	

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
Additions:				
10/27/2020	Courtyard Roof	\$ 16,250	20	\$ 745
1/15/2021	Kitchen Hood Suspension	\$ 2,233	10	\$ 158
7/27/2021	Doors	\$ 3,744	20	\$ 31
7/28/2021	Fire Sprinkler	\$ 2,772	10	\$ 46
8/20/2021	Fire Sprinkler	\$ 3,304	10	\$ 28
Total additions for Building Improvement		\$ 28,303		\$ 1,008 *
Deletions:				
Total deletions for Building Improvement		\$ -		\$ - ***

***Ties to Page 23, Line B3**

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Total deletions for Non-Movable Equipment	\$ -	\$ -	Attachment Pages 23 24
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*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:				
10/21/2020	Computers	\$ 1,590	5	\$ 291
12/5/2020	Electrostatic Sprayer	\$ 1,738	5	\$ 290
12/21/2020	TV's	2277.36	5	341.6
1/15/2021	TV's	2277.36	5	322.63
2/15/2021	TV's	2277.36	5	284.67
5/13/2021	Dietary Stand Mixer	2839.55	5	212.97
7/22/2021	Food Processor	1171.17	5	39.04
7/31/2022	Laptops	2753.11	5	91.77
Total additions for Movable Equipment		\$ 16,924		\$ 1,874 *
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:				
Total additions for Leasehold Improvements		\$ -		\$ - *
Deletions:				
Total deletions for Leasehold Improvements		\$ -		\$ - **

*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 9/30/2021			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									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									

* Straight-line method must be used.

** Specify which of the following bases were used:

- Minimum of 5 years or 60 months.
- Life of mortgage; OR
- Remaining Life of Lease; OR
- 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 9/30/2021	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 9/30/2021	4,084,727			

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 9/30/2021			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						
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
		9/30/2021			27	37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		\$				
12. D. Other Interest Expense (Specify)		\$	242,618	242,618		
Interest Expense						
13. Total All Interest Expense (12B7 + 12C3 + 12D)		\$	242,618	242,618		
14. Insurance						
a. Insurance on Property (buildings only)		\$	13,722	13,722		
b. Insurance on Automobiles		\$	3,392	3,392		
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$	95,411	95,411		
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$				
14d. Total Insurance Expenditures (14a + b + c)		\$	112,525	112,525		
15. Total All Expenditures (A-13 thru C-14)		\$	10,123,392	10,123,392		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of	
Item No.	Page No.	Line No.		839-C	9/30/2021	28 37	
			Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<i>Page 10 - Salaries and Wages</i>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	A12g	Occupational Therapy	\$ 143,564	143,564		
4.			Other - See attached Schedule	\$			
<i>Page 13 - Professional Fees</i>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<i>Pages 15 & 16 - Administrative and General</i>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 205,982	205,982		
10.			Accounting	\$			
10a.			Legal	\$ 6,834	6,834		
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.	16	16	Automobile Expense (e.g. personal use)	\$ 20	20		
18.	16	m3	Unallowable Advertising *	\$ (4,674)	(4,674)		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 2,679	2,679		
<i>Page 18 - Dietary Expenditures</i>							
24.			Meals to employees, guests and others who are not residents	\$			
<i>Page 19 - Laundry Expenditures</i>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<i>Page 20 - Housekeeping Expenditures</i>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$ 355,476	355,476			

* 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)
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	l7	Meals & Entertainment	\$ 2,389		
16	m8a	Chamber of Commerce	\$ 290		
Total Other A&G Adjustments			\$ 2,679	\$ -	\$ -

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 9/30/2021		Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 355,476	355,476		
<i>Page 20 - Resident Care Supplies***</i>							
27.	20	5a2	Prescription Drugs	\$ 193,170	193,170		
28.	20	5d	Ambulance/Limousine	\$ 21,115	21,115		
29.	20	5f	X-rays, etc	\$ 11,455	11,455		
30.	20	5h	Laboratory	\$ 43,888	43,888		
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 20,093	20,093		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 17,680	17,680		
<i>Page 22 - Maintenance and Property</i>							
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	\$			
<i>Page 27 - Insurance</i>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<i>Other - Miscellaneous</i>							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<i>Not For Profit Providers Only</i>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 662,877	662,877		

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

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	51	PT Supplies	\$ 17,680		
Total Other Ancillary Costs			\$ 17,680	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Property Adjustments			\$ -	\$ -	\$ -

Schedule of Other - 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		Page	of
		9/30/2021		30	37
Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 6,209,138	6,209,138			
b. Medicaid Room and Board Contractual Allowance **	\$ (1,950,607)	(1,950,607)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,553,011	1,553,011			
b. Medicare Room and Board Contractual Allowance **	\$ 668,759	668,759			
4. a. Private-Pay Residents and Other	\$ 3,043,073	3,043,073			
b. Private-Pay Room and Board Contractual Allowance **	\$ (468,738)	(468,738)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 201,792	201,792			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (201,792)	(201,792)			
c. Prescription Drugs - Non-Medicare	\$ 5,373	5,373			
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	\$ 264,522	264,522			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (264,522)	(264,522)			
c. Physical Therapy - Non-Medicare	\$ 282,299	282,299			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$ 47,824	47,824			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (47,824)	(47,824)			
c. Speech Therapy - Non-Medicare	\$ 53,301	53,301			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 243,057	243,057			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (243,057)	(243,057)			
c. Occupational Therapy - Non-Medicare	\$ 202,750	202,750			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other (<i>Specify</i>) - Medicare	\$ (0)	(0)			
b. Other (<i>Specify</i>) - Non-Medicare	\$ 53,062	53,062			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 9,651,420	9,651,420			
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>)	\$ 292	292			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 308,831	308,831			
V. Total Other Revenue (1 thru 8)	\$ 309,123	309,123			
VI. Total All Revenue (III +V)	\$ 9,960,543	9,960,543			

* 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	\$ 1,750		
	X-Ray	\$ 9,678		
	Lab	\$ 43,298		
	Contractuals	\$ (54,726)		
Total Other Resident Revenue - Medicare		\$ (0)	\$ -	\$ -

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

Page Ref	Description	CCNH	RHNS	(Specify)
	Oxygen - Managed Care	\$ 45		
	X-Ray - Managed Care	\$ 140		
	Pharmacy - Medicaid	\$ 52,102		
	Lab - Managed Care	\$ 775		
Total Other Resident Revenue		\$ 53,062	\$ -	\$ -

Interest Income**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Income	\$ 292			
Total Interest Income		\$ 292	\$ -	\$ -	

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Medicaid - CRF Grant	\$ 75,000		
	Medicare - PRF Grant	\$ 233,831		
Total Other Revenue		\$ 308,831	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page of
Mystic Healthcare & Rehabilitation, LL	839-C	9/30/2021	31 37
Account			Amount
Assets			
A. Current Assets			
1. Cash (<i>on hand and in banks</i>)			\$ 631,526
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 1,828,607
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$
4. Inventories			\$
5. Prepaid Expenses			\$
a. _____			
b. _____			
c. _____			
d. See Schedule			
6. Interest Receivable			\$
7. Medicare Final Settlement Receivable			\$
8. Other Current Assets (<i>itemize</i>)			\$ (453,320)
Medicaid Advances			(75,013)
Medicare Advances			(6,890)
Loans & Exchanges			(381,976)
See Schedule			10,559
A-9. Total Current Assets (Lines A1 thru 8)			\$ 2,006,813
B. Fixed Assets			
1. Land			\$
2. Land Improvements	*Historical Cost	_____	\$
	Accum. Depreciation	Net	
3. Buildings	*Historical Cost	2,813,606	\$ 1,051,237
	Accum. Depreciation	1,762,369 Net	
4. Leasehold Improvements	*Historical Cost	_____	\$
	Accum. Depreciation	Net	
5. Non-Movable Equipment	*Historical Cost	461,247	\$ 129,887
	Accum. Depreciation	331,360 Net	
6. Movable Equipment	*Historical Cost	389,490	\$ 56,563
	Accum. Depreciation	332,927 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-10. Total Fixed Assets (Lines B1 thru 9)			\$ 1,237,687

* 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

Total Prepaid Expenses		\$ -

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

Page Ref Line Ref Description

	Prepaid Expenses	\$ 1,341
	Prepaid Insurance	\$ 2,594
	Refunds	\$ 6,624
Total Other Current Assets (Itemize)		\$ 10,559

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

Page Ref Line Ref Description

Total Other Other Fixed Assets (Itemize)		\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref Line Ref Description

	Due from BA Realty	\$ 833
	Due from CH Realty	\$ 833
	Due from Lighthouse Home Care	\$ 64,000
	Due from Lighthouse Home Health	\$ 98,875
Total Other Assets		\$ 164,542

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref Line Ref Description

Total Notes Payable		\$ -

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

Page Ref Line Ref Description

Total Other Current Liabilities (Itemize)		\$ -

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

Page Ref Line Ref Description

	Due to Chamberlain Manor	\$ 980,767
	Due to Cheshire House	\$ 187,096
	Due to Greentree Manor	\$ 44,164
	Due to Lord Chamberlain	\$ 478,488
	Due to GT Realty	\$ 640,000
	Due to MH Realty	\$ 1,928,075
Total Other Current Liabilities (Itemize)		\$ 4,258,590

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Mystic Healthcare & Rehabilitation, LLC	839-C	9/30/2021	32 37
Account	Amount		
Total Brought Forward:			\$ 3,244,499
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>)			\$ 197,401
Due from Douglas Manor	1,390		
Due from Ryders Health Management	31,469		
See Schedule	164,542		
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ 197,401
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 3,441,900

* 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 Mystic Healthcare & Rehabilitation, LLC	License No. 839-C	Report for Year Ended 9/30/2021	Page 33	of 37
Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				\$ 514,785
2. Notes Payable (<i>itemize</i>)				\$ 1,168
Dish Machine Lease				1,168
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>)				\$ 70,059
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>)				\$ 969,758
Patient Fund	83,333	Accrued PTO	135,151	
Accrued Expenses	198,395	Accrued User Fee	548,727	
Accrued 401k Withholding	995			
Aflac - Individual	3,157	See Schedule		
A-13. Total Current Liabilities (Lines A1 thru 12)				\$ 1,555,770

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

G. Balance Sheet (cont'd)

Name of Facility Mystic Healthcare & Rehabilitation, LLC	License No. 839-C	Report for Year Ended 9/30/2021	Page 34	of 37
Account			Amount	
Total Brought Forward:			1,555,770	
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>)			\$	
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)			\$	4,667,030
Due to Martin Sbriglio	347,200			
Due to Aaron Manor	23,445			
Due to Bel-Air Manor	37,795			
See Schedule	4,258,590			
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$	4,667,030
C. Total All Liabilities (Lines A-13 + B-5)			\$	6,222,800

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

Name of Facility	License No.	Report for Year Ended	Page	of
Mystic Healthcare & Rehabilitation, LLC	839-C	9/30/2021	35	37
Account				Amount
A. Reserves				
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. Net Worth				
1. Owner's Capital				\$
2. Capital Stock				\$ 100,000
3. Paid-in Surplus				\$
4. Treasury Stock				\$
5. Cumulated Earnings				\$ (2,718,051)
6. Gain or Loss for Period		10/1/2020	thru	9/30/2021
				\$ (162,849)
7. Total Net Worth				\$ (2,780,900)
C. Total Reserves and Net Worth				\$ (2,780,900)
D. Total Liabilities, Reserves, and Net Worth				\$ 3,441,900

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Mystic Healthcare & Rehabilitation, LLC	839-C	9/30/2021	36	37
Account				Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2020				\$ (2,618,051)
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 9,960,543
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 10,123,392
D. Net Income or Deficit				\$ (162,849)
E. Balance				\$ (2,780,900)
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. Balance at End of Period				\$ (2,780,900)

I. Preparer's/Reviewer's Certification

Name of Facility Mystic Healthcare & Rehabilitation, LLC	License No. 839-C	Report for Year Ended 9/30/2021	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	Phone Number	
88 Ryders Lane, Stratford, CT 06614	203-381-1327	
Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number	
Elizabeth Maglio	203-381-1327	
Contact Email Address		
emaglio@rydershealth.com		