State of Connecticut



Annual Report of Long-Term Care FacilityCost Year 2016

Name of Facility (as	licensed)								
Eliza Huntington Me	morial Home of	f Norwich, Inc							
Address (No. & Stree	et, City, State, Z	Zip Code)							
99 Washington St., N	Norwich, CT 06	360							
Type of Facility									
Chronic and Convalescent			Rest Home wit	h Nursing					
☐ Nursing Home	e only		Supervision on	ıly	$\overline{\checkmark}$	Residenti	al Ca	re Home	
(CCNH)	-		(RHNS)						
Report for Year Begi	nning		Report for Year Ending						
10/1/2015	C		9/30/2016						
License Numbers:		CCNH	RHNS	David	antial Canal	II.	Ма	diaana Duayidan	
License Numbers.		CCNH	RHNS Residential Care					dicare Provider	
					1219	127)			
			!						
Medicaid Provider N	umbers:	CC	CNH	RHNS		ICF-IID		F-IID	
	0.1								
For Department Use					1				
Sequence Number	Signed and	Date	Sequence N		Signed a	nd Notari	zed	Date Received	
Assigned	Notarized	Received	Assign	ed	2-8				
					1				

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Eliza Huntington Memorial Home of Norwich, Inc.	1279	9/30/2016	1	37

Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISIONMENT 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 Eliza Huntington Memorial Home of Norwich, Inc. [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 2016, 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) Theresa Madonna			Printed Name (Owner)			
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires		
Address of Notary Public			1			

(Notary Seal)

State of Connecticut **Department of Social Services**

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	Page	of		
	1A	37		
Name of Facility	Period Cov	ered:	From	То
Eliza Huntington Memorial Home of Norwich, Inc.			10/1/2015	9/30/2016
Address of Facility				
99 Washington St., Norwich, CT 06360				
Report Prepared By	Phone Nun	nber	Date	
CJLC LLC	860-610-90)09	2/14/2017	
				Residentia 1 Care
Item	Total	CCNH	RHNS	Home
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire Type of Facility - Organization Structure

	-								_
				cility	Report for Ye	ar Ended	Page	of	
		860-	-887-0684		9/30/2016		2	37	
Name of Facility (as shown on license)	-		Address (No	o. & S	Street, City, Sto	ıte, Zip)			
Eliza Huntington Memorial Home of Norwich, In	ıc.		99 Washing	ton S	t., Norwich, C	T 06360			
CC	CNH		RHNS	Resi	dential Care H		Medicare I	Provider No.	
License Numbers:					1	279			
Type of Facility (Check appropriate box(es))									
Chronic and Convalescent Nursing Home only (CCNH)			t Home with it ervision only			Residenti	al Care Hor	ne	
Type of Ownership (Check appropriate box)									-
O Proprietorship O LLC O Partner	rship	0	Profit Corp.	•	Non-Profit Con	rp. O	Government	O Trust	
If this facility opened or closed during report year	provide	:		Date	Opened	Date Clos	sed		
Has there been any change in ownership									-
or operation during this report year?		0	Yes	•	No	If "Yes,"	explain full	y.	
Administrator									=
Name of Administrator					Nursing Ho	ome			
Theresa Madonna					Administrat	or's			
					License N	No.:			
Other Operators/Owners who are assistant admini	istrators	(full	or part time)	of th	•				
Name					License 1	No.:			
									-
									_
		_							

General Information and Questionnaire Partners/Members

Name of Facility Eliza Huntington Memorial Ho	ome of Norwich, Inc.	License No. 1279	Report for Y 9/30/2016	ear Ended	Page of 3 37
Legal Name of Part		Business A			or Town(s) in egistered
Name of Partners/Members	Business A	ddress		Γitle	% Owned
N/A					

General Information and Questionnaire Corporate Owners

Name of Facility	License No. Report for Year E	nded	Page of
Eliza Huntington Memorial Home of Norw	ic 1279 9/30/2016		3A 37
If this facility is owned or operated as a cor	poration, provide the following information	ation:	
Legal Name of Corporation	Business Address	State(s) in Whi	ch Incorporated
Eliza Huntington Memorial Home of Norwich, Inc.	99 Washington St., Norwich, CT 06360	СТ	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Angelo Yeitz	29 N. Wawecus Hill Rd., Norwich, CT 06360	President	
Atty Chuck Norris	181 Wightman Ave., Norwich, CT 06360	Vice President	
Gerard Egan	140 Est Thames St., Norwich, CT 06360	Treasurer	
Jodie Bartnicki	79 Warner St., Groton, CT 06340	Secretary	
Names of Stockholders Owning at Least 10% of Shares			

CSP-3B Rev. 10/2005

General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Eliza Huntington Memorial Home of Norwich, Inc	1279	9/30/2016	3B	37
If this facility is owned or operated as an individua		rovide the following informat	ion:	
	ner(s) of Facility			
	•			
N/A				

General Information and Questionnaire Related Parties*

Name of Facility		License	e No.		Report for Year Ended		Page	of
Eliza Huntington Memorial Home	e of Norwich, Inc.		1279		9/30/2016		4	37
Are any individuals receiving cor	mpensation from the facility related th	rough				If "Yes," provide th	ne Name/Ad	dress and
marriage, ability to control, owne	rship, family or business association?	?		•	Yes O No	complete the inform		
						-		-
Are any individuals or companies	s which provide goods or services,							
_	r the loaning of funds to this facility,							
	n, common ownership, control, or bus	siness			⊙ Yes ○ No			
association to any of the owners,	operators, or officials of this facility?	•				If "Yes," provide th	ne following	information:
						/ 1		
		Als	so Provi	des		Indicate Where		
		Good	ls/Servi	ces to		Costs are Included		
Name of Related	Business	Non-F	Related	Parties	Description of Goods/Services	in Annual Report	Cost	Actual Cost to the
Individual or Company	Address	Yes	No	%**	Provided	Page # / Line #	Reported	Related Party
N/A								
		0	•					
		0	•					
		0	•					
		0	•					
			U					
		0	•					
		0	•					
		0	•					
		0	•					
		0	0					
		1	I	l	1		1	1

^{*} Use additional sheets if necessary.

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

General Information and Questionnaire Basis for Allocation of Costs

Name of Facility	License No).	Report for Year Ended	Page	of		
Eliza Huntington Memorial Home of Norwich,	1279		9/30/2016	5	37		
If the facility is licensed as CDH and/or RCH or	r provides A	AIDS or TB	I services with special Medicai	d rates,	costs		
must be allocated to CCNH and RHNS as follow	ws:		-				
Item			Method of Allocation				
must be allocated to CCNH and RHNS as follows: Item Dietary Laundry Housekeeping Nursing Direct Resident Care Consultants Maintenance and operation of plant		Number of	meals served to residents				
Laundry		Number of	pounds processed				
Item Dietary Laundry Housekeeping Nursing Direct Resident Care Consultants Maintenance and operation of plant Property costs (depreciation) Employee health and welfare Management services All other General Administrative expenses The preparer of this report must answer the following 1. In the preparation of this Report, were all		Number of	square feet serviced				
		Number of	hours of routine care provided	by EAG	CH		
Eliza Huntington Memorial Home of Norwich, If the facility is licensed as CDH and/or RCH or provide must be allocated to CCNH and RHNS as follows: Item Dietary Laundry Housekeeping Nursing Direct Resident Care Consultants Maintenance and operation of plant Property costs (depreciation) Employee health and welfare Management services All other General Administrative expenses The preparer of this report must answer the following of the preparation of this Report, were all		employee c	classification, i.e., Director (or	Charge	Nurse),		
		Registered	Nurses, Licensed Practical Nu	rses, Ai	des and		
		Attendants					
Direct Resident Care Consultants	Number		hours of resident care provide	d by EA	.CH		
		specialist ((See listing page 13)				
Maintenance and operation of plant		Square feet	t				
Property costs (depreciation)		Square feet	t				
Employee health and welfare		Gross salar	ries				
Management services All other General Administrative expenses		Appropriat	e cost center involved				
All other General Administrative expenses		Total of Di	rect and Allocated Costs				
The preparer of this report must answer the following	owing quest	tions applic	able to the cost information pro	ovided.			
1. In the preparation of this Report, were all	O V	O N-	If "No," explain fully why suc	h alloca	tion was		
costs allocated as required?	• Yes	O No	not made.				
2. Explain the allocation of related company ex	penses and	attach copy	of appropriate supporting data	ι.			
3. Did the Facility appropriately allocate and se	elf-disallow	direct and i	ndirect costs to non-nursing ho	me cost	centers?		
(e.g., Assisted Living, Home Health, Outpati	ent Services	s, Adult Day	y Care Services, etc.)				
If "No " analoia fully why analoila action							
	• Yes	O No	not made.				

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility	·		License No.	Report for Y	Report for Year Ended			
Eliza Huntington Memorial Home of Nor	wich, Inc.		1279	9/30/2016		6	37	
		ed * to ners,						
	_	ators,		Date of	Term of	Annual Amount	Amoui	nt
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	of Lease	Claime	
N/A	0	0	·					
	0	0						
	0	0						
	0	0						
	0	0						
	0	0						
	0	0						
	0	0						
	0	0						
	0	0						
Is a Mileage Log Book Maintained for Al	ll I eased V	ehicles	2 O Ye	es O	No	Total ***		

Is a Mileage Log Book Maintained for All Leased Vehicles?

^{*} 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

Eliza Huntington Memorial Home 1279 9,50/2016 7 The records of this facility for the period covered by this report were maintained on the following basis: ② Accrual O Cash O Modified Cash Is the accounting basis for this period the same as for the O No Independent Accounting Firm Address (No. & Street, City, State, Zip Code) 225 Pikin Street, East Hartford, CT 06108 Independent Accounting Firm Address (No. & Street, City, State, Zip Code) 225 Pikin Street, East Hartford, CT 06108 Independent Accounting Firm Address (No. & Street, City, State, Zip Code) 225 Pikin Street, East Hartford, CT 06108 Independent Accounting Firm Address (No. & Street, City, State, Zip Code) 225 Pikin Street, East Hartford, CT 06108 Independent Accounting Firm Address (No. & Street, City, State, Zip Code) 225 Pikin Street, East Hartford, CT 06108 Independent Accounting Firm Address (No. & Street, City, State, Zip Code) 225 Pikin Street, East Hartford, CT 06108 Independent Accounting Firm Address (No. & Street, City, State, Zip Code) 11,950 Independent Accounting Firm Address (No. & Street, City, State, Zip Code) 11,950 Independent Accounting Firm Address (No. & Street, City, State, Zip Code) 11,950 Independent Accounting Firm Address (No. & Street, City, State, Zip Code) 11,950 Independent Accounting Firm Address (No. & Street, City, State, Zip Code) 11,950 Independent Accounting Firm Address (No. & Street, City, State, Zip Code) 11,950 Independent Accounting Firm Address (No. & Street, City, State, Zip Code) 11,950 Independent Accounting Firm Address (No. & Street, City, State, Zip Code) 11,950 Independent Accounting Firm Address (No. & Street, City, State, Zip Code) 11,950 Independent Accounting Firm Address (No. & Street, City, State, Zip Code) 11,950 Independent Accounting Firm Address (No. & Street, City, State, Zip Code) 11,950 Independent Accounting Firm Address (No. & Street, City, State, Zip Code)	Name of Facility	License No.	Report for Year Ended		Page	ot
O Accrual O Cash O Modified Cash Is the accounting basis for this period the same as for the O Yes If "No," explain. previous period? No No Independent Accounting Firm Name of Accounting Firm 1 CJIC LIC 2 SPitkin Street, Fast Hartford, CT 06108 2 Services Provided by This Firm (describe fully) 1 Medicaid Cost Report, Financial Statements, Tax Services \$ \$ 11,950 2 \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	Eliza Huntington Memorial Home	1279	9/30/2016		7	37
Independent Accounting Firm Name of Accounting Firm Name of Accounting Firm 1	The records of this facility for the	period covered by this report	were maintained on the following basis:			
Periodic the same as for the O No	• Accrual • Cash	Modified Cash				
Independent Accounting Firm Name of Accounting Firm Address (No. & Street, City, State, Zip Code) 225 Pitkin Street, East Hartford, CT 06108 225 Pitkin Street, East Hartford, CT 06108 226 Pitkin Street, East Hartford, CT 06108 227 Pitkin Street, East Hartford, CT 06108 228 Pitkin Street, East Hartford, CT 06108 23						
Independent Accounting Firm Name of Accounting Firm 1 CILC LLC 225 Pitkin Street, City, State, Zip Code) 225 Pitkin Street, East Hartford, CT 06108 23	•		If "No," explain.			
Name of Legal Firm or Independent Attorney Address (No. & Street, City, State, Zip Code) 225 Pitkin Street, East Hartford, CT 06108 23	previous period?) No				
Name of Legal Firm or Independent Attorney Address (No. & Street, City, State, Zip Code) 225 Pitkin Street, East Hartford, CT 06108 23						
1 CJLC LLC 225 Pitkin Street, East Hartford, CT 06108 28 3 4 28 28 28 29 3						
2 Services Provided by This Firm (describe fully) 1 Medicaid Cost Report, Financial Statements, Tax Services S 11,950 2 S S S S S S S S S S S S S S S S S S S						
Services Provided by This Firm (describe fully) 1			225 Pitkin Street, East Hartford, CT 061	08		
Services Provided by This Firm (describe fully) 1						
1 Medicaid Cost Report, Financial Statements, Tax Services 2 S 3 S 4 S 4 S Charge for Services Provided by This Firm (describe fully) 1 Services Provided by This Firm (describe fully) 1 Services Provided by This Firm (describe fully) 1 Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. 9 Yes O No Pg 15/1d Charge for Services Provided by This Firm (describe fully) 1 Services Provided by This Firm (describe fully) 1 S 2 Services Provided by This Firm (describe fully) 1 S 3 S 4 S 5 Services Provided by This Firm (describe fully) 1 S 5 Services Provided by This Firm (describe fully) 1 S 5 Services Provided by This Firm (describe fully) 1 S 5 Services Provided by This Firm (describe fully) 2 S 6 S 7 S 7 S 8 S 8 S 8 S 8 S 8 S 8 S 8 S 8 S 8 S 8	Δ					
S 3	Services Provided by This Firm (a	lescribe fully)				
\$ Charge for Services P \$ 11,950 Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. Yes	Medicaid Cost Report, Financial Sta	atements, Tax Services		\$	11,950	
Charge for Services P Charge for Services P Charge for Services P S 11.950 Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. Yes O No Pg 15/1d Degal Services Information Telephone Number Telephone Number Telephone Number Address (No. & Street, City, State, Zip Code) Services Provided by This Firm (describe fully) Services Provided by This Firm (describe fully) Address Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.	2			\$		
Charge for Services P \$ 11,950 Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.	3			\$		
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. Yes O No Pg 15/1d Pg 15/1d	4			\$		
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. ② Yes ○ No				Charge for	Services Pr	rovided
Name of Legal Firm or Independent Attorney Telephone Number 1 2 3 4 5 Address (No. & Street, City, State, Zip Code) 1 2 3 4 5 Services Provided by This Firm (describe fully) 1 \$ 2 \$ 3 \$ 4 \$ 5 \$ 4 \$ 5 \$ 4 \$ 5 \$ 6 \$ 6 \$ 7 Charge for Services Postification and Line No.				\$	11,950	
Telephone Number Telephone N			Yes, Specify Expense Classification and Line No.			
Name of Legal Firm or Independent Attorney 1 2 3 4 5 Address (No. & Street, City, State, Zip Code) 1 2 3 4 5 Services Provided by This Firm (describe fully) 1 \$ \$ 2 \$ \$ \$ \$ \$ \$ \$ \$ Charge for Services Parallel Attorney Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.		rg 13/10				
1 2 3 4 5 5 Address (No. & Street, City, State, Zip Code) 1 2 3 4 5 5 5 5 5 5 5 5 6 Charge for Services P Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.		nt Attorney		Telephone	Number	
3 4 5 5 Address (No. & Street, City, State, Zip Code) 1 2 3 4 5 5 5 \$ \$ \$ Charge for Services Particles Provided by This Firm (describe fully) 1	1	iii Attorney		relephone	Nullibei	
3 4 5 5 Address (No. & Street, City, State, Zip Code) 1 2 3 4 5 5 5 \$ \$ \$ Charge for Services Particles Provided by This Firm (describe fully) 1	2					
Address (No. & Street, City, State, Zip Code) 1 2 3 4 5 Services Provided by This Firm (describe fully) 1 2 3 4 5 Services Provided by This Firm (describe fully) 1 2 3 4 5 Charge for Services P \$ Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.						
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 P \$ Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.						
1 2 3 4 5 5 Services Provided by This Firm (describe fully) 1 \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	5					
3 4 5 Services Provided by This Firm (describe fully) 1 \$ 2 \$ 3 \$ 4 \$ 5 Charge for Services P \$ Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.	Address (No. & Street, City, State,	Zip Code)				
3 4 5 Services Provided by This Firm (describe fully) 1 \$ 2 \$ 3 \$ 4 \$ 5 Charge for Services P \$ Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.	1					
5 Services Provided by This Firm (describe fully) 1 \$ 2 \$ 3 \$ 4 \$ 5 \$ Charge for Services P Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.						
Services Provided by This Firm (describe fully) 1 \$ 2 \$ 3 \$ 4 \$ 5 \$ Charge for Services P \$ Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.						
Services Provided by This Firm (describe fully) 1						
1 \$ 2 \$ 3 \$ 4 \$ 5 \$ Charge for Services P \$ Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.	_	logorile o fulls				
2 \$ 3 \$ 4 \$ 5 \$ Charge for Services P \$ Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.	Services Provided by This Firm (a	tescribe jully)				
\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	1					
4 \$ 5 \$ Charge for Services P \$ Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.						
5 \$ Charge for Services P \$ Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				\$		
Charge for Services P \$ Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.	4			\$		
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.	5			1		
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.					Services Pr	rovided
	Ara Thasa Chargas Paffastad in the Euro	nditure Portion of This Denome If Y	Vac Spacify Expanse Classification and Line Ma	\$		
• Yes • O No Pg 15/1e			tes, specify expense Classification and Line 140.			
	⊙ Yes O No	Pg 15/1e				

Schedule of Resident Statistics

Name of Facility		License l	No.			Report fo	or Year Ende	ed		Page	of	
Eliza Huntington Memorial Home of Norwich, Inc.			1	.279			9/30/201	6			8	37
						Period 10/1 Thru 6/30				Period 7/	1 Thru 9/.	30
	T . 1 A 11	Total	Total	Total				D 11 (11				D :1 ::1
	Total All Levels	CCNH Level	RHNS Level	Residential Care Home	Total	CCNH	RHNS	Residential Care Home	Total	CCNH	RHNS	Residential Care Home
Certified Bed Capacity												
A. On last day of PREVIOUS report period	22			22	22			22	22			22
B. On last day of THIS report period	22			22	22			22	22			22
2. Number of Residents												
A. As of midnight of PREVIOUS report period	22			22	22			22	22			22
B. As of midnight of THIS report period	22			22	22			22	22			22
3. Total Number of Days Care Provided During Period												
A. Medicare												
B. Medicaid (Conn.)												
C. Medicaid (other states)												
D. Private Pay	2,093			2,093	1,617			1,617	476			476
E. State SSI for RCH	4,773			4,773	3,542			3,542	1,231			1,231
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	6,866			6,866	5,159			5,159	1,707			1,707
Total Number of Days Not Included in Figures in 3G 4. for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	559			559	433			433	126			126
B. Other Bed Reserve Days	113			113	113			113				
5. Total Resident Days (3G + 4A + 4B)	7,538			7,538	5,705			5,705	1,833			1,833

Schedule of Resident Statistics (Cont'd) License No. Report for Year Ended

Name of Faci	lity			Licer	ise No.				Repor	t for Year	Ended		Page	. 10
Eliza Hunting	ton Mei	norial H	Iome of Norwich]	1279					9/30/201	6		9	37
			in the certified b		pacity du	ring tl	he repo	rt yea	r?	0	Yes	•	No	
			f Change		Cl	nange	in Bed	ç		Ca	pacity Afte	er Change		
		1 lace of	Residential		Ci	lange	III Dea			Ca	pacity 7 tite	er enange		
Date of	CCNH	RHNS	Care Home		Lost			Gaine	d					
												Residential		
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Care Home	Reason fo	or Change
							<u> </u>							
	-	_	in certified bed o 90 days followin	_	-	the re	eport ye	ear (as	s report	ted in item	14 above)	provide the nun		
														tial Care
	Change in Resident Days									CC	NH	RHNS	Но	ome
1st chang														
2nd char	_													
3rd chan 4th chan														
		lents and	d Rates on Septe	mher	30 of Co	st Ve	ar							
o. Ivalliber	or resid	icits air	Medicare	inoci	Medi		.11			Se	elf-Pay		Other Sta	te Assisted
		İ												
												Residential		
	Item		CCNH	C	CNH	RI	HNS	CO	CNH	RF	INS	Care Home	R.C.H.	ICF-IID
No. of R	esidents											10	11	
Per Dien														
a. One b	ed rm.											141.37	121.63	
b. Two														
c. Three														
		5												
bed r	ms.													
		-	al Therapy Treat	ments						ТО	TAL	CCNH	RHNS	Residential Care Home
		re - Par												
В.			lusive of Part B) e Treatments											
			Treatments											
C.	Other	ioruirve	Treatments											
		hysical	Therapy Treatn	nents										
			Therapy Treatm											
		re - Par												
B.			lusive of Part B)											
			e Treatments											
		torative	Treatments											
	Other Total S	ma1 7	Thomas T.	0 × 4 -										
			Therapy Treatme		namta									
		re - Par	ational Therapy	ı ı call	nems									
			lusive of Part B)											
]			e Treatments											
			Treatments											
	Other													
D.	Total C	Occupati	ional Therapy T	reatm	ents									

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.		Report for Yea	r Ended	Page	of
Eliza Huntington Memorial Home of Norwich, Inc.	1279		9/30/2016		10	37
Are time records maintained by all individuals receiving co	mpensation?	•	Yes	0	No	
			Total Cost a			
			Total Cost a	liu Hours		
					Residential	
Item	CCNH	Hours	RHNS	Hours	Care Home	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I						
of Schedule A1)						
2. Administrator(s) (Complete also Sec. III					50.275	2.000
of Schedule A1)					58,375	2,093
3. Assistant Administrator (Complete also Sec. IV						
of Schedule A1)						
 Other Administrative Salaries (telephone operator, clerks, receptionists, etc.) 					100,002	5,13
5. Dietary Service					100,002	3,13
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers					135,031	9,333
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers					37,768	2,610
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance b. Other Maintenance Workers					54,046	2 72
8. Laundry Service					34,040	3,730
a. Supervisor						
b. Other Laundry Workers					6,833	472
Barber and Beautician Services					3,000	
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses						
b. RN						
1. Direct Care 2. Administrative**						
c. LPN						
1. Direct Care						
2. Administrative**						
d. Aides and Attendants					129,861	8,97
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						4 =0.
h. Recreation Workers					22,887	1,582
i. Physicians1. Medical Director						
2. Utilization Review						
3. Resident Care***	1		1	1	1	
4. Other (Specify)						
**						
j. Dentists						
k. Pharmacists						
1. Podiatrists	1					
m. Social Workers/Case Management			-	1		
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures				+	544,803	33,940

^{*} 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)

	CCNH		RH	NS	Residential Care Home		
Position	\$	Hours	\$	Hours	\$	Hours	
Total	¢		¢		¢.		
Total	\$ -	-	\$ -	-	\$ -	-	

Schedule of Other Fees (Page 13)

	CC	NH	RH	INS	Residential Care Home		
Service	\$	Hours	\$	Hours	\$	Hours	
Total	\$ -	-	\$ -	-	\$ -	-	

CSP-11 Rev. 10/2005

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

Name of Facility				License No.	Report for	Year Ended		Page	of	
Eliza Huntington Memorial Home	e of Norwic	h, Inc.		1279		9/30/2016			11	37
Name	CCNH	Salary Pai	Residential Care Home	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	KIINS	Care nome	(describe fully)	Services Rendered	Worked	rage 10	Other Employment**	Worked	Received
Section I - Operators/Owners										
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.

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 Y	ear Ended		Page	of	
Eliza Huntington Memorial Home	of Norwich	n, Inc.		1279		9/30/2016			12	37
		Salary Pai	Residential	Fringe Benefits and/or Other Payments	Full Description of	Total Hours	Line Where Claimed on	Name and Address of All	Total Hours	Compensation
Name	CCNH	RHNS	Care Home	(describe fully)	Services Rendered	Worked	Page 10	Other Employment**	Worked	Received
Section III - Administrators***										
Theresa Madonna (10/1/15 to 9/30/16)			58,375		Administrator	2,093		Law Office of Theresa I. Madonna LLC		
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.

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.		Report for Y	ear Ended	Page	of
Eliza Huntington Memorial Home of Norwich, Inc.	12	79	9/30/2016		13	37
			Total Cost	and Hours		
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
B. Direct care consultants paid on a fee						
for service basis in lieu of salary						
(For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)						
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee						
(Quarterly meetings) 2. Pharmaceutical Committee						
(Quarterly meetings)						
 Staff Development Committee (Once annually) 						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***					1	
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries					 	

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

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

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

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

Name of Facility Eliza Huntington Memorial Home of Norv	License No. vich, Inc. 1279		Report for Ye 9/30/2016	ear Ended	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Operato	* to Owners, rs, Officers	Expla	nation of Rela	tionship
N/A		Yes	No			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			

^{*} 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 Ye	ear Ended	Page	of
Eliza Huntington Memorial Home of Norwich, Ir 1279	Ģ	9/30/2016		15	37
					Residential
Item		Total	CCNH	RHNS	Care Home
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	14,008			14,008
2. Disability Insurance	\$				
3. Unemployment Insurance	\$	6,456			6,456
4. Social Security (F.I.C.A.)	\$	40,685			40,685
5. Health Insurance	\$	46,346			46,346
6. Life Insurance (employees only)					
(not-owners and not-operators)	\$	1,053			1,053
7. Pensions (Non-Discriminatory)	\$				
(not-owners and not-operators)					
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>)	\$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and	\$				
Profit Sharing Plans for Owners and	_				
Operators (Discriminatory)*	_				
c. Bad Debts*	\$				
d. Accounting and Auditing	\$	11,950			11,950
e. Legal (Services should be fully described on Page 7)	\$				
f. Insurance on Lives of Owners and	\$				
Operators (Specify)*					
g. Office Supplies	\$	9,253			9,253
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	5,551			5,551
2. Cellular Phones	\$	846			846
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 (<i>Specify</i>)	\$	10			10
See Attached Schedule					
3. Resident Day User Fee	\$				
Subtotal	\$	136,158			136,158

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

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

Eliza Huntington Memorial Home of Norwich, Inc. 9/30/2016

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Residential Care Home
Description	CCITI	KIII	
Total	\$ -	\$ -	\$ -

Schedule of Other Taxes

			Reside	ntial
Description	CCNH	RHNS	Care F	Iome
SALES TAX			\$	10
Total	\$ -	\$ -	\$	10

CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for `	Year Ended	Page	of
Eliza Huntington Memorial Home of Norwich, Inc.	1279	9/30/2016		16	37
	-				
					Residential
Item		Total	CCNH	RHNS	Care Home
Subtota	ls Brought Forward	: 136,158			136,158
Travel and Entertainment	<u> </u>				
1. Resident Travel and Entertainment		\$ 125			125
2. Holiday Parties for Staff		\$			
3. Gifts to Staff and Residents		\$ 1,477			1,477
4. Employee Travel		\$ 489			489
5. Education Expenses Related to Seminars ar	nd Conventions	\$			
6. Automobile Expense (not purchase or depr	eciation)	\$ 749			749
7. Other (<i>Specify</i>)		\$			
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (all such expense	s)	\$			
2. Advertising Telephone Directory (all such	expenses)***	\$			
3. Advertising Other (Specify)***		\$ 714			714
See Attached Schedule					
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	ce)***				
7. Postage		\$			
* 8. Dues and Membership Fees to Professional		\$ 550			550
Associations (Specify)					
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-A	llowable Org.***	\$			
9. Subscriptions		\$ 1,676			1,676
10. Contributions***		\$			
See Attached Schedule					
11. Services Provided by Contract (Specify and	Complete	\$			
Schedule C-2, Page 21 for each firm or ind	ividual)				
12. Administrative Management Services**		\$			
13. Other (<i>Specify</i>)		\$ 5,176			5,176
See Attached Schedule					
C-14 Total Administrative & General Expenditures	-	\$ 147,114			147,114

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

			Resid	lential
Description	CCNH	RHNS	Care	Home
UNALLOWABLE ADVERTISING			\$	714
Total Other Advertising	\$ -	\$ -	\$	714

Schedule of Dues

			Residential
Description	CCNH	RHNS	Care Home
CARCH			\$ 550
Total Dues	\$ -	\$ -	\$ 550
-			

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
RECONCILIATION DISCREPANCY - UNALLOWABLE			\$ 21
LICENSES AND PERMITS			\$ 970
PROFESSIONAL FEES			\$ 12,367
FREIGHT EXPENSE			\$ 659
MISC - UNALLOWABLE			\$ (4,290)
BANK SERVICE CHARGES - UNALLOWABLE			\$ (5,028)
RFP			\$ 34
NON-RESIDENT FUNCTIONS			\$ (384)
CWPM			\$ 5
SECRETARY OF STATE			\$ 200
ACSA - UNALLOWABLE			\$ 120
SHOP RITE DELIVERY FEES			\$ 503
Total Other Administrative and General	\$ -	\$ -	\$ 5,176

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Eliza Huntington Memorial Home of Nor	1279	9/30/2016	17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
N/A			
		l	

^{*} 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)

a. In-House Preparation & Service 1. Raw Food 2. Non-Food Supplies 5. 6,252 3. Other (Specify) 5. Ditary Questionnaire 2. Total Dietary Expenditures (2a + b + c + d) 5. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes O No If yes, specify amt. If yes, specify amt. If yes, specify cost. If yes, specify cost. If yes, specify amt. If yes, specify cost. If yes, specify cost. If yes, specify amt. If yes, specify cost. If yes, specify cost. If yes, specify amt. If yes, specify cost.	Nan	Name of Facility License No.				Report for Y	Page of	
Item	Eliza	a Huntington Memorial Home of Norwich, Inc			1279	9/30/201	6	18 37
2. Dietary a. In-House Preparation & Service 1. Raw Food \$\$ 58,447 \$\$ 58,447 2. Non-Food Supplies \$\$ 6,252 \$\$ 6,252 3. Other (Specify) \$\$ \$\$ 6,252 \$\$ 6,252 b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) c. Management Services** d. Other (Specify) \$\$ \$\$ \$\$ 64,699 \$\$ 64,699 2E. Total Dietary Expenditures (2a + b + c + d) \$\$ 64,699 \$\$ 64,699 2F. Dietary Questionnaire \$\$ Total CCNH RHNS \$\$ Residential Care Home G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? \$\$ Yes \$\$ No \$\$ If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other K. than employees or residents (i.e., Board Members, Guests) included in 2E? L. Is any revenue collected from these people? \$\$ Yes \$\$ No \$\$ If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees? \$\$ Yes \$\$ No \$\$ No \$\$ If yes, specify cost. O Yes \$\$ No \$\$ No \$\$ If yes, specify cost. If yes, specify cost. If yes, specify cost. If yes, specify cost.								Residential Care
a. In-House Preparation & Service 1. Raw Food 2. Non-Food Supplies 5. 6,252 3. Other (Specify) 5. Diter (Specify) 5. Diter (Specify) 6. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) c. Management Services** d. Other (Specify) 5. Dietary Questionnaire 2F. Dietary Questionnaire G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes No If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? L. Is any revenue collected from these people? No If yes, specify cost. If yes, specify amt. If yes, specify cost. If yes, specify amt. If yes, specify cost.		Item			Total	CCNH	RHNS	Home
1. Raw Food \$ \$ 58,447 \$ 58,447 \$ 2. Non-Food Supplies \$ 6.252	2.	•						
2. Non-Food Supplies \$ 6,252 \$ 6,252 \$ 6,252 \$ 3. Other (Specify) \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$		=						
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) c. Management Services** \$ d. Other (Specify) 2E. Total Dietary Expenditures (2a + b + c + d) \$ 64,699 \$ 64,699 2F. Dietary Questionnaire G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes O No I. Did you receive revenue from employees? O Yes O No I. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other K. than employees or residents (i.e., Board O Yes O No Members, Guests) included in 2E? I. Is any revenue collected from these people? O Yes O No M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify cost. If yes, specify cost.								
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) c. Management Services** d. Other (Specify) 2E. Total Dietary Expenditures (2a + b + c + d) S 64,699 2E. Total Dietary Expenditures (2a + b + c + d) S 64,699 2E. Total Dietary Expenditures (2a + b + c + d) S 64,699 CCNH RHNS Residential Care Home G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes No If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other K. than employees or residents (i.e., Board O Yes O No If yes, specify cost. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., N. snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes No If yes, specify cost. If yes, specify cost.								6,252
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than through Management Services) (Complete Schedule C-2 att. Page 21) c. Management Services** d. Other (Specify) 2E. Total Dietary Expenditures (2a + b + c + d) \$ 64,699 \$ 64,699 2E. Dietary Questionnaire G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes O No I. Did you receive revenue from employees? O Yes O No If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other than employees or residents (i.e., Board O Yes O No If yes, specify cost. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify cost. O Is any revenue collected from employees? O Yes O No If yes, specify cost. If yes, specify cost.								
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c. Management Services** d. Other (Specify) S d. Other (Specify)		• •		Þ				
c. Management Services** \$ d. Other (Specify) \$ d. Other (Specify) \$ \$ d. Other (D. Other) \$ d. Other) \$ d. Other (D. Other) \$ d. Other) \$ d. Other (D. Other) \$ d. Other (D. Other) \$ d. Other) \$ d. Other) \$ d. Other (D. Other) \$ d. Othe								
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2E. Total Dietary Expenditures (2a + b + c + d) \$ 64,699 \$ 64,699 \$ 64,699 2F. Dietary Questionnaire		-						
2F. Dietary Questionnaire G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes O No I. Did you receive revenue from employees? O Yes No If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) K. Is any revenue collected from these people? O Yes No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other than employees or residents (i.e., Board O Yes O No If yes, specify cost. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify amt. If yes, specify cost. If yes, specify cost. If yes, specify cost.		u. Offici (Specify)		_ Ψ				
2F. Dietary Questionnaire G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes O No I. Did you receive revenue from employees? O Yes No If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) K. Is any revenue collected from these people? O Yes No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other than employees or residents (i.e., Board O Yes O No If yes, specify cost. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify amt. If yes, specify cost. If yes, specify cost. If yes, specify cost.								
2F. Dietary Questionnaire G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes O No I. Did you receive revenue from employees? O Yes No If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify cost. If yes, specify cost. If yes, specify cost. If yes, specify cost.	2E.	Total Dietary Expenditures $(2a + b + c + d)$		\$	64,699			64,699
2F. Dietary Questionnaire G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes O No I. Did you receive revenue from employees? O Yes No If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify cost. If yes, specify cost. If yes, specify cost. If yes, specify cost.								Residential Care
G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes O No I. Did you receive revenue from employees? O Yes O No If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other than employees or residents (i.e., Board O Yes O No If yes, specify cost. L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify amt.	2F.	Dietary Ouestionnaire			Total	CCNH	RHNS	
H. Is cost of employee meals included in 2E? O Yes O No I. Did you receive revenue from employees? O Yes No If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify amt.		I	r dav	v:*				
I. Did you receive revenue from employees? O Yes O No amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other K. than employees or residents (i.e., Board O Yes O No Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify amt.	H.	-			•	No		•
Is cost of meals provided to persons other K. than employees or residents (i.e., Board O Yes O No Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify cost. If yes, specify cost.	I.	Did you receive revenue from employees?	0	Yes	•	No		
 K. than employees or residents (i.e., Board Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes No If yes, specify amt. 	J.	Where is the revenue received reported in the	Cos	st Repoi	t? (Page/Line	Item)		
Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes		Is cost of meals provided to persons other					If you are aif-	
Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes	K.	than employees or residents (i.e., Board	0	Yes	•	No		
M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes No No If yes, specify cost. If yes, specify amt.		Members, Guests) included in 2E?					COSt.	
Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify cost. If yes, specify amt.	L.	Is any revenue collected from these people?	0	Yes	•	No		
Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify cost. If yes, specify amt.	M.	Where is the revenue received reported in the	Cos	st Repoi	t? (Page/Line	Item)		
 N. snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes No If yes, specify cost. If yes, specify amt. 		<u> </u>				· · · · · · · · · · · · · · · · · · ·		
O. Is any revenue collected from employees? O Yes O No If yes, specify amt.	N.	snacks at monthly staff meetings, board meetings) provided to employees included	0	Yes	•	No		
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)	O.		0	Yes	•	No		
	P.	Where is the revenue received reported in the	Cos	st Repoi	t? (Page/Line	Item)		

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

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

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

Name of Facility		No.	Report for	Year Ended	Page	of
Eliza Huntington Memorial Home of Norwich, Inc.		1279	9/30/2010	5	19	37
Item		Total	CCNH	RHNS		ential Care Iome
 3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, 	Lbs.					
gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	2,927				2,927
2. Employee items including uniforms, gowns, etc. washed, ironed and/or	Lbs.					
processed.***	Amt. \$					
3. Personal clothing of residents	Lbs.					
washed, ironed, and/or processed.***	Amt. \$					
4. Repair and/or purchase of linens.***	Lbs.					
b. Purchased Services (by contract other	Amt. \$					
than through Management Services) (Complete Schedule C-2 att. Page 21)	\$					
c. Management Services**	\$					
d. Other (Specify)	\$					
3E. Total Laundry Expenditures $(3a + b + c + d)$	\$	2,927				2,927
3F. Laundry Questionnaire						
G. Is cost of employee laundry included in 3E?) Yes	•	No	If yes, specify cost.		
H. Did you receive revenue from employees?) Yes	•	No	If yes, specify amt.		
I. Where is the revenue received reported in the Co	st Report?		(Page/Lin	e Item)		
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?) Yes	•	No	If yes, specify cost.		
K. Did you receive revenue from these people?) Yes	•	No	If yes, specify amt.		
L. Where is the revenue received reported in the Co	st Report?		(Page/Lin	e Item)		

^{*} Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4. All allocations should add to total recorded in 3E.

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

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

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

Nan	ne of Facility	License No.	Repo	ort for Year E	nded	Page	of
Eliz	a Huntington Memorial Home of Norwich,	1279		9/30/2016		20	37
	Item			Total	CCNH	RHNS	Residential Care Home
4.	Housekeeping	Sq. Ft. Serviced		Total	CCMI	Kiivs	Care Home
4.	a. In-House Care	_					
	1. Supplies - Cleaning (<i>Mops</i> ,	by Personnel Amt.	\$	6,816			6,816
	pails, brooms, etc.)	Aiiit.	Ψ	0,810			0,810
	b. Purchased Services (by contract other	Sq. Ft. Serviced					
	than through Management Services)	by Personnel					
	(Complete Schedule C-2 att.	Amt.	\$				
	Page 21)	7 XIIIC.	Ψ				
	c. Management Services*		\$				
	d. Other (<i>Specify</i>)		\$				
	(-1 - 35)		- 1				
4E.	Total Housekeeping Expenditures (4a +	b+c+d)	\$	6,816			6,816
5.	Resident Care (Supplies)**	•					
	a. Prescription Drugs***		- 1				
	1. Own Pharmacy		\$				
	2. Purchased from		\$				
	b. Medicine Cabinet Drugs		\$	390			390
	c. Medical and Therapeutic Supplies		\$				
	d. Ambulance/Limousine***		\$				
	e. Oxygen						
	1. For Emergency Use		\$				
	2. Other***		\$				
	f. X-rays and Related Radiological		\$				
	Procedures***						
	g. Dental (Not dentists who should be inc	luded under	\$				
	salaries or fees)						
	h. Laboratory***		\$	7.057			7 0-7
	i. Recreation		\$	5,965			5,965
	j. Other (Specify)****		\$	1,206			1,206
£17	See Attached Schedule	:)	d.	7.561			7.561
OK.	Total Resident Care Expenditures (5a - 5	J <i>)</i>	\$	7,561			7,561

^{*} 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	dential Home
BEAUTY SUPPLIES			\$ 1,206
Total Other Resident Care	\$ -	\$ -	\$ 1,206

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

Name of Facility		License No. Report for Year Ended					Page 21	of 37		
Eliza Huntington Memorial Ho	ome of Norwich, Inc.			1279	9/30/2016	1				
		Related ** Operators					Total Cost	/Page Ref.**	*	
Name of Individual or Company	Address	Yes	No	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	Residential Care Home		Line
N/A	radioss			readionship	Service Frovided	COLVII	Tarris		1.5	Line
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							

^{*} List all contracted services over \$10,000. Use additional sheets if necessary.

^{**} Refer to Page 4 for definition of related.

^{***} Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility License No.).	Report for Ye	ear Ended		Page of
Eliza Huntington Memorial Home of Norwich 1279		9/30/2016			22 37
					Residential Care
Item		Total	CCNH	RHNS	Home
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$	33,567			33,567
b. Heat	\$	8,829			8,829
c. Light & Power	\$	44,349			44,349
d. Water	\$	8,567			8,567
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$				
f. Other (<i>itemize</i>)	\$	24,370			24,370
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)	\$	119,682			119,682
7. Depreciation (<i>complete schedule page 23*</i>)					
a. Land Improvements	\$	403			403
b. Building & Building Improvements	\$	29,925			29,925
c. Non-Movable Equipment	\$				
d. Movable Equipment	\$	4,583			4,583
*7e. Total Depreciation Costs $(7a + b + c + d)$	\$	34,911			34,911
8. Amortization (Complete att. Schedule Page 24*)					
a. Organization Expense	\$				
b. Mortgage Expense	\$	295			295
c. Leasehold Improvements	\$				
d. Other (Specify)	\$				
*8e. Total Amortization Costs $(8a + b + c + d)$	\$	295			295
9. Rental payments on leased real property less					
real estate taxes included in item 10b	\$				
10. Property Taxes					
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$				
c. Personal property taxes	\$				
11. <i>Total Property Expenses</i> (7e + 8e + 9 + 10)	\$	35,206			35,206

^{*} 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

	COM	DING	Residential	
Description Description	CCNH	RHNS	Care Home	
REFUSE REMOVAL			\$ 3,75	
109 WASHINGTON			\$ 4,50	00
1 BUCKINGHAM			\$ 1,01	6
107 WASHINGTON			\$ 15,09)5
Total Other Repairs and Maintenance	\$ -	\$ -	\$ 24,37	0

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Depreciation Schedule

Name of Facility Eliza Huntington Memorial Home of Norwich, Inc.					License No.	9		Report for Year E	Ended		Page 23	of 37
				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												
Acquired prior to this report period					216,543		216,543	41,068	SL	Var	403	
2. Disposals (attach schedule)												
3. Acquired during this report period (atta	ch sch	edule)										
A-4. Subtotal												403
B. Building and Building Improvements												
Acquired prior to this report period					2,095,001		2,095,001	1,553,713	SL	Var	18,895	
2. Disposals (attach schedule)												
3. Acquired during this report period (atta	ch sch	edule)			108,497		108,497				11,030	
B-4. Subtotal												29,925
C. Non-Movable Equipment												
 Acquired prior to this report period 												
2. Disposals (attach schedule)												
3. Acquired during this report period (atta	ch sch	edule)										
C-4. Subtotal												
	logl maint	nileage book ained?	Acqu	e of isition	Historical Cost Exclusive of	Less Salvage	Cost to Be	Accumulated Depreciation to Beginning of	Method of Computing	Useful	Depreciation	
	Yes	No	Month	Year	Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
D. Movable Equipment 1. Motor Vehicles (Specify name, model and year of each vehicle)								12.200				
a. 2005 Ford F-250 Plow Truck	X		9	2010	15,200		15,200	15,200	SL	5		
b.												
c.												
Movable Equipment												
a. Acquired prior to this report period Var Var		293,573		293,573	283,708	CI	Var	2,996				
b. Disposals (attach schedule)			v ai	v ai	473,373		293,373	203,700	DL.	v ai	2,590	
b. Disposals (attach schedule) c. Acquired during this report period												
(attach schedule)					7,935		7,935				1,587	
D-3. Subtotal					1,933		1,933				1,38/	4,583
E. Total Depreciation												34,911

Eliza Huntington Memorial Home of Norwich, Inc. $9/30/2016\,$

Schedule of Land Improvements Acquired during this report period

Selleddie of Land 1	nprovements required during this report period		Useful		
Acquisition Date	Description of Item	Cost	Life	Depreciation	
Additions:	•				1
					ĺ
					1
					1
					1
					4
					1
Total additions for l	Land Improvements	\$ -		\$ -	*
Deletions:					1
					Ī
					1
					i
					1
					4
					4
Total deletions for I	Land Improvements	\$ -		\$ -	**

^{*}Ties to Page 23, Line A3

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
11/6/2015	Roof	\$ 106,697	10	\$	10,670
12/7/2015	Elevator Shaft Repairs	\$ 1,800	5	\$	360
		100.405			11.020
	Building Improvements	\$ 108,497		\$	11,030
Deletions:					
					·
Total deletions for	Building Improvements	\$ -		\$	-

^{*}Ties to Page 23, Line B3

Schedule of Non-Movable Equipment Acquired during this report period

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

^{*}Ties to Page 23, Line C3

^{**}Ties to Page 23, Line A2

^{**}Ties to Page 23, Line B2

^{**}Ties to Page 23, Line C2

			Useful		
Acquisition Date	Description of Item	Cost	Life	Dep	reciation
Additions:					
10/29/2015	2 Mattresses	\$ 338	5	\$	68
11/2/2017	Carpeting	\$ 480	5	\$	96
11/27/2015	Cabinet	\$ 90	5	\$	18
12/15/2015	Carpeting	\$ 480	5	\$	96
1/15/2016	Mattress	\$ 169	5	\$	34
4/29/2016	Patio Umbrella	\$ 30	5	\$	6
5/2/2016	Patio Umbrella	\$ 60	5	\$	12
5/6/2016	Wood Flooring	\$ 3,500	5	\$	700
6/4/2016	Carpeting	\$ 960	5	\$	192
7/5/2016	Wood Flooring	\$ 1,650	5	\$	330
8/6/2016	Mattress	\$ 178	5	\$	36
Total additions for	Movable Equipment	\$ 7,935		\$	1,587
Deletions:					
Total deletions for	Movable Equipment	\$ -		\$	-

^{*}Ties to Page 23, Line D2c

Schedule of Leasehold Improvements Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
Total additions for	Leasehold Improvement	\$ -		\$ -
Deletions:				
Total deletions for l	Leasehold Improvement	\$ -		\$ -

^{*}Ties to Page 24, Line C3

^{**}Ties to Page 23, Line D2b

^{**}Ties to Page 24, Line C2

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Amortization Schedule*

Name of Facility				License No.		Report for Year Ended			Page	of
Eliza Huntington Memorial Home of Norwich, Inc.			1279		9/30/2016			24	37	
			e of sition			Accumulated Amort. to Beginning of	Basis for			
	<u>-</u> .		3 .7	Length of	Cost to Be	Year's	Computing		Amortization	m . 1
<u> </u>	Item	Month	Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
A.	Organization Expense									
	1.									
	2.									
	3.									
A-4.										
B.	Mortgage Expense									
	1. Loan Costs	3	2006	240 months	2,500	2,500	Life of Mortgage	5		
	2. Jewett City Loan Costs	6	2015	15 yrs	4,419	147	Life of Mortgage	15 yrs	295	
	3.									
B-4.	Subtotal									295
C.	Leasehold Improvements and Other									
	1. Acquired prior to this report period									
	2. Disposals (attach schedule)									
	3. Acquired during this report period									
	(attach schedule)									
	Subtotal									26.7
D.	Total Amortization									295

^{*} Straight-line method must be 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.

^{**} Specify which of the following bases were used:

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

Name of Facility Eliza Huntington Memorial Home of N License N	o. 279	Report for Year En 9/30/2016		Page of 25 37	
	217	<i>7/30/2010</i>			23 31
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility	•	Yes	0	No	If "Yes," complete Part B.
or leased from a Related Party?*					If "No," complete Part C.
*If any owner or operator of this facility is relate business association to any person or organization					
a related party transaction.					
Description		Total			
Date Land Purchased	1943	,1997,2000,2001,2006			
Date Structure Completed		1943, 2997			
3. If NOT Original Owner, Date of Purcha	se				
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity		22			
6. Square Footage		6,761			
7. Acquisition Cost					
a. Land		53,098			
b. Building		199,137			
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, varial	ole)	Term Mortgage			
b. Date Mortgage Obtained		06/26/15			
c. Interest Rate for the Cost Year		4.13%			
d. Term of Mortgage (number of years)	1	15			
e. Amount of Principal Borrowed		413,000			
f. Principal balance outstanding as of 9	/30/2016	409,741			
Complete if Mortgage was Refinanced	l				
During Current Cost Year					
g. Type of Financing (e.g., fixed, varial	ole)	Fixed			
h. Date of Refinancing		06/26/15			
i. New Interest Rate		4.13%			
j. Term of Mortgage (number of years)		15			
k. Amount of Principal Borrowed		413,000			
Principal Outstanding on Note Paid-		405,016			
Part C - Arms-Length Leases for Real		<u> </u>			
Name and Address of Lessor	Prop	perty Leased	Date of Lease	Term of Lease	Annual Amount of Lease
	<u> </u>				

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 Yea		Page of	
Eliza Huntington Memorial Home of 1279		9/30/2016			26 37
					Residential Care
Item		Total	CCNH	RHNS	Home
12. Interest					
A. Building, Land Improvement & Non-Movable					
Equipment 1. First Mortgage	\$	16,794			16,794
Name of Lender	Rate	10,794			10,794
Ivalie of Ecider	Rate				
Address of Lender		1			
2. Second Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
3. Third Mortgage	\$				
Name of Lender	Rate				
Traine of Bonder	11410				
Address of Lender					
4. Fourth Mortgage	\$				
Name of Lender	Rate				
A 11 CX 1					
Address of Lender					
B. CHEFA Loan Information					
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)	\$	16,794			16,794
			Subtatals t	. 1,	

(Carry Subtotals forward to next page)

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

Name of Facility Eliza Huntington Memorial Home 12	No. 79		Report for Ye 9/30/2016	ear Ended		Page of 27 37
						Residential
Item			Total	CCNH	RHNS	Care Home
Subt	otals Brou	ight Forward:	16,794			16,794
12. C. Movable Equipment						
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		<u> </u>				
Address of Lender						
12. C. 3. Total Movable Equipment Inter Expense (C1 + 2)	est	\$				
12. D. Other Interest Expense (<i>Specify</i>)		\$				
13. Total All Interest Expense (12B7 + 12	C3 + 12D) \$	16,794			16,794
14. Insurance						
a. Insurance on Property (buildings o	nly)	\$				21,598
b. Insurance on Automobiles		\$	1,108			1,108
c. Insurance other than Property (as s	pecified a	(bove) \$				
1. Umbrella (Blanket Coverage)						
2. Fire and Extended Coverage						
3. Other (<i>Specify</i>)		\$				
14d. Total Insurance Expenditures (14a + 1	(b+c)	\$	22,706			22,706
15. Total All Expenditures (A-13 thru C-1		\$				968,307

D. Adjustments to Statement of Expenditures

Name	e of Fa	cility		Lic	ense No.	Report for Ye	ar Ended	Page of
Eliza	Hunti	ngton	Memorial Home of Norwich, Inc.		1279	9/30/2016		28 37
					Total			
Item	Page	Line			Amount of			Residential Care
	No.		Item Description		Decrease	CCNH	RHNS	Home
			es and Wages					
1.			Outpatient Service Costs	\$				
2.			Salaries not related to Resident Care	\$				
3.			Occupational Therapy	\$				
4.			Other - See attached Schedule	\$				
Page	13 - I	rofes	sional Fees					
5.			Resident Care Physicians **	\$				
6.			Occupational Therapy	\$				
7.			Other - See attached Schedule	\$				
Page	s 15 &	16 -	Administrative and General					
8.			Discriminatory Benefits	\$				
9.			Bad Debts	\$				
10.			Accounting & Legal	\$				
11.			Telephone	\$				
12.	15	1h2	Cellular Telephone	\$	126			126
13.			Life insurance premiums on the life					
			of Owners, Partners, Operators	\$				
14.			Gifts, flowers and coffee shops	\$				
15.			Education expenditures to colleges or					
			universities for tuition and related costs					
			for owners and employees	\$				
16.			Travel for purposes of attending					
			conferences or seminars outside the					
			continental U.S. Other out-of-state					
			travel in excess of one representative	\$				
17.			Automobile Expense (e.g. personal use)	\$				
18.	16	m3	Unallowable Advertising *	\$	714			714
19.	10	1113	Income Tax / Corporate Business Tax	\$	711			71.
20.			Fund Raising / Contributions	\$				
21.			Unallowable Management Fees	\$				
22.	20	5i	Barber and Beauty	\$	1,206			1,206
23.		<i>-</i> ارد	Other - See attached Schedule	\$	(9,177)			(9,177)
	18 - I)ietar	y Expenditures	Ψ	(2,111)			(2,111)
24.			Meals to employees, guests and others					
			who are not residents	\$				
Page	19 ₋ 1	aund	ry Expenditures	Ψ				
25.	1/ - L		Laundry services to employees, guests					
			and others who are not residents	\$				
Page	20 - F	Iouse	keeping Expenditures	Ψ				
26.	20 - I	Louse	Housekeeping services to employees, guests					
20.			and others who are not residents	\$				
			Subtotal (Items 1 - 26)		(7,131)			(7,131)
			Wented"	, ψ		Carry Subtotal f		•

^{*} 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

					Residential
Page Ref	Line Ref	Description	CCNH	RHNS	Care Home
	·				
	·				
Total Othe	r Salaries A	Adjustment	\$ -	\$ -	\$ -

.....

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Othe	r Fees Adji	ustments	\$ -	\$ -	\$ -

Schedule of Other A&G Adjustments

					Res	sidential
Page Ref	Line Ref	Description	CCNH	RHNS	Care Home	
16	M13	RECONCILIATION DISCREPANCIES			\$	21
16	M13	BANK CHARGES			\$	(5,028)
16	M13	MISC			\$	(4,290)
16	M13	ACSA			\$	120
						·
Total Other	Total Other A&G Adjustments		\$ -	\$ -	\$	(9,177)

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

Eliza Huntington Memorial Home of Norwich, Inc. 1279 9/30/2016 29 3		c =	•••	D. Adjustments to Statemer					I n	-
Total					Lic			ear Ended	_	of
Item Page Line No. No. Item Description Decrease CCNH RHNS Residential C Home Subtotals Brought Forward S (7,131) (7	Eliza	Hunti	ngton	Memorial Home of Norwich, Inc.			9/30/2016	ī	29	37
No. No. No. Item Description Decrease CCNH RHNS Home Subtotals Brought Forward \$ (7,131) (7, 131)	_	_	٠.							
Subtotals Brought Forward S (7,131) (7,		_								
Page 20 - Resident Care Supplies** 27.	No.	No.	No.		_		CCNH	RHNS	He	
27. Prescription Drugs S	_				\$	(7,131)				(7,131)
28.		20 - K	Reside							
29.					_					
30. Laboratory S					_					
31. Medical Supplies S S S S S S S S S				·	_					
32.				·	_					
33. Occupational Therapy \$				11						
34. Other - See Attached Schedule \$\ Page 22 - Maintenance and Property\$ 35. Excess Movable Equipment Depreciation See Attached Schedule \$\ S\$ 36. Depreciation on Unallowable Motor Vehicles \$\ S\$ 37. Unallowable Property and Real Estate Taxes \$\ S\$ 38. Rental of Building Space or Rooms \$\ S\$ 39. Other - See Attached Schedule \$\ \$\ 20,610\$ Page 27 - Insurance 40. Mortgage Insurance \$\ \$\ \$\ \$\ \$\ \$\ \$\ \$\ \$\ \$\ \$\ \$\ \$\					_					
Page 22 - Maintenance and Property 35. Excess Movable Equipment Depreciation See Attached Schedule \$ S					\$					
Section See Attached Schedule Setate Taxes See Attached Schedule Setate Taxes See Attached Schedule Setate Taxes See Attached Schedule					\$					
See Attached Schedule \$	Page	22 - N	Iainte							
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 \$ 20,610 \$ 20,610 \$ 20,610 \$ Page 27 - Insurance \$ 40. Mortgage Insurance \$ 41. Property Insurance \$ 42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only 50. Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$	35.			Excess Movable Equipment Depreciation						
Motor Vehicles \$ 1 1 1 1 1 1 1 1 1				See Attached Schedule	\$					
37. Unallowable Property and Real Estate Taxes \$ 38. Rental of Building Space or Rooms \$ 39. Other - See Attached Schedule \$ 20,610 \$ 20,6 Page 27 - Insurance \$ 40. Mortgage Insurance \$ 41. Property Insurance \$ 42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only 50. Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$	36.			Depreciation on Unallowable						
Estate Taxes				Motor Vehicles	\$					
38. Rental of Building Space or Rooms \$ 39. Other - See Attached Schedule \$20,610 20,4 Page 27 - Insurance 40. Mortgage Insurance \$ 41. Property Insurance \$ Other - Miscellaneous \$ 42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only \$ 50. Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$	37.			Unallowable Property and Real						
39. Other - See Attached Schedule \$ 20,610 20,000 Page 27 - Insurance 40. Mortgage Insurance \$ 41. Property Insurance \$ 900 Other - Miscellaneous 42. Research or Experimental Activities \$ 900 43. Radio and Television Revenue \$ 900 44. Vending Machine Revenue \$ 900 45. Purchase Discounts and Allowances \$ 900 46. Duplications of functions or services \$ 900 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 900 48. Interest Income on Accounts Rec \$ 900 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ 100 Not For Profit Providers Only 500 Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$ 100 See Attached Schedule \$ 1				Estate Taxes	\$					
39. Other - See Attached Schedule \$ 20,610 20,000 Page 27 - Insurance 40. Mortgage Insurance \$ 41. Property Insurance \$ 900 Other - Miscellaneous 42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 900 44. Vending Machine Revenue \$ 900 45. Purchase Discounts and Allowances \$ 900 46. Duplications of functions or services \$ 900 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 900 48. Interest Income on Accounts Rec \$ 900 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ 900 Not For Profit Providers Only 500. Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$ 900 100. See Attac	38.			Rental of Building Space or Rooms	\$					
40. Mortgage Insurance \$ 41. Property Insurance \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	39.				\$	20,610				20,610
A1. Property Insurance \$	Page	27 - I	nsura	nce						
Other - Miscellaneous 42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only \$ 50. Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$	40.			Mortgage Insurance	\$					
42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only \$ 50. Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$ \$ \$ 48. Depreciation Unallowable Building Interest - See Attached Schedule \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	41.			Property Insurance	\$					
43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only 50. Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$	Other	r - Mis	scella	neous						
44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only 50. Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$	42.			Research or Experimental Activities	\$					
45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only 50. Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$	43.			Radio and Television Revenue	\$					
46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only 50. Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$	44.			Vending Machine Revenue	\$					
47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only 50. Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$	45.			Purchase Discounts and Allowances	\$					
47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only 50. Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$	46.			Duplications of functions or services	\$					
enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only 50. Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$	47.									
providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only 50. Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$										
48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only 50. Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$				•	\$					
49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only 50. Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$	48.			1	_					
costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only 50. Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$										
Attached Schedule \$ Not For Profit Providers Only 50. Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$				•						
Not For Profit Providers Only 50. Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$, · · · · · · · · · · · · · · · · · · ·	\$					
50. Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule \$	Not I	or Pr	ofit P							
Unallowable Building Interest - See Attached Schedule \$				•	ᅦ					
See Attached Schedule \$										
				S .	\$					
51. Total Amount of Decrease (Items 1 - 50) \$ 13,479 13,479	51.	Total	Amo		\$	13,479				13,479

^{***} 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.

Eliza Huntington Memorial Home of Norwich, Inc. $9/30/2016\,$

Schedule of Other Ancillary Costs

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

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

					Res	sidential
Page Ref	Line Ref	Description	CCNH	RHNS	Car	e Home
22	6f	109 WASHINGTON			\$	4,500
22	6f	1 BUCKINGHAM			\$	1,016
22	6f	107 WASHINGTON			\$	15,095
Total Othe	Total Other Property Adjustments \$ - \$				\$	20,610

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

Schedule of Unallowable Building Interest

					Residential
Page Ref	Line Ref	Description	CCNH	RHNS	Care Home
Total Unal	lowable Bu	ilding Interest	\$ -	\$ -	\$ -

CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility License No.	V CIII	Report for Ye	ear Ended		Page of
Eliza Huntington Memorial Home of Nor 1279		9/30/2016			30 37
					Residential Care
Item		Total	CCNH	RHNS	Home
I. Resident Room, Board & Routine Care Revenue					
1. <u>a. Medicaid Residents (CT only)</u>	\$	630,100			630,100
b. Medicaid Room and Board Contractual Allowance **	\$				
2. a. Medicaid (All other states)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. <u>a. Medicare Residents (all inclusive)</u>	\$				
b. Medicare Room and Board Contractual Allowance **	\$				
4. a. Private-Pay Residents and Other	\$	337,765			337,765
b. Private-Pay Room and Board Contractual Allowance **	\$				
II. Other Resident Revenue					
a. Prescription Drugs - Medicare	\$				
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
2. a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$				
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$				
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$				
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other (Specify) - Medicare	\$				
b. Other (Specify) - Non-Medicare	\$				
III. Total Resident Revenue (Section I. thru Section II.)	\$	967,865			967,865
IV. Other Revenue*		,			Í
Meals sold to guests, employees & others	\$				
Rental of rooms to non-residents	\$				
3. Telephone	\$				
Rental of Television and Cable Services	\$				
5. Interest Income (Specify)	\$	42,190			42,190
6. Private Duty Nurses' Fees	\$,.,,			.2,170
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$	19,587			19,587
V. Total Other Revenue (1 thru 8)	\$	61,777		1	61,777
VI. Total All Revenue (III +V)	\$	1,029,642			1,029,642

 $^{* \ \}textit{Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost \textit{Report}.}$

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

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

					Resi	dential
Page Ref		Balance	CCNH	RHNS	Care	Home
31/1A	INTEREST INCOME				\$	524
	INTEREST INCOME - USB				\$	10,416
	DIVIDENDS				\$	31,250
Total Inter	Total Interest Income		\$ -	\$ -	\$	42,190

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	sidential re Home
g	RENTAL 107 WASHINGTON	3 3 4 4 5		\$ 7,700
	RENTAL 109 WASHINGTON			\$ 12,100
	ANNUAL DONATION (Unrestricted)			\$ 20
	ANNUAL DONATION: LADIES (Unrestricted)			\$ 1,350
	LOSS ON SALE OF SEC			\$ (10,682)
	UNREALIZED GAIN			\$ 9,099
Total Othe	er Revenue	\$ -	\$ -	\$ 19,587

.....

G. Balance Sheet

Name of Facility	License No.	Report for Year End	ed Pag	e of
Eliza Huntington Memorial Home o	of N 1279	9/30/2016	31	37
	Account			Amount
Assets				
A. Current Assets				
1. Cash (on hand and in bank			\$	301,756
2. Resident Accounts Receiv	· · · · · · · · · · · · · · · · · · ·		\$	100,008
3. Other Accounts Receivabl	e (Excluding Owners	or Related Parties)	\$	
4 Inventories			\$	
5. Prepaid Expenses			\$	20,512
a. PREPAID EXPENSES		1,687		
b. PREPAID INSURANC	E	18,825		
c				
d.				
6. Interest Receivable			\$	
7. Medicare Final Settlement			\$	
8. Other Current Assets (<i>item</i>	nize)		\$	
			_	
A-9. Total Current Assets (Lines A	A1 thru 8)		\$	422,277
B. Fixed Assets				
1. Land			\$	139,766
2. Land Improvements	*Historical Cost	216,543	\$	175,072
	Accum. Depreci			
3. Buildings	*Historical Cost	2,203,498	\$	619,861
	Accum. Depreci	ation 1,583,638 Net		
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreci	ntion Net	-	
5. Non-Movable Equipment	*Historical Cost		\$	
	Accum. Depreci	ation Net	-	
6. Movable Equipment	*Historical Cost	301,507	\$	13,216
	Accum. Depreci	ation 288,291 Net	-	
7. Motor Vehicles	*Historical Cost	15,200	\$	1
	Accum. Depreci	ation 15,199 Net		
8. Minor Equipment-Not Dep	preciable		\$	
9. Other Fixed Assets (<i>itemiz</i>	re)		\$	4,600
LOAN COSTS	•	3,977	[,
COST REPORT VRS I	BOOK	623		
B-10. Total Fixed Assets (Lines			\$	952,517

^{*} 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		Facility	License No.	Report for Year Ended		Page		of
Eliza Huntington Memorial Home of N		intington Memorial Home of N	1279	9/30/2016		32		37
			Account			Amo	ount	
				Total Brought Forward:	\$		1,374	4,794
C.	Le	asehold or like property record	ed for Equity Purpose	S.				
	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	<u> </u>				
			Accum. Depreciation	Net	\$			
	7.	Minor Equipment-Not Depre	ciable		\$			
C-8	To	tal Leasehold or Like Propert	ies (C1 thru 7)		\$			
D.	Inv	vestment and Other Assets						
	1.	Deferred Deposits			\$			
	2.	Escrow Deposits			\$			
	3.	Organization Expense	*Historical Cost	<u></u>				
			Accum. Depreciation	Net	\$			
	4.	Goodwill (Purchased Only)			\$			
	5.	Investments Related to Reside	ent Care (itemize)		\$		1,186	6,200
		Corp Bonds \$262,643 + M	lutual Funds \$379,307	641,951				
		Equity Securities		544,249				
	6.	Loans to Owners or Related F	Parties (itemize)		\$			
		Name and Address	Amount	Loan Date				
	7.	Other Assets (itemize)			\$			
		tal Investments and Other Ass	,		\$			6,200
D-9.	To	tal All Assets (Lines A9 + B10	0 + C8 + D8		\$		2,560	0,994

^{*} 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	
Eliza Huntington Memorial Home of Norwich		1279	9/30/2016		33	37	
		I	Account			A	mount
Liabilities							
A.	Cu	rrent Liabilities					
	1.	Trade Accounts Payable				\$	4,646
	2.	Notes Payable (itemize)				\$	
		T D 11 C F :				ф	
	3.	Loans Payable for Equipme			ln . n	\$	
		Name of Lender	Purpose	Amount	Date Due		
	4.	Accrued Payroll (Exclusive	of Owners and/or S	Stockholders only)	•	\$	7,617
	5.	Accrued Payroll (Owners a	_	•		\$	·
	6.	Accrued Payroll Taxes Pay		•		\$	19
	7.	Medicare Final Settlement	Payable			\$	
	8.	Medicare Current Financin	g Payable			\$	
	9.	Mortgage Payable (Current	Portion)			\$	
	10.	Interest Payable (Exclusive	of Owner and/or R	elated Parties)		\$	
	11.	Accrued Income Taxes*				\$	
	12.	Other Current Liabilities (in	temize)			\$	82,613
		DUE TO DSS	25,	866 SECURITY DEPOSI	Т 3,200		
		DUE TO RESIDENT FUNDS		206)			
		TENANT SECURITY DEPOSITS	46,	350			
		DUE TO THE STATE OF CT		404			
A-13.	Tot	tal Current Liabilities (Line	es A1 thru 12)			\$	94,895

^{*} 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	License No.	Report for Year	Ended	Page	of	
Eliza Huntington Memorial Home of Norw	i 1279	9/30/2016		34	37	
1	A	mount				
		Total Broug	ht Forward:		94,895	
Liabilities (cont'd)						
B. Long-Term Liabilities	<i>.</i>			*		
1. Loans Payable-Equipment		<u> </u>	<u> </u>	\$		
Name of Lender	Purpose	Amount	Date Due			
2. Mortgages Payable			9	\$	389,410	
3. Loans from Owners or Rel	ated Parties (itemize)	1	9	\$		
Name and Address of Lender	Amount	Loan D	ate			
4. Other Long-Term Liabilitie	es (itemize)		9	\$		
B-5. Total Long-Term Liabilities (\$	389,410 484,305	
C. Total All Liabilities (Lines A-	13 + B-5)	C. <i>Total All Liabilities</i> (Lines A-13 + B-5)				

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

	ne of Facility License No. Report for Year I	Ended	Page of
Eliz	za Huntington Memorial Home of 1 1279 9/30/2016		35 37
	Account	Amount	
A.	Reserves		
	1. Reserve for value of leased land	\$	
	2. Reserve for depreciation value of leased buildings and appurtenance	ces	
	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 b	pased \$	
	5. Reserve for funds set aside as donor restricted	\$	
	6. Total Reserves	\$	
B.	Net Worth		
	1. Owner's Capital	\$	
	2. Capital Stock	\$	
	3. Paid-in Surplus	\$	
	4. Treasury Stock	\$	
	5. Cumulated Earnings	\$	2,015,352
	6. Gain or Loss for Period 10/1/2015 thru 9	0/30/2016 \$	61,334
	7. Total Net Worth	\$	2,076,687
C.	Total Reserves and Net Worth	\$	2,076,687
D.	Total Liabilities, Reserves, and Net Worth	\$	2,560,992

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year	Ended	Page	of
Eliza Huntington Memorial Ho	me of Nor 1279	9/30/2016		36	37
	An	nount			
	eriod as shown on Report of	09/30/2015	9		2,073,237
	tement of Revenue Page 30)		9		1,029,642
_	n Statement of Expenditures I	Page 27)	9	3	968,307
D. Net Income or Deficit			9	3	61,334
E. Balance			9	3	2,134,571
F. Additions 1. Additional Capital Co	ontributed (itemize)				
2. Other (itemize)					
F-3. Total Additions			\$	<u> </u>	
G. Deductions					
	Operators/Partners (Specify)		9	3	
Name and Address (No., City, State, Zip)	Title	Amount		
2. Other Withdrawings	(Specify)		\$	3	
Pur	pose	Amo	ount		
3. Total Deductions			9	3	
H. Balance at End of Period	d 09/30/	16	9	6	2,134,571

I. Preparer's/Reviewer's Certification

Name of Facility		License No.	Report for Year Ended Page of
Eliza Huntington Memorial Home of		1279	9/30/2016 37 37
Check appropriate category			
	Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☑ Residential Care Home
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.			
Signat	ure of Preparer	Title	Date Signed
Printed Name of Preparer			
CJLC LLC			
Address			Phone Number
225 Pitkin Street, East Hartford, CT 06108			860-610-9009