

Craig J. Lubitski Consulting LLC & CJLC LLC

CERTIFIED PUBLIC ACCOUNTANTS & ADVISORS

Mr. Chris LaVigne
CON & Reimbursement
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Mr. LaVigne:

This enclosed 2015 Medicaid Cost Report intentionally omits the following disallowances:

- a. Administrator and Related Party salaries
- b. Dues and Membership Fees to Professional Associations
- c. Physical or Speech Therapy salaries or fees
- d. Depreciation and/or interest expense related to capitalized items previously deemed unallowable by the Department



225 Pitkin Street
East Hartford
Connecticut 06108

860.610.9009 (t)
860.610.9030 (f)

cjl.com

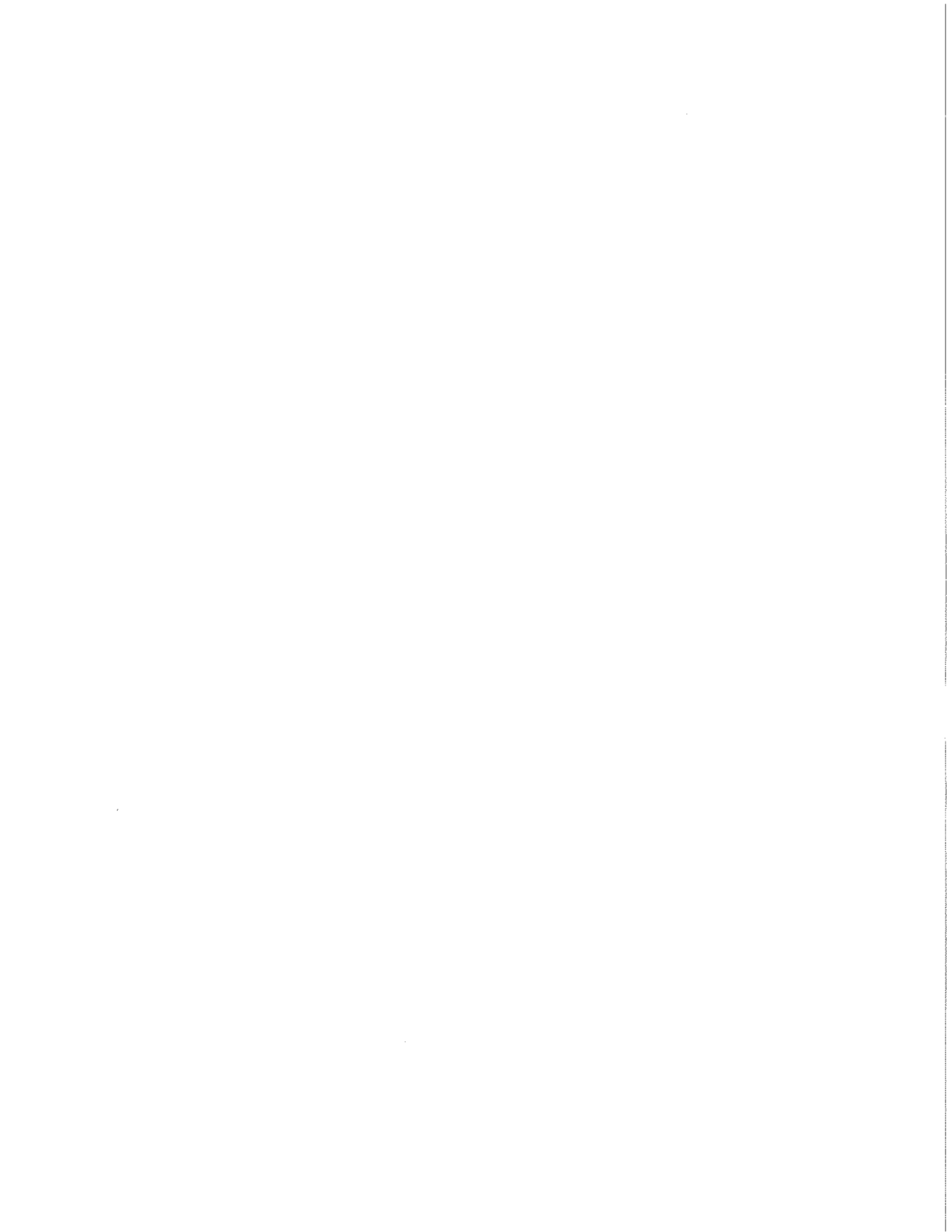
It is our understanding that the software utilized by the Department in the rate setting process computes the necessary disallowances for these areas and our intention is to eliminate the potential for a duplicate disallowance.

If you have any questions, please contact me at 860-610-9009.

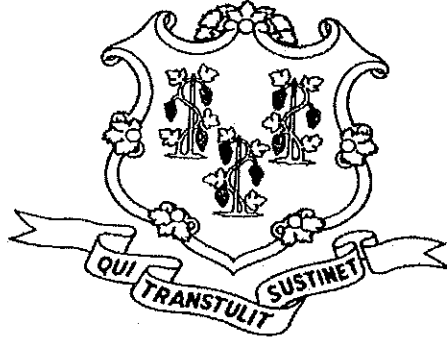
Respectfully,

A handwritten signature in black ink, appearing to read 'CJL', written over a horizontal line.

Craig J. Lubitski, CPA
Partner



State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2015

Name of Facility (as licensed) Fernwood Rest Home, Inc.	
Address (No. & Street, City, State, Zip Code) 400 Torrington Road, Litchfield, CT 06759	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> Residential Care Home	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH	RHNS	Residential Care Home 1699	Medicare Provider
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Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
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For Department Use Only

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

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General Information

Name of Facility (as licensed) Fernwood Rest Home, Inc.	License No. 1699	Report for Year Ended 9/30/2015	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Fernwood Rest Home, Inc. [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, 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) <i>Karyn Cosgrove</i>		Date <i>1/27/16</i>	Signed (Owner)		Date
Printed Name (Administrator) Karyn Cosgrove			Printed Name (Owner) Raymond Adkins		
Subscribed and Sworn to before me: <i>Susan M. Adkins</i>	State of <i>CT</i>	Date <i>1/27/16</i>	Signed (Notary Public) <i>Susan M Adkins</i>	Comm. Expires <i>02/28/2019</i>	
Address of Notary Public <i>231 Fern Avenue Litchfield CT 00759</i>					

(Notary Seal)

State of Connecticut
Department of Social Services
 25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Fernwood Rest Home, Inc.		Period Covered:	From 10/1/2014	To 9/30/2015
Address of Facility 400 Torrington Road, Litchfield, CT 06759				
Report Prepared By Craig J. Lubitski Consulting LLC		Phone Number 860-610-9009	Date 1/31/2016	
Item	Total	CCNH	RHNS	Residential Care Home
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-567-9558		Report for Year Ended 9/30/2015	Page 2	of 37
Name of Facility (as shown on license) Fernwood Rest Home, Inc.		Address (No. & Street, City, State, Zip) 400 Torrington Road, Litchfield, CT 06759		
License Numbers:	CCNH	RHNS	Residential Care Home 1699	Medicare Provider No.
Type of Facility (Check appropriate box(es))				
<input type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input checked="" type="checkbox"/> Residential Care Home
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:			Date Opened	Date Closed
Has there been any change in ownership or operation during this report year?				
		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," explain fully.
Administrator				
Name of Administrator Karyn Cosgrove			Nursing Home Administrator's License No.:	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name			License No.:	

General Information and Questionnaire
Corporate Owners

Name of Facility Fernwood Rest Home, Inc.	License No. 1699	Report for Year Ended 9/30/2015	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address	State(s) in Which Incorporated		
Fernwood Rest Home, Inc.	400 Torrington Road, Litchfield, CT 06759	Connecticut		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Raymond Adkins	400 Torrington Road, Litchfield, CT 06759	President	297	
Vivian Adkins	400 Torrington Road, Litchfield, CT 06759	Vice President	296	
Brad Adkins	400 Torrington Road, Litchfield, CT 06759	Treasurer	110	
Karyn Cosgrove	400 Torrington Road, Litchfield, CT 06759	Secretary	110	
Names of Stockholders Owning at Least 10% of Shares				
Raymond Adkins	400 Torrington Road, Litchfield, CT 06759	President	297	
Vivian Adkins	400 Torrington Road, Litchfield, CT 06759	Vice President	296	
Brad Adkins	400 Torrington Road, Litchfield, CT 06759	Treasurer	110	
Karyn Cosgrove	400 Torrington Road, Litchfield, CT 06759	Secretary	110	

State of Connecticut
Annual Report of Long-Term Care Facility
 CSP-4 Rev. 10/2005

**General Information and Questionnaire
 Related Parties***

Name of Facility Fernwood Rest Home, Inc.	License No. 1699	Report for Year Ended 9/30/2015	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No				
Brad Adkins	400 Torrington Rd, Litchfield, CT 06759	<input type="radio"/>	<input checked="" type="radio"/>	Maintenance Assistant	10/A7b	36,900	36,900
Neville Duncan	400 Torrington Rd., Litchfield, CT 06759	<input type="radio"/>	<input checked="" type="radio"/>	Dietary Staff	10/A5c	19,034	19,034
Karyn Cosgrove	400 Torrington Rd, Litchfield, CT 06759	<input type="radio"/>	<input checked="" type="radio"/>	Other Administrative / Administrator	10/A4 - 10/A2	42,211	42,211
Raymond & Vivian Adkins	400 Torrington Rd, Litchfield, CT 06759	<input type="radio"/>	<input checked="" type="radio"/>	Loans to Facility	34/B3	6,059	6,059
Raymond & Vivian Adkins	400 Torrington Rd, Litchfield, CT 06759	<input type="radio"/>	<input checked="" type="radio"/>	Interest on Loans	16/m13, 28/23	120	120
Raymond & Vivian Adkins	400 Torrington Rd, Litchfield, CT 06759	<input type="radio"/>	<input checked="" type="radio"/>	Accrued Interest	33/A12	66,275	66,275
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				

* Use additional sheets if necessary.

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

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility Fernwood Rest Home, Inc.	License No. 1699	Report for Year Ended 9/30/2015	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility		License No.	Report for Year Ended		Page	of	
Fernwood Rest Home, Inc.		1699	9/30/2015		6	37	
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
CBS, PO Box 790448, Saint Louis, MO	<input type="radio"/>	<input checked="" type="radio"/>	Copier	02/10/14	60	5,104	5,104
Clean Force, Saint Paul, MN	<input type="radio"/>	<input checked="" type="radio"/>	Dishwasher	03/17/15	1 year	1,562	1,562
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
Total ***							6,666

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

* 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.



CLEAN FORCE RENTAL AGREEMENT



Type New:	<input checked="" type="checkbox"/> Change of Owner:	<input type="checkbox"/> Change of Dishmachine:	<input type="checkbox"/> Contract Change:
Requested Delivery Date: 4-22-14	Delivery Contact Name: Lorraine Claffey	Phone: 860-567-9558	
Order Comments: Lift Gate / Place machine inside building III	Order By:		
Old Owner Account #:	New Owner Start Date:	US Foods Division: Southern New England/ Norwich, CT	

THIS AGREEMENT is among US Foods, Inc. ("Lessor"), PureForce™, and Fernwood Rest Home (Business/Account Name)
Norma Bariffe 400 Torrington Road Litchfield, CT 06759
(Print Complete Name) (Street Address, City, State)

860-567-9558 (Phone #) (Fax #) (Email) (Contract Name / Number)

Delivery address (if different from account address): _____
If other than above, address where Equipment is located: _____

In consideration of Lessor leasing to Customer the following equipment ("Equipment") and Customer purchasing the Clean Force Products and services set forth below, the parties agree as follows:

A. LESSOR WILL PROVIDE:

1. Equipment:

- Single Tank _____ (Model) Double Tank _____ (Model) Glasswasher _____ (Model)
- High Temp (Single) _____ (Model) Voltage _____ Elec. Phase Single or Three (Circle One)
- Conveyor _____ (Model) Temp. High Temp (Circle One) Direction _____ (Circle One) Voltage _____ Elec. Phase Single or Three (Circle One)

2. Optional Equipment:

- Booster Heater: Voltage 208 KW _____ Phase 3 C-9 70 Degree Other _____
- Water Softener Side Loader Hooded: Y or N (circle one) Vent Cows Vapor Vent

3. Parts and service to maintain the Equipment in good condition.

B. PAYMENTS: Customer agrees to make the following payments upon execution of this Agreement:

1. Initial Payment \$ 0.00
2. Customer agrees to pay Lessor the following:
 - A base lease rate of \$ 84.95 for each monthly service period (payable in advance) and,
 - Customer also agrees to purchase a monthly minimum of \$ 180.00 of Clean Force Dishmachine Products and two or more other Clean Force Products. A failure to purchase the Monthly Minimum for two consecutive months subjects Customer to an adjustment charge. This adjustment charge is equal to the Monthly Minimum less the actual purchases of Clean Force Products for that month.
 - The price for the Products will be as determined by PureForce and stipulated on each invoice.
3. These prices may be increased as provided on the reverse side of this Agreement.

C. TERM:

The term of this Agreement is 1 year(s) beginning on the day the Equipment is delivered (the "Initial Term") and will continue from year-to-year thereafter (each year being a "Renewal Term"). Any party may terminate this Agreement at the end of the Initial Term or on the anniversary of that date by giving at least 60 days prior written notice to the other parties.

THE TERMS ON THIS PAGE, THE REVERSE SIDE, AND ON ANY SCHEDULE ATTACHED HERETO OR ON ANY AMENDMENT CONTAIN THE FULL AGREEMENT OF THE PARTIES. THIS AGREEMENT MAY NOT BE MODIFIED EXCEPT BY A WRITTEN AMENDMENT SIGNED BY THE PARTIES.

Owner: [Signature] Salesperson: Dov Pick Employee # 42377
Authorized Signature
US Foods Representative: Faye Cameron
Print Owner Name: Norma Bariffe Lessor Customer No: 40668790
Date: 3/17/15 PureForce Account No. 53713232

FOR LESSOR USE ONLY: This Agreement is made subject to and shall be attached to the Clean Force Dishmachine Program Master Agreement between Lessor and PureForce.
Accepted: [Signature] Title: Chadler Date: 3-18-15

FOR OFFICE USE ONLY: This Agreement will not be binding upon PureForce Inc. unless and until it is countersigned below by a proper official at PureForce's offices in St. Paul, Minnesota.
Accepted: _____ Title: _____ Date: _____

ADDITIONAL TERMS

- **Pricing.** The prices under this Agreement will remain in effect for a minimum of one year. Thereafter, Lessor and PureForce may increase the base rental rate and any additional charges and extended service prices at any time upon notice to Customer. In the event of a price increase, Customer may terminate this Agreement by giving 60 days' written notice to Lessor and PureForce. To be effective, notice must be received by Lessor and PureForce within 30 days after the price increase takes effect. Where applicable, Customer must pay any sales tax and any personal property taxes levied upon the Equipment.
- **Delivery.** Delivery will be at Customer's request or as soon thereafter as is practicable. Customer must provide plumbing and electrical hookups and any and all required governmental permits. Customer will provide all utilities (including, without limitation, electricity, 140 degree F hot water and maintain water hardness no higher than 8 grains per gallon) necessary to operate the Equipment.
- **Ownership.** The Equipment (including but not limited to dispensing equipment) will at all times be the sole and exclusive property of PureForce. Customer will have no right of ownership of such property, but only the right to use the Equipment subject to this Agreement. The Equipment will remain personal property and not become a fixture of any building. Customer will not remove the Equipment without prior written approval of PureForce or Lessor. Customer agrees that PureForce may file and the Customer will execute documentation as PureForce deems necessary to evidence PureForce's ownership. Upon termination of this Agreement, Customer must return the Equipment in as good a condition as when received, reasonable wear and tear expected. Customer may not change, alter, or repair the Equipment, or use any detergents or sanitizers in the operation of the Equipment except those Clean Force Products provided by PureForce or Lessor or approved by PureForce in writing. Upon termination of this Agreement or upon Customer default, Lessor or PureForce may enter Customer's premises for removal of the Equipment.
- **Default.** Customer will be in default under this Agreement if Customer fails to comply with any terms of this Agreement (time being of the essence), if the Equipment is moved, substantially damaged or encumbered, Customer dies, is dissolved or becomes insolvent, or any action for the benefit of creditors is taken with respect to Customer.

Upon default, Customer's rights under this Agreement will, at the option of the PureForce or Lessor and without notice to Customer, be terminated (but Customer's outstanding obligations under this Agreement will survive any termination) and Lessor or PureForce will have the right to take immediate possession of the Equipment and to exercise any other remedies available to it in law or in equity. If Customer fails to surrender the Equipment within 30 days from the effective date of termination, Lessor or PureForce will invoice Customer for the fair market value of the Equipment and any other outstanding payments due to Lessor or PureForce. Customer must pay all reasonable costs incurred by Lessor or PureForce, including, without limitation, collection costs and reasonable attorneys' fees, to collect any amounts due Lessor or PureForce, or to enforce any Lessor or PureForce right, under this Agreement.
- **Early Termination.** If this Agreement is terminated by Customer for any reason prior to the end of the Initial Term or any Renewal Term, then Customer must promptly pay to Lessor an amount equal to the sum of the number of months remaining in the Term or the Renewal Term multiplied by the sum of (i) 50% of the Monthly Minimum and (ii) the then-current periodic base rate. The parties agree that this is a reasonable estimate of the damages suffered by Lessor for Customer's early termination.
- **Loss and Damage.** Customer is responsible for any loss, damage, theft, or destruction of the Equipment. In addition, Customer is responsible for any damage or destruction caused by the removal of the Equipment.
- **General.** Customer is solely liable for all claims including, but not limited to, Workers' Compensation claims, resulting from the operation or use of the Equipment or work thereon by Customer's employees or agents. Customer may not assign this Agreement without PureForce's prior written consent. This Agreement will be binding upon each of the parties hereto and their representative heirs, successors, and assigns. Neither Lessor nor PureForce will be liable for consequential or any other damages which may result from any cause beyond the reasonable control of Lessor or PureForce including, but not limited to, acts of God or government, supply or labor shortages, or transportation delays.

PureForce, St. Paul, MN 55102

General Information and Questionnaire
Accounting Basis

Name of Facility Fernwood Rest Home, Inc.	License No. 1699	Report for Year Ended 9/30/2015	Page 7	of 37
The records of this facility for the period covered by this report were maintained on the following basis:				
<input checked="" type="radio"/> Accrual <input type="radio"/> Cash <input type="radio"/> Modified Cash				
Is the accounting basis for this period the same as for the previous period? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain.				
Independent Accounting Firm				
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)		
1 Craig J. Lubitski Consulting LLC		225 Pitkin Street, East Hartford, CT 06108		
2				
3				
4				
Services Provided by This Firm (<i>describe fully</i>)				
1 Medicaid Cost Report, Bookkeeping				\$ 11,595
2				\$
3				\$
4				\$
				Charge for Services Provided
				\$ 11,595
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="radio"/> Yes <input type="radio"/> No Pg 15/1d				
Legal Services Information				
Name of Legal Firm or Independent Attorney			Telephone Number	
1				
2				
3				
4				
5				
Address (<i>No. & Street, City, State, Zip Code</i>)				
1				
2				
3				
4				
5				
Services Provided by This Firm (<i>describe fully</i>)				
1				\$
2				\$
3				\$
4				\$
5				\$
				Charge for Services Provided
				\$
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="radio"/> Yes <input type="radio"/> No				

Schedule of Resident Statistics

Name of Facility Fermwood Rest Home, Inc.	License No. 1699	Report for Year Ended 9/30/2015						Page 8	of 37
		Period 10/1 Thru 6/30			Period 7/1 Thru 9/30				
		Total All Levels	Total CCNH Level	Total RHNS Level	Total Residential Care Home	Total	CCNH		
1. Certified Bed Capacity									
A. On last day of PREVIOUS report period		68			68			68	
B. On last day of THIS report period		68			68			68	
2. Number of Residents									
A. As of midnight of PREVIOUS report period		57			57			66	
B. As of midnight of THIS report period		67			66			67	
3. Total Number of Days Care Provided During Period									
A. Medicare									
B. Medicaid (Conn.)									
C. Medicaid (other states)									
D. Private Pay	1,367				1,367			276	
E. State SSI for RCH	22,512				22,512			5,810	
F. Other (Specify)									
G. Total Care Days During Period (3A thru F)	23,879				23,879			6,086	
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds									
A. Medicaid Bed Reserve Days									
B. Other Bed Reserve Days									
5. Total Resident Days (3G + 4A + 4B)		23,879			23,879	17,793		6,086	

Schedule of Resident Statistics (Cont'd)

Name of Facility Fernwood Rest Home, Inc.			License No. 1699			Report for Year Ended 9/30/2015			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	Residential Care Home	Lost			Gained			CCNH	RHNS	Residential Care Home	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days										CCNH	RHNS	Residential Care Home	
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	Residential Care Home	R.C.H.	ICF-IID				
No. of Residents													
Per Diem Rate													
a. One bed rm.							88.00						
b. Two bed rms.							77.00						
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments										TOTAL	CCNH	RHNS	Residential Care Home
A. Medicare - Part B													
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other													
D. Total Physical Therapy Treatments													
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B													
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other													
D. Total Speech Therapy Treatments													
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B													
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other													
D. Total Occupational Therapy Treatments													

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Fernwood Rest Home, Inc.	1699	9/30/2015	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)					67,386	2,344
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)					68,731	5,368
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers					111,285	7,854
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers					19,800	2,100
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers					93,659	6,819
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers					27,056	2,173
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses						
b. RN						
1. Direct Care					20,514	1,008
2. Administrative**						
c. LPN						
1. Direct Care					36,365	2,100
2. Administrative**						
d. Aides and Attendants					225,792	20,839
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers					18,900	1,396
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management						
n. Marketing						
o. Other (Specify)						
See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>					689,487	52,000

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.
 ** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.
 *** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

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

Name of Facility		License No.		Report for Year Ended		Page	of			
Fernwood Rest Home, Inc.		1699		9/30/2015		11	37			
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Residential Care Home							
Section I - Operators/Owners										
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).										
Karyn Cosgrove			29,640		Secretary, Admin Assistant	1,640	A4			
Neville Duncan			19,034		Dietary Staff	1,829	A5c			
Brad Adkins			36,900		Maintenance	2,080	A7b			

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

** Include all employment worked during the cost year.

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

Name of Facility (as licensed) Fernwood Rest Home, Inc.	License No. 1699	Report for Year Ended 9/30/2015			Page 12	of 37	
		CCNH	RHNS	Residential Care Home			
Name	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
Section III - Administrators***							
Norma Bariffe (10/1/14 - 7/3/15)		Administrator	54,815	1,784 A2			
Karyn Cosgrove (7/3/15 - 9/30/15)		Administrator	12,571	560 A2			
Section IV - Assistant Administrators							

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Fernwood Rest Home, Inc.	1699	9/30/2015	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)						
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries						

* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.
 ** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.
 *** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Fernwood Rest Home, Inc.	1699	9/30/2015	15	37
Item	Total	CCNH	RHNS	Residential Care Home
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 19,986			19,986
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 26,178			26,178
4. Social Security (F.I.C.A.)	\$ 54,187			54,187
5. Health Insurance	\$ 27,761			27,761
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
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	\$ 11,595			11,595
e. Legal (<i>Services should be fully described on Page 7</i>)	\$			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$ 8,570			8,570
g. Office Supplies	\$ 7,178			7,178
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 2,043			2,043
2. Cellular Phones	\$			
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 250			250
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$			
2. Other (<i>Specify</i>) See Attached Schedule	\$			
3. Resident Day User Fee	\$			
Subtotal	\$ 157,748			157,748

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended		Page	of
Fernwood Rest Home, Inc.	1699	9/30/2015		16	37
Item	Total	CCNH	RHNS	Residential Care Home	
Subtotals Brought Forward:	157,748			157,748	
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$ 1,032			1,032	
4. Employee Travel	\$ 225			225	
5. Education Expenses Related to Seminars and Conventions	\$ 613			613	
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 3,443			3,443	
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 981			981	
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 1,147			1,147	
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 462			462	
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 1,107			1,107	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 40			40	
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$				
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$ 120,878			120,878	
C-14 Total Administrative & General Expenditures	\$ 287,676			287,676	

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	Residential Care Home
Promotional Advertising			\$ 1,147
Total Other Advertising	\$ -	\$ -	\$ 1,147

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
CARCH			\$ 650
B.J. Warehouse			\$ 280
American Express			\$ 42
NFIB			\$ 135
Total Dues	\$ -	\$ -	\$ 1,107

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
Bank Service Fees			\$ 124
Late Fee/Finance Charges			\$ 120
Payroll Processing Fees			\$ 3,012
Licenses			\$ 1,201
Internet			\$ 664
Unallowable			\$ 51,959
Fire Expense			\$ 63,800
Total Other Administrative and General	\$ -	\$ -	\$ 120,878

Schedule C-1 - Management Services*

Name of Facility Fernwood Rest Home, Inc.	License No. 1699	Report for Year Ended 9/30/2015	Page 17	of 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 #	

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

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

Name of Facility Fernwood Rest Home, Inc.		License No. 1699	Report for Year Ended 9/30/2015		Page 18	of 37
Item		Total	CCNH	RHNS	Residential Care Home	
2. Dietary						
a. In-House Preparation & Service						
1.	Raw Food	\$ 152,577				152,577
2.	Non-Food Supplies	\$ 16,628				16,628
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) _____ Small Equipment/Supplies						
2E. Total Dietary Expenditures (2a + b + c + d)		\$ 169,611				169,611
2F. Dietary Questionnaire		Total	CCNH	RHNS	Residential Care Home	
G. Resident Meals: Total no. of meals served per day:*						
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No						
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.						
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.						
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.						
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.						
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.						
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)						

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

** 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 Fernwood Rest Home, Inc.		License No. 1699	Report for Year Ended 9/30/2015	Page 19	of 37
Item		Total	CCNH	RHNS	Residential Care Home
3. Laundry					
a. In-House Processing*		Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$	897		897
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***		Lbs.			
		Amt. \$			
3. Personal clothing of residents washed, ironed, and/or processed.***		Lbs.			
		Amt. \$			
4. Repair and/or purchase of linens.***		Lbs.			
		Amt. \$	1,238		1,238
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$			
c. Management Services**		\$			
d. Other (Specify) Laundry Supplies		\$	22,521		22,521
3E. Total Laundry Expenditures (3a + b + c + d)		\$	24,657		24,657
3F. Laundry Questionnaire					
G.	Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
H.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
I.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

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

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

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Fernwood Rest Home, Inc.		1699	9/30/2015		20	37
Item			Total	CCNH	RHNS	Residential Care Home
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
1.	Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	22,502			22,502
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$				
c.	Management Services*	\$				
d.	Other (<i>Specify</i>) Housekeeping Supplies	\$	167			167
4E.	Total Housekeeping Expenditures (4a + b + c + d)	\$	22,669			22,669
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from	\$				
b.	Medicine Cabinet Drugs	\$				
c.	Medical and Therapeutic Supplies	\$				
d.	Ambulance/Limousine***	\$				
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$				
f.	X-rays and Related Radiological Procedures***	\$				
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$				
i.	Recreation	\$	5,754			5,754
j.	Other (<i>Specify</i>)**** See Attached Schedule	\$	7,202			7,202
5K.	Total Resident Care Expenditures (5a - 5j)	\$	12,956			12,956

* 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.

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

Name of Facility	License No.	Report for Year Ended			Page	of
Fernwood Rest Home, Inc.	1699	9/30/2015			22	37
Item	Total	CCNH	RHNS	Residential Care Home		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 43,587				43,587	
b. Heat	\$ 29,717				29,717	
c. Light & Power	\$ 21,787				21,787	
d. Water	\$ 11,484				11,484	
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 6,666				6,666	
f. Other (<i>itemize</i>)	\$ 63,265				63,265	
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 176,506				176,506	
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$ 19,626				19,626	
c. Non-Movable Equipment	\$ 3,438				3,438	
d. Movable Equipment	\$ 6,718				6,718	
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 29,782				29,782	
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$ 214				214	
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 214				214	
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	\$ 22,951				22,951	
c. Personal property taxes	\$ 978				978	
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 53,925				53,925	

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	Residential Care Home
Fire - Monitoring Services			\$ 6,678
R&M Purchased Services			\$ 19,710
Exterminating Expense			\$ 1,276
R&M Minor Equipment			\$ 9,947
Rental Expense			\$ 25,654
Total Other Repairs and Maintenance	\$ -	\$ -	\$ 63,265

Fernwood Rest Home, Inc.
9/30/2015

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
12/22/2014	Kitchen Cabinets	\$ 21,386	15	\$ 1,426
4/8/2015	Doors	\$ 7,885	5	\$ 788
5/8/2015	Boaster Heater	\$ 1,595	5	\$ 160
5/15/2015	Water Line	\$ 867	5	\$ 87
6/5/2015	Gas Line	\$ 1,914	5	\$ 191
6/12/2015	Doors	\$ 7,915	5	\$ 791
9/17/2015	Trim Windows	\$ 2,552	5	\$ 255
9/24/2015	Doors	\$ 7,975	5	\$ 798
Total additions for Building Improvements		\$ 52,090		\$ 4,496 *
Deletions:				
Total deletions for Building Improvements		\$ -		\$ - **

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
2/25/2015	ID Maker Value	\$ 1,544	5	\$ 154
3/27/2015	Refrigerator	\$ 1,828	5	\$ 183
4/30/2015	Ice Machine	\$ 2,061	5	\$ 207
7/1/2015	2 Beds	\$ 1,196	5	\$ 120
7/5/2015	Chair	\$ 2,365	5	\$ 236
Total additions for Movable Equipment		\$ 8,994		\$ 900 *
Deletions:				
Total deletions for Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

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

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Fernwood Rest Home, Inc.	Date of Acquisition		Length of Amortization	License No. 1699	Report for Year Ended 9/30/2015			Page 24	of 37
	Month	Year			Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**		
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1. Thomaston Savings Bank	2	2011	25 Years		5,356	733 SL	214		
2.									
3.									
B-4. Subtotal							214		
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization								214	

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility Fernwood Rest Home, Inc.	License No. 1699	Report for Year Ended 9/30/2015	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description	Total			
1. Date Land Purchased	1954 and 1979			
2. Date Structure Completed	Various			
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	68			
6. Square Footage				
7. Acquisition Cost				
a. Land	35,417			
b. Building	44,830			
Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Commerical			
b. Date Mortgage Obtained	02/28/11			
c. Interest Rate for the Cost Year	600.00%			
d. Term of Mortgage (number of years)	25			
e. Amount of Principal Borrowed	425,000			
f. Principal balance outstanding as of	387,001			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
Part C - Arms-Length Leases for Real Property Improvements Only				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility		License No.	Report for Year Ended			Page	of
Fernwood Rest Home, Inc.		1699	9/30/2015			26	37
Item		Total	CCNH	RHNS	Residential Care Home		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$ 22,372				22,372	
Name of Lender		Rate					
Thomaston Savings Bank							
Address of Lender							
Main Street Thomaston, CT							
2. Second Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
3. Third Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
4. Fourth Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount		\$					
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expense							
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$ 22,372				22,372	

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended			Page	of
Fernwood Rest Home, Inc.		1699		9/30/2015			27	37
Item				Total	CCNH	RHNS	Residential Care Home	
Subtotals Brought Forward:				22,372			22,372	
12. C. Movable Equipment								
1. Automotive Equipment				\$				
A. Item		Rate	Amount					
Lender								
Address of Lender								
2. Other (Specify)				\$				
A. Item		Rate	Amount					
Lender								
Address of Lender								
B. Item		Rate	Amount					
Lender								
Address of Lender								
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$				
12. D. Other Interest Expense (Specify)				\$	743		743	
Other Interest Expense								
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	23,115		23,115	
14. Insurance								
a. Insurance on Property (buildings only)				\$	30,014		30,014	
b. Insurance on Automobiles				\$	2,667		2,667	
c. Insurance other than Property (as specified above)								
1. Umbrella (Blanket Coverage)				\$				
2. Fire and Extended Coverage				\$				
3. Other (Specify)				\$				
14d. Total Insurance Expenditures (14a + b + c)				\$	32,681		32,681	
15. Total All Expenditures (A-13 thru C-14)				\$	1,493,284		1,493,284	

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Fernwood Rest Home, Inc.			1699	9/30/2015	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 1,304			1,304
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.			Accounting & Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.	15	1f	Life insurance premiums on the life of Owners, Partners, Operators	\$ 8,570			8,570
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 *	\$ 1,147			1,147
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 116,104			116,104
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 127,125			127,125

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
30	11a	MAT Training - Recreation Disallowance			\$ 508
30	11a	MAT Training - Office Disallowance			\$ 186
30	11a	MAT Training - Aides & Attendants Disallowance			\$ 610
Total Other Salaries Adjustment			\$ -	\$ -	\$ 1,304

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
30	11a	MAT Training Travel			\$ 225
16	m13	Late Fee/Finance Charges			\$ 120
16	m13	Unallowable Expense			\$ 51,959
16	m13	Fire Expenses			\$ 63,800
Total Other A&G Adjustments			\$ -	\$ -	\$ 116,104

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

Name of Facility				License No.	Report for Year Ended	Page	of
Fernwood Rest Home, Inc.				1699	9/30/2015	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward				\$ 127,125			127,125
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$			
28.			Ambulance/Limousine	\$			
29.			X-rays, etc	\$			
30.			Laboratory	\$			
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$			
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.	22	10b	Unallowable Property and Real Estate Taxes	\$ 333			333
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 27,199			27,199
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.	27	14a	Property Insurance	\$ 186			186
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	\$ 2,991			2,991
51. Total Amount of Decrease (Items 1 - 50)				\$ 157,834			157,834

*** 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.

Fernwood Rest Home, Inc.
9/30/2015

Schedule of Other Ancillary Costs

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

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
22	6a-d	Apartment disallowances - see attachment			\$ 1,545
22	6f	Rental Expense			\$ 25,654
Total Other Property Adjustments			\$ -	\$ -	\$ 27,199

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

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
22	7b	Depreciation on Rental			\$ 2,991
Total Unallowable Building Interest			\$ -	\$ -	\$ 2,991

Fernwood Rest Home
9/30/2015
Apartment Calculation

Apartment Allocation Percentage

Total Beds (licensed 68 + 1 for Apartment)	69
Addition bed for Apartment	1
Costs as a percent of total	1.45%

Expenses

A&G	Repairs & Maintenance	43,587
	Heat	29,717
	Light and Power	21,787
	Water	11,484
	Total	106,575
	Apartment Allocation	1.45%
	Unallowable Amount	1,545 29/39

Capital

Property Insurance Only (No Lab)	12,854
Apartment Amount	1.45%
Unallowable Amount	186 29/41
Real Estate Taxes	22,951
Apartment Amount	1.45%
Unallowable Amount	333 29/37

Total Disallowed Expenses	2,063
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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Fernwood Rest Home, Inc.	1699	9/30/2015			30	37
Item	Total	CCNH	RHNS	Residential Care Home		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (CT only)	\$ 1,288,971			1,288,971		
b. Medicaid Room and Board Contractual Allowance **	\$					
2. a. Medicaid (All other states)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (all inclusive)	\$					
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$ 112,778			112,778		
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$					
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$					
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$					
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$					
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$					
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$					
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$					
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$					
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (Specify) - Medicare	\$					
b. Other (Specify) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 1,401,749			1,401,749		
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$ 27,350			27,350		
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (Specify)	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (Specify)	\$ 168,914			168,914		
V. Total Other Revenue (1 thru 8)	\$ 196,264			196,264		
VI. Total All Revenue (III +V)	\$ 1,598,013			1,598,013		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

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

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
30/IV8	Fire Proceeds			\$ 167,385
30/IV8	MAT Training			\$ 1,529
Total Other Revenue		\$ -	\$ -	\$ 168,914

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Fernwood Rest Home, Inc.	1699	9/30/2015	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	58,436
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	121,782
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	60,954
a. Prepaid - Insurance	60,954			
b. _____				
c. _____				
d. _____				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

A-9. Total Current Assets (Lines A1 thru 8)			\$	241,172
B. Fixed Assets				
1. Land			\$	35,417
2. Land Improvements	*Historical Cost	20,252	\$	
	Accum. Depreciation	20,252		Net
3. Buildings	*Historical Cost	882,429	\$	209,503
	Accum. Depreciation	672,926		Net
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation			Net
5. Non-Movable Equipment	*Historical Cost	151,705	\$	19,620
	Accum. Depreciation	132,085		Net
6. Movable Equipment	*Historical Cost	233,093	\$	10,915
	Accum. Depreciation	222,178		Net
7. Motor Vehicles	*Historical Cost	21,342	\$	1,520
	Accum. Depreciation	19,822		Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

B-10. Total Fixed Assets (Lines B1 thru 9)			\$	276,975

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Fernwood Rest Home, Inc.		1699	9/30/2015	32	37
Account				Amount	
Total Brought Forward:				\$	518,147
C. Leasehold or like property recorded for Equity Purposes.					
1. Land					
2. Land Improvements					
		*Historical Cost	_____		
		Accum. Depreciation	_____	Net	\$
3. Buildings					
		*Historical Cost	_____		
		Accum. Depreciation	_____	Net	\$
4. Non-Movable Equipment					
		*Historical Cost	_____		
		Accum. Depreciation	_____	Net	\$
5. Movable Equipment					
		*Historical Cost	_____		
		Accum. Depreciation	_____	Net	\$
6. Motor Vehicles					
		*Historical Cost	_____		
		Accum. Depreciation	_____	Net	\$
7. Minor Equipment-Not Depreciable					
C-8 Total Leasehold or Like Properties (C1 thru 7)					
D. Investment and Other Assets					
1. Deferred Deposits					
2. Escrow Deposits					
3. Organization Expense					
		*Historical Cost	5,356		
		Accum. Depreciation	947	Net	\$ 4,408
4. Goodwill (Purchased Only)					
5. Investments Related to Resident Care (<i>itemize</i>)					

6. Loans to Owners or Related Parties (<i>itemize</i>)					
Name and Address		Amount	Loan Date		
_____		_____	_____		
7. Other Assets (<i>itemize</i>)					
Due From Owners		52	\$ 52		
D-8. Total Investments and Other Assets (Lines D1 thru 7)					
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)					

* 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
Fernwood Rest Home, Inc.		1699	9/30/2015	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	108,612
2. Notes Payable (<i>itemize</i>)				\$	

3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	20,869
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	5,641
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	120,956
Accrued - Other		1,247	Accrued Property Tax (408)		
Accrued Interest - R. Adkins		66,275	Due to DSS	19,117	
Payroll Clearing		(102)			
Line of Credit		34,827			
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	256,079

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Fernwood Rest Home, Inc.		License No. 1699	Report for Year Ended 9/30/2015	Page 34	of 37
Account				Amount	
Total Brought Forward:				256,079	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					
\$					
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$ 387,001	
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$ 97,877	
Name and Address of Lender	Amount	Loan Date			
Various	97,877				
4. Other Long-Term Liabilities (<i>itemize</i>)				\$	
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 484,878	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 740,957	

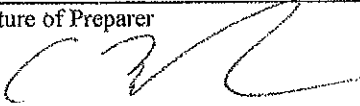
G. Balance Sheet (cont'd)
Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Fernwood Rest Home, Inc.	1699	9/30/2015	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	10,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	(47,046)
5. Cumulated Earnings			\$	(286,031)
6. Gain or Loss for Period			\$	104,728
	10/1/2014	thru 9/30/2015		
7. Total Net Worth			\$	(218,349)
C. Total Reserves and Net Worth			\$	(218,349)
D. Total Liabilities, Reserves, and Net Worth			\$	522,608

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Fernwood Rest Home, Inc.	1699	9/30/2015	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2014			\$	(371,031)
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	1,598,013
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	1,493,284
D. Net Income or Deficit			\$	104,728
E. Balance			\$	(266,303)
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	
Name and Address (<i>No., City, State, Zip</i>)	Title	Amount		
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose	Amount			
3. Total Deductions			\$	
H. Balance at End of Period			\$	(266,303)
	09/30/15			

I. Preparer's/Reviewer's Certification

Name of Facility Fernwood Rest Home, Inc.		License No. 1699	Report for Year Ended 9/30/2015	Page 37	of 37
<i>Check appropriate category</i>					
<input type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input checked="" type="checkbox"/> Residential Care Home	
Preparer/Reviewer Certification					
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>					
Signature of Preparer 		Title Partner		Date Signed 2-4-16	
Printed Name of Preparer Craig J. Lubitski Consulting LLC					
Address 225 Pitkin Street, East Hartford, CT 06108				Phone Number 860-610-9009	