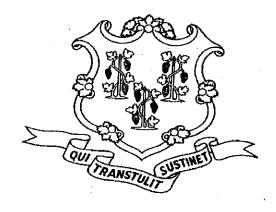
State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2015

Name of Facility (as	licensed)							
Shailerville Manor L								
Address (No. & Stree	et, City, State, 2	Zip Code)						
1179 Saybrook Rd, H	laddam, CT 06	438						i
Type of Facility								
Chronic and C	Convalescent		Rest Home wit	th Nursing	g			
☐ Nursing Home	e only		Supervision on	-	•	Residenti	al Ca	re Home
(CCNH)			(RHNS)	•				
Report for Year Begi	nning		Report for Yea	r Ending				
10/1/2014			9/30/2015	ŭ				
License Numbers:		CCNH	RHNS	Resid	ential Care I 1882	Home	Me	dicare Provider
Medicaid Provider N	umbers:	CC	NH	RI	HNS		IC.	F-IID
For Department Use	e Only							
Sequence Number	Signed and	Date	Sequence N	lumber	0:1-	131.7	1	5 . 5 . 1
Assigned	Notarized	Received	Assign	ed	Signed a	nd Notariz	zed	Date Received
					<u> </u>			

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Shailerville Manor LLC	1882	9/30/2015	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 Shailerville Manor LLC [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)		Date	Signed (Owner)	Date
Printed Name (Administrator) William Boisvert			Printed Name (Owner) William Boisvert	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires
Address of Notary Public				/ /

(Notary Seal)

State of Connecticut **Department of Social Services**

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	tm	ent		Page	of
				1A	37
Name of Facility		Period Cov	ered:	From	То
Shailerville Manor LLC				10/1/2014	9/30/2015
Address of Facility					
1179 Saybrook Rd, Haddam, CT 06438				·	
Report Prepared By		Phone Nun		Date	
Davis, Mascola & Phillips, LLC		203-265-04	88		
					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

	_							
	Ph	one No. of Fa	cility		ear Ended	Page		of
				9/30/2015		2		37
Name of Facility (as shown on license)				Street, City, St				
Shailerville Manor LLC		1179 Saybr	·	Rd, Haddam, C				
License Numbers:	CNH	RHNS	Resi	dential Care H	Iome 1882	Medicare P	rovid	ler No.
Type of Facility (Check appropriate box(es))								
☐ Chronic and Convalescent Nursing Home only (CCNH)		st Home with pervision only			Resident	ial Care Hom	ıe	
Type of Ownership (Check appropriate box)								
O Proprietorship O LLC O Partne	ership C	Profit Corp.	0	Non-Profit Co	гр. О	Government	0	Trust
If this facility opened or closed during report yea	r provide:		Date	Opened	Date Clo	sed		
Has there been any change in ownership			L		l			
or operation during this report year?	0	Yes	•	No	If "Yes."	explain fully		
Administrator								
Name of Administrator				Nursing Ho	me			
William Boisvert				Administrat				
				License 1	•			
Other Operators/Owners who are assistant admini	istrators (ful	ll or part time)	of th					
Name				License 1	No.:			
							•	

General Information and Questionnaire Partners/Members

Name of Facility		License No.	Report for Y	ear Ended	Page of
Shailerville Manor LLC		1882	9/30/2015		3 37
				State(s) and/	or Town(s) in
Legal Name of Part	nership/LLC	Business A	Address		egistered
Shailerville Manor, LLC		1179 Saybrook l	Rd, Haddam,		
		СТ 06438	,		
			l		
Name of Partners/Members	Business Ac	ddress	7	Γitle	% Owned
William Boisvert	1170 Saybrook Rd, Ha	ddam, CT	Member		50
	06438				
Rhonda Boisvert	1170 Saybrook Rd, Ha	ddam CT	Member		50
Miona Boisvert	06438	adam, O1	1,110111001		
	00150				
	İ				

General Information and Questionnaire Corporate Owners

Name of Facility	License No. Report for Yea	r Ended	Page of
Shailerville Manor LLC	1882 9/30/2015		3A 37
If this facility is owned or operated as a corp			
Legal Name of Corporation	Business Address	State(s) in Wh	ich Incorporated
Name of Directors, Officers	Business Address	Title	No. Shares
	Dusiness riddress	Title	Held by Each
			:
Names of Stockholders Owning at Least			
10% of Shares			
		I	

State of Connecticut Annual Report of Long-Term Care Facility CSP-3B Rev. 10/2005

General Information and Questionnaire Individual Proprietorship

Name of Facility Shailerville Manor LLC	License No. 1882	Report for Year Ended 9/30/2015	Page of 3B 37
If this facility is owned or operated as an individu			
Ov	vner(s) of Facility	y	
	•		

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

General Information and Questionnaire Related Parties*

Name of Facility Shailerville Manor LLC		License No.	No. 1882	Report for Year Ended 9/30/2015		Page 4	of 37
Are any individuals rece marriage, ability to cont	Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?	acility rel	ated through iation?	Yes O No	If "Yes," provide the Name/Address and complete the information on Page 11 of the report.	e Name/Ada	dress and ge 11 of the report.
Are any individuals or c including the rental of p related through family a association to any of the	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?	or service to this far control, of this far	cility, or business	• Yes O No	If "Yes," provide the following information:	e following	information:
			j				
		Also	Also Provides		Indicate Where		
Name of Related	Business	Non-R	Goods/Services to Non-Related Parties	Description of Goods/Services	Costs are Included	ţ	A 27.00 J Court to 4.20
Individual or Company	Address	Yes	%** No N	Provided	Page # / Line #	Reported	Related Party
William Boisvert	467 Foot Hills Rd, Higganum, CT 06441	•	0	Rental of real estate	Pg 22, Line 9	57.086	57.086
William Boisvert	467 Foot Hills Rd, Higganum, CT 06441	0	0	Loan	Pg 34, Line B3	119.311	119.311
Pleasant View Manor	225 Bunker Hill Rd, Watertown, CT 06795	•	0	Shared Health Insurance	Pg 15, Line 1a5	38.146	38.146
		0	0				
		0	0				
		0	0				
		0	0				
		0	0				
		0	0				
7 7 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8							

^{*} 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
Shailerville Manor LLC	1882		9/30/2015	5 37
If the facility is licensed as CDH and/or RCH o	r provides A	AIDS or TBI	services with special Medic	aid rates, costs
must be allocated to CCNH and RHNS as follo	ws:			
Item			Method of Allocation	n
Dietary		Number of	meals served to residents	
Laundry		Number of	pounds processed	
Housekeeping			square feet serviced	
		Number of	hours of routine care provide	ed by EACH
Nursing			lassification, i.e., Director (o	_ ,
		Registered	Nurses, Licensed Practical N	lurses, Aides and
	:	Attendants		
Direct Resident Care Consultants		Number of	hours of resident care provid	led by EACH
			See listing page 13)	
Maintenance and operation of plant		Square feet		
Property costs (depreciation)		Square feet		
Employee health and welfare		Gross salar		
Management services		<u> </u>	e cost center involved	
All other General Administrative expenses		<u> </u>	rect and Allocated Costs	
The preparer of this report must answer the foll	lowing ques			
1. In the preparation of this Report, were all	⊙ Yes	O No	If "No," explain fully why su	ich allocation was
costs allocated as required?	O 165	0 140	not made.	
2. Explain the allocation of related company ex	kpenses and	attach copy	of appropriate supporting da	ıta.
		•		
3. Did the Facility appropriately allocate and se				home cost centers?
(e.g., Assisted Living, Home Health, Outpat	ient Service	s, Adult Day	y Care Services, etc.)	
	⊙ Yes	O NO	If "No," explain fully why sunot made.	ich allocation was

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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.

should not be included in these amounts.							
Name of Facility			License No.	Report for Year Ended	ear Ended		Page of
Shailerville Manor LLC			1882	9/30/2015			
	Related * to	to * b	William Control of the Control of th				
	Owr	Owners,					
	Opera	Operators,				Annual	
	Offi	Officers		Date of	Term of	Amount	Amount
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	ofLease	Claimed
Avaya Financial Services, PO Box 550599, Jacksonville, FL 32255	0	•	Master Telephone Equipment Lease	02/07/07	Monthly	610	610
	0	0		on the same			
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					

Is a Mileage Log Book Maintained for All Leased Vehicles?

O Yes

% O

610

Total ***

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

** Attach copies of newly acquired leases.

*** Amount should agree to Page 22, Line 6e.

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General Information and Questionnaire Accounting Basis

Name of Facility	License No.	Report for Year Ended		Page	01
Shailerville Manor LLC	1882	9/30/2015		7	37
The records of this facility for the p	period covered by this report	were maintained on the following basis:			
	Modified Cash				
Is the accounting basis for this					
1	Yes	If "No," explain.			
previous period? O	No				
Independent Accounting Firm				 	
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)			
1 Davis, Mascola & Phillips, LLG	С	1062 Barnes Rd, STE 203, Wallingford, O	CT 06492		
2 CT Bookkeeping		PO Box 454, Essex, CT 06426			
3					
4					
Services Provided by This Firm (de.	scribe fully)				
1 Cost Report, Tax Preparationg, and 2	011 audit review		\$	7,600	
2 Monthly bookkeeping & payroll proc	essing		\$	4,200	
3			\$		
4			\$		
			Charge for	Services Pr	ovided
			\$	11,800	
Are These Charges Poffeeted in the Evnen	diture Portion of This Penort? If V	es, Specify Expense Classification and Line No.	Ψ	11,000	
	Page 15, Line 1 d	es, openly emperate examination and emoritar			
Legal Services Information	1 ago 10, Billo 1 a			W	
Name of Legal Firm or Independen	t Attorney		Telephone 1	Vumher	
· ·	tAttorney		Totophone :	, will out	
1					
2					
3					
4					
5	7:- (1- d-)				~
Address (No. & Street, City, State, 2	Zip Coae)				
1					
2					
3					
4					
5	· · · · · · · · · · · · · · · · · · ·	And the second s			<u>.</u>
Services Provided by This Firm (de	scribe jully)				
1	and the second s		\$		
2			\$		
3		- AMARIAN	\$		
4			\$		
5			\$		
			Charge for	Services Pi	ovided
			\$		
Are These Charges Reflected in the Evnen	diture Portion of This Report? If V	es, Specify Expense Classification and Line No.	Ψ		***
·	and or or on or the report! If I	- 10, op - 10, on print of the contract of the contract of			
O Yes O No					

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CSP-8 Rev. 9/2002

Schedule of Resident Statistics

						i						
Name of Facility			License No.	Jo.			Report fo	Report for Year Ended	را		Расъ	Jo
Shailerville Manor LLC			1	1882			9/30/2015	2	ı		- 8 8	37
						Period 10/1 Thru 6/30	1 Thru 6/	30		Period 7/	Period 7/1 Thru 9/30	0
		Total	Total	Total								- Landard Control of the Control of
	Levels	CCNH	KHNS Level	Residential Care Home	Total	CCNH	RHNS	Residential Care Home	Total	CCNH	RHNS	Residential
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	15			15	15			15	15			15
B. On last day of THIS report period	15			15	15			15	15			1,4
2. Number of Residents												
A. As of midnight of PREVIOUS report period	15			15	15			15	15		,	15
B. As of midnight of THIS report period	15			\$1	15			15	15			7
3. Total Number of Days Care Provided During Period									2			CT
A. Medicare												
B. Medicaid (Conn.)												
C. Medicaid (other states)												
D. Private Pay												
E. State SSI for RCH	5,369			5,369	4,030			4,030	1.339			1 339
F. Other (Specify)							;					
G. Total Care Days During Period (3A thru F)	5,369			5,369	4,030			4.030	1 339			1 330
Total Number of Days Not Included in Figures in 3G 4. for Which Revenue Was Received for Reserved												ì
Beds					•••							
ı												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	5,369			5,369	4,030			4,030	1,339			1,339

Schedule of Resident Statistics (Cont'd)

Name of Facil	ity			Licer	ise No.				Report	for Year	Ended		Page	of
Shailerville M	anor LI	LC		1	1882					9/30/201	5		9	37
			in the certified b		pacity du	ring th	ie repo	rt yea	r?	0	Yes	0	No	
H YES				IOII.	Ch	anga	in Dad			Car	pacity Afte	er Change		
		Place of	f Change Residential		Cr	lange	in Bed	S		Caj	pacity And	or Change		
Date of	CCNH	RHNS	Care Home		Lost		(Gaine	d			D 11 (11		
Change	(1)	(0)	(0)	(1)	(0)	(2)	(1)	(2)	(2)	COMI	DUNIC	Residential Care Home	Danson f	or Change
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Care Home	Reason	of Change
!								!		·				
			in certified bed o 90 days followir			the re	eport ye	ear (as	report	ed in item	4 above)	provide the nur	nber of	
			Change in Re	esiden	t Days					CC	NH	RHNS	Residential	Care Home
1st chang										<u></u>				
2nd chan														
3rd chan														
4th changes 4th ch		lonta an	d Rates on Septe	mhar	30 of Co	et Ves	3r			l				
O. INGITUEI	or Kesic	icins an	Medicare	MIOCI	Medi		A1			Se	lf-Pay		Other Sta	te Assisted
		ľ	Wouldard		11,204.									
												Residential		
	Item		CCNH	C	CNH	RE	INS	co	CNH	RF	INS	Care Home	R.C.H.	ICF-MR
No. of R			001111		01.11							15		
Per Dien														
a. One b	ed rm.											98.00		-
b. Two	oed rms													
c. Three	or more	е												
bed r	ms.					<u> </u>		<u> </u>						
		f Physica are - Pari	al Therapy Treat t B	ments	3					ТО	TAL	CCNH	RHNS	Residential Care Home
			lusive of Part B)											
			e Treatments										ļ	
		torative	Treatments											
	Other													
			Therapy Treate											
A.	Medica	ire - Par												
В.		•	lusive of Part B)											
			e Treatments							<u> </u>				
		torative	Treatments											
	Other	Y J. 7	Pt							!		<u> </u>		<u> </u>
			Therapy Treatm ational Therapy		manta									
		re - Par		Heau	nents						A STATE OF THE STA			
			lusive of Part B)											
]			e Treatments											
			Treatments											
	Other													
		Эссирац	ional Therapy T	reatn	nents									

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Report of Ex	^	- Salati			T	
Name of Facility	License No.		Report for Yea	r Ended	Page	of
Shailerville Manor LLC	1882		9/30/2015		10	37
Are time records maintained by all individuals receiving co	mpensation?	0	Yes	0	No	
	_	w.L	Total Cost	and Houre		
		1	Total Cost i	and Hours		
		İ			Residential	
Item	CCNH	Hours	RHNS	Hours	Care Home	Hours
A. Salaries and Wages*		Hours	Idhas	Tions	Care Home	110013
Operators/Owners (Complete also Sec. I						
of Schedule A1)					, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	The state of the s
Administrator(s) (Complete also Sec. III						
of Schedule A1)					47,167	1,895
Assistant Administrator (Complete also Sec. IV						
of Schedule A1)						
4. Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)					19,417	1,040
5. Dietary Service				(Cable States		
a. Head Dietitian b. Food Service Supervisor	 					
c. Dietary Workers					27,655	1,898
6. Housekeeping Service					27,033	1,098
a. Head Housekeeper						
b. Other Housekeeping Workers					15,803	1,085
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers					19,774	1,357
8. Laundry Service						
a. Supervisor b. Other Laundry Workers					15 002	1.005
9. Barber and Beautician Services					15,803	1,085
10. Protective Services	 	<u> </u>				
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**		Warning of the Control of the Contro			140000000000000000000000000000000000000	
c. LPN						
Direct Care Administrative**						
d. Aides and Attendants					108,627	7,455
e. Physical Therapists					100,027	7,400
f. Speech Therapists						TW
g. Occupational Therapists	77,000			711111111111111111111111111111111111111		
h. Recreation Workers					9,877	678
i. Physicians						
1. Medical Director	 					
2. Utilization Review 3. Resident Care***						
4. Other (Specify)						
4. Onler (openity)						
j. Dentists	-					T11111
k. Pharmacists						
1. Podiatrists						
m. Social Workers/Case Management						
n. Marketing						
o. Other (Specify)						
See Attached Schedule					264 122	17.400
A-13. Total Salary Expenditures		<u> </u>			264,123	16,493

^{*} 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)

	CC	CNH	RE	INS	Residential	Care Home
Position	\$	Hours	\$	Hours	\$	Hours
		0.00				
	E (14 7) 65 (14 E) 70					
and the second s		50,260,251,050,050,05	Services supplied to the	Security and property		
		2000 Bl (6.00)	0.000			
					(C) (C) (C)	
			7 m	halo di Santa di Santa di	000000000000000000000000000000000000000	
	10 AS 45 SA 15 SA 16 SA 16	and contract on the sta	12 (3) (3) (3) (6) (6)	0.000		0.00
				ili grafia de pluses de		
	9 40 30 50 60 60 60	33,700, 30,700,000,0	8301 (2000) 185 (185 (185	2. April 12. (19. (19. (19. (19. (19. (19. (19. (19		00/50/62/55/55
				1. 1. 1. 1. 1. 1. 1.		
	de la companya de la	servis robordinosts	701 101 101 101 101 101	50 5 75 80 76 9	100000000000000000000000000000000000000	terror est
		100		70 TO 10 TO 10 TO 10		2011
The state of the s						
			36.33.33.33.33.33		(9/3) (9/3)	
			35	20 10 20 20 10 11	an one (Dr. co. ce)	100 (100 (100 (100 (100 (100 (100 (100
T-4-1	\$ -		\$ -	68 00 00 00 00 00 00 00 00 00 00 00 00 00	\$ -	
Total	\$ -	-	μ		w	gggesterninger von Williams

Schedule of Other Fees (Page 13)

	CC	NH	RII	NS	Residential	Care Home
Service	\$	Hours	\$	Hours	\$	Hours
			(US 40 00 00 00			
	der også raktivation og h					
	60.00.00.00.00		25			Green de les
	0.0000000000000000000000000000000000000					6 m (c. 0)
	60.00 00 00 00	\$1.60 S. S. S. S.				
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			(4) (4) (5) (5) (6) (6)			
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Section 2015				0.60 8 9 2 0		
	1					II.
Total	3 -		\$ -	-	\$ -	5 (0 0) 5 (0 0) 6 (0 0) 5 (0 0)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-11 Rev. 10/2005

Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties*

		7	Assistan	nellilling	Assistant Aunthinstrators and Other Related Parties?	Relate	u rarues			
Name of Facility				License No.		Report for	Report for Year Ended		Page	Jo
Shailerville Manor LLC				1882		9/30/2015			11	37
		Salary Paid	q					The state of the s		
Name	HNCC	RHNS	Residential	Fringe Benefits and/or Other Payments	Full Description of	Total Hours	Line Where Claimed on	Name and Address of All	Total Hours	Compensation
Section I - Operators/Owners				(funt paragraph)		DWI O	1 480 10	Caret Employment	w orked	Kecelved
, . Rhonda Boisvert			19,417	Pension and 19,417 health insurance	Clerical	1,040	Pg.10,A4	Pleasant View Manor, 225 Bunker Hill Rd, Watertown, CT 06795	1.040	19.417
								J		
Section II - Other related parties of Operators/Owners employed in and paid by	,									
facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

^{**} Include all employment worked during the cost year.

State of Connecticut
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Annual Report of Long-Term Care Facility CSP-12 Rev. 10/2005

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

		T.	ssistalli	Aummsta	Assistant Authinishators and Other Netated Falties	nelated	raines.			
Name of Facility (as licensed)				License No.		Report for Year Ended	ear Ended		Page	Jo
Shailerville Manor LLC				1882		9/30/2015			12	37
		Salary Paid	1							
				Fringe Benefits and/or Other		Total			Total	
Name	CCNH	RHINS	Residential Care Home	Payments (describe fully)	Full Description of Services Rendered	Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours Worked	Compensation Received
Section III - Administrators***)			
William Boisvert			47,167	Pension and 47,167 health insurance	Administration	1,895				
Section IV - Assistant Administrators										
bearing for call and the collision of the formation is the formation is a second of the collision of the col	P. Canada	t pool are pool	iil informatic	a is associated The	of distance to hoose it acc	inimod.				

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

^{**} Include <u>all</u> other employment worked during the cost year.

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

Annual Report of Long-Term Care Facility

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Pacility	License No.	CO - KIU			De	
Name of Facility Shailerville Manor LLC	1	P.3	Report for Y	ear Ended	Page	of
SHARETVILE IMANOF LLU	18	04	9/30/2015		13	37
		T	Total Cost	and Hours	ı	r '
					Residential	
Item	CCNH	Hours	RHNS	Hours	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						
Infection Control Committee						
(Quarterly meetings) 2. Pharmaceutical Committee						
(Quarterly meetings)						
3. Staff Development Committee						
(Once annually)						
e. Other (Specify)						
		THE STATE OF THE PERSON NAMED IN		CONTRACTOR OF THE PARTY OF TAXABLE		I Marana de la companya de la compa
9. Speech Therapist						
a. Resident Care			Control of the Contro			
b. Other						
10. Occupational Therapist						
a. Resident Care		tricate and processing are made				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care	Research Control of the Control of t				Wasaning Town	
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)		En				
See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries						
* Do not include in this section management consultants or services which		D 16 2 1	10 1 (11			

^{*} 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 Shailerville Manor LLC	License No. 1882	• •	Report for Y 9/30/2015	ear Ended	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Operato	to Owners, rs, Officers	Expla	nation of Rel	
		Yes	No			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
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and the there is a second of the second of t		0	0		- W	

^{*} 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 Y	ear Ended	Page	of
Shailerville Manor LLC	1882		9/30/2015		15	37
			•			Residential
Item			Total	CCNH	RHNS	Care Home
1. Administrative and General						
a. Employee Health & Welfare Benefits						
1. Workmen's Compensation		\$	12,732			12,732
2. Disability Insurance		\$				
3. Unemployment Insurance		\$	5,896			5,896
4. Social Security (F.I.C.A.)		\$	19,858		,	19,858
Health Insurance		\$	38,146			38,146
6. Life Insurance (employees only)						
(not-owners and not-operators)		\$				
7. Pensions (Non-Discriminatory)		\$				
(not-owners and not-operators)						
8. Uniform Allowance		\$				
9. Other (Specify)		\$				
See Attached Schedule						
b. Personal Retirement Plans, Pensions, and		\$				
Profit Sharing Plans for Owners and						
Operators (Discriminatory)*						
·						
c. Bad Debts*		\$				
d. Accounting and Auditing		\$	11,800			11,800
e. Legal (Services should be fully described a	on Page 7)	\$				
f. Insurance on Lives of Owners and	<u> </u>	\$				
Operators (Specify)*		·				
g. Office Supplies		\$	731			731
h. Telephone and Cellular Phones			100			
1. Telephone & Pagers		\$	3,327			3,327
2. Cellular Phones		\$				3,321
i. Appraisal (Specify purpose and		\$				
attach copy)*		-				
j. Corporation Business Taxes (franchise tax	c)	\$				
k. Other Taxes (Not related to property - See		*				
1. Income*		\$				
2. Other (Specify)		\$				
See Attached Schedule		Ψ				
3. Resident Day User Fee		\$				
Subtotal Substitution Substitut		\$	92,490			92,490

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

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

Shailerville Manor LLC 9/30/2015

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Residential Care Home
Description		Tun (S	
	100 (100 (100 (100 (100 (100 (100 (100	35 mg	
	2 000 000 000 000 000 000 000 000 000 0		
The state of the s		1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	
		an en en en en en en en	
			UECUSE CENTRALES
			ing the second second
Total	\$ -	\$ -	\$ -

Schedule of Other Taxes

Description	CCNH	RHNS	Residential Care Home
Description	COLIA	Tun (
	66 (1) 62 (6) (6) (1) (1996) 66 (6) (7) (7) (7)		
Total	\$ -		\$ -

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

Name of Facility	License No.	•	Report for Y	Year Ended	Page	of
Shailerville Manor LLC	1882		9/30/2015		16	37
						Residential
Item			Total	CCNH	RHNS	Care Home
	ototals Brought Forwa	ard:	92,490			92,490
1. Travel and Entertainment						
 Resident Travel and Entertainment 		\$				
2. Holiday Parties for Staff		\$				
3. Gifts to Staff and Residents		\$				
4. Employee Travel		\$				
Education Expenses Related to Semina		\$				
6. Automobile Expense (not purchase or a	depreciation)	\$	1,488			1,488
7. Other (<i>Specify</i>)		\$				
See Attached Schedule						
m. Other Administrative and General Expense	S					
1. Advertising Help Wanted (all such expe		\$				
2. Advertising Telephone Directory (all sa	uch expenses)***	\$				
3. Advertising Other (Specify)***		\$				
See Attached Schedule						
4. Fund-Raising***		\$				
5. Medical Records		\$				
Barber and Beauty Supplies (if this serve	vice is supplied	\$				
directly and not by contract or fee for se	ervice)***					
7. Postage		\$	402			402
* 8. Dues and Membership Fees to Profession	onal	\$	75			75
Associations (Specify)						
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other No.	on-Allowable Org.***	\$				
9. Subscriptions		\$	509			509
10. Contributions***		\$				
See Attached Schedule						
11. Services Provided by Contract (Specify	and Complete	\$				
Schedule C-2, Page 21 for each firm or	individual)					
12. Administrative Management Services**	k	\$				
13. Other (Specify)		\$	5,276			5,276
See Attached Schedule						
C-14 Total Administrative & General Expenditu	res	\$	100,240			100,240

^{*} 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
			10 m 10 m
		(1)	
			58 (B) (C) (B)
		(6) (80 (6) AS (6)	
			150 (5) (6) (6)
Total Other Travel and Entertainment	\$ -	\$	\$ -

Schedule of Other Advertising

			Residential
Description	CCNH	RHNS	Care Home
			100 (100 (100 (100 (100 (100 (100 (100
		100	
	i da ay ay sala	Section of the section of	28, 152, 152, 150
Total Other Advertising	\$ -	\$ -	\$

Schedule of Dues

Description	CCN	ih ri	Reside	
CARCH			\$	75
	(1 to 10 to	esculus esculusia		1900
		Jacobski danicka.		
		18466	0.000	
	3000		0.000	
	1			
Company of the compan	and the second second		Charles of Linear	
Total Dues	\$	- \$	- \$	75

Schedule of Contributions

		Residential
CCNH	RHNS	Care Home
9 9 9 9 9		
\$ -	\$ =	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
Payroll processing fee			\$ 4,129
Pension admin expense		28 (12) (13) (14)	\$ 1,147
	(paris) (41, 52) (5	300000000000000000000000000000000000000	150 180 184 194
			100.00
		10. 45. (6. 5.)	
	0 all 60 egs (6) ex	es la la la la la la la la la la la la la	Sile Park Sile
	i 35. 30. sii 35. 93	HER OF SUPPLY SEASON	A 100 Miles
	a 2 de a de ab	150 (2) (6) (15) (8	9 (8) (8) (8)
		(60,000,000,000,000,000,000,000,000,000,	1953 (65) (55) (66)
	se les sais estar de sais	\$10 m 1 m 1 m 1 m 1 m 1 m 1 m 1 m 1 m 1 m	
		500 Car 150 Car 1	0.0000000000000000000000000000000000000
Total Other Administrative and General	s -	\$ -	\$ 5,276

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Schedule C-1 - Management Services*

Name of Facility Shailerville Manor LLC	License No. 1882	Report for Year Ended 9/30/2015	Page 17	of 37
Shanervine Manor LLC				
Name & Address of Individual or	Cost of Management	Full Description of Mgmt. Service		here Costs d in Annual
Company Supplying Service	Service	Provided Provided		ge #/Line #
T			Troport x ag	50 11.131110 11
*				
				-
• • • • • • • • • • • • • • • • • • • •				

^{*} 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)

Mar	ne of Facility		Licens	n Fage	<u> </u>	Report for Y	Zear Ended	Page	of
•	ilerville Manor LLC		Licens	1882	9/30/2015			18	37
Sila	HOLYMO TYMINOT DESC		1	T		3,00,201			ntial Care
	Item			Tot	al	CCNH	RHNS	l .	Iome
2.	Dietary	••••							
<u> </u>	a. In-House Preparation & Service								
	1. Raw Food			3 2	8,168			a. <u>Barrers</u>	28,168
	2. Non-Food Supplies			1	1,270				1,270
	3. Other (Specify)		. (3					
								10000	
	b. Purchased Services (by contract other		(3		V.	na wasanina kata kata kata kata kata kata kata ka	y <u>e. Garanazian anan</u>	
	than through Management Services)								
	(Complete Schedule C-2 att. Page 21)								
	c. Management Services**			8					
	d. Other (Specify)			3					
2E.	Total Dietary Expenditures (2a + b + c + d)		(5 2	9,438				29,438
								Reside	ential Care
2F.	Dietary Questionnaire			Tot	al	CCNH	RHNS	ŀ	Iome
G.	Resident Meals: Total no. of meals served per	r day	y:*		45	1			45
Н.	Is cost of employee meals included in 2E?		Yes		0	No			
ĭ.	Did you receive revenue from employees?	0	Yes		•	No	If yes, specify amt.		
J.	Where is the revenue received reported in the	Cos	st Repo	rt? (Page	/Line	Item)			
	Is cost of meals provided to persons other						If you appoint		
K.	than employees or residents (i.e., Board	0	Yes		•	No	If yes, specify cost.		
	Members, Guests) included in 2E?						cost.		
L.	Is any revenue collected from these people?	0	Yes		•	No	If yes, specify amt.		
M.	Where is the revenue received reported in the	Co	st Repo	rt? (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?	0	Yes	•	•	No · · ·	If yes, specify cost.		
O.	Is any revenue collected from employees?	0	Yes		•	No	If yes, specify amt.		

^{*} 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		License		Report for Year Ended		Page of
Sha	ilerville Manor LLC	anor LLC 1882 9/30/2015		19 37		
						Residential Care
	Item	,	Total	CCNH	RHNS	Home
3.	Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items	Lbs.	373			373
	washed, ironed, and/or processed.***	Ι ΙΙΙΚ Φ	3,5]
	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.				
		Amt. \$	372			372
	b. Purchased Services (by contract other	\$				
	than through Management Services)					
	(Complete Schedule C-2 att. Page 21)					
	c. Management Services**	\$				
	d. Other (Specify)	\$				
3E.	Total Laundry Expenditures $(3a+b+c+d)$	\$	745			745
3F.	Laundry Questionnaire					
G.	Is cost of employee laundry included in 3E? O	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 Cost	Report?		(Page/Line	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? O	Yes	•	No	If yes, specify amt.	
L.	Where is the revenue received reported in the Cost	Report?		(Page/Line		, , , , , , , , , , , , , , , , , , , ,

^{*} 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)

1	ne of Facility	License No.	Rep	ort for Year E	nded	Page	of
Sha	Shailerville Manor LLC 1882			9/30/2015		20	37
	Item			Total	CCNH	RHNS	Residential Care Home
4.	Housekeeping	Sq. Ft. Serviced		10001			
''	a. In-House Care	by Personnel					
	1. Supplies - Cleaning (<i>Mops</i> ,	Amt.	\$	1,357			1,357
	pails, brooms, etc.)		. [,			
	b. Purchased Services (by contract other	Sq. Ft. Serviced					
	than through Management Services)	by Personnel					
	(Complete Schedule C-2 att.	Amt.	\$				
	Page 21)						
	c. Management Services*	V	\$				
	d. Other (Specify)		\$				
	\ • • • • • • • • • • • • • • • • • • •						
4E.	Total Housekeeping Expenditures (4a +	b+c+d)	\$	1,357			1,357
5.	Resident Care (Supplies)**						
	a. Prescription Drugs***						
	1. Own Pharmacy	\$					
	2. Purchased from		\$				
	b. Medicine Cabinet Drugs		\$	40			40
	c. Medical and Therapeutic Supplies		\$				
	d. Ambulance/Limousine***		\$	I Company of the Comp			
	e. Oxygen						
	1. For Emergency Use		\$				
	2. Other***		\$				
	f. X-rays and Related Radiological		\$				
	Procedures***	2 3 3 3	, ds				
	g. Dental (Not dentists who should be inc	tuded under	\$				
<u> </u>	salaries or fees)		 ტ				
	h. Laboratory***		\$	0.7700			0.720
	i. Recreation		\$	2,730			2,730
	j. Other (Specify)****		\$				
ETZ	See Attached Schedule	::\	φ	2.770		22.20	2.770
JSK.	Total Resident Care Expenditures (5a - 5) <i>)</i>	\$	2,770			2,770

^{*} 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	Residential Care Home
	Al-Street and an arrangement		
	ell och stillni mangelättig för signarlaget.	es allos allos	10.000
			1000 1000 1000 1000
			rate of
			20.001
Total Other Resident Care	\$ -	\$ -	\$ -

State of Connecticut Annual Report of Long-Term Care Facility CSP-21 Rev. 10/2001

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

Name of Facility Shailerville Manor LLC				License No. 1882	Report for Year Ended 9/30/2015				Page 21	of 37
		Related ** to Owner: Operators, Officers	** to Owners, tors, Officers				Total Cost/	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	Pg	Line
		0	0							
		0	0							
		0	0							
		0	0					,		
		0	0							
		0	0							
		0	0							
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		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 Y	ear Ended		Page	of
Shailerville Manor LLC	1882	9/30/2015			22	37
					Residen	tial Care
Item		Total	CCNH	RHNS	Ho	me
6. Maintenance & Operation of Plant]				
a. Repairs & Maintenance	\$	22,141				22,141
b. Heat	\$					
c. Light & Power	\$	17,336				17,336
d. Water	\$					
e. Equipment Lease (Provide detail on p	page 6) \$	610				610
f. Other (itemize)	\$					
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a -	- 6f) \$	40,087				40,087
7. Depreciation (complete schedule page 23	*)					
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$	442				442
*7e. Total Depreciation Costs $(7a + b + c + d)$) \$	442				442
8. Amortization (Complete att. Schedule Page	ge 24*)					
a. Organization Expense	\$			4		
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$	3,726				3,726
d. Other (Specify)	\$					
*8e. Total Amortization Costs (8a + b + c + d) \$	3,726				3,726
9. Rental payments on leased real property l	ess					
real estate taxes included in item 10b	\$	57,086				57,086
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	10,664				10,664
c. Personal property taxes	\$	399				399
11. Total Property Expenses (7e + 8e + 9 +		72,317				72,317

^{*} 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
			Section According
	Military and Committee	in Samuel and Samuel St.	1
MARKET CONTRACTOR OF THE PROPERTY OF THE PROPE		(a) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c	
			4
		1168 100 (200 pt 200 pt	A C C C C C C C C C C C C C C C C C C C
			eta esapera premio astronomento.
		76 (9) (6) (6) (6) (6) (6) (6) (6) (6) (6) (6	
			<u> </u>
Total Other Repairs and Maintenance	\$ -	\$ -	\$ -

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Depreciation Schedule

Property Item											
Excitite Manner LLC	Name of Facility			License No.			Report for Year E	nded		Page	of
Property Item Property Item Historical Each Land Property Item Historical Each Land Each value Property Item Historical Land Improvements	Shailerville Manor LLC			188	.2		9/30/2015			23	37
Property Item Property Item Exclusive of Salvage Cost to Be Beginning of Computing Item Property Item I. and Improvements				Historical			Accumulated				
Property Item Property Item Exclusive of Salvage Cost to Be Beginning of Computing	-			Cost	Less		Depreciation to	Method of			
Land Improvements				Exclusive of	Salvage	Cost to Be	Beginning of	Computing	Useful	Depreciation	
Land Improvements	Property Item			Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
1. Acquired prior to this report period (attach schedule) 2. Disposals (attach bedoule) 2. Disposals (attach bedoule) 3. Acquired during this report period (attach schedule) 4. Acquired prior to this report period (attach schedule) 5. Acquired during this report period (attach schedule) 6. Disposals (attach schedule) 7. Acquired furing this report period (attach schedule) 8. Acquired furing this report period (attach schedule) 9. Acquired furing this report period (attach schedule) 1. Acquired furing this report period (attach schedule) 1. Acquired furing this report period (attach schedule) 2. Disposals (attach schedule) 3. Acquired furing this report period (attach schedule) 4. Saboral attach schedule 5. Acquired furing this report period (attach schedule) 6. Acquired during this report period (attach schedule) 7. Acquired furing this report period (attach schedule) 8. Acquired furing this report period (attach schedule) 9. Acquired furing this report period (attach schedule) 9. Acquired during this report period (attach schedule) 9. Acquired d											
2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) 4. Acquired during this report period (attach schedule) 5. Acquired during this report period (attach schedule) 6. Subtosals (attach schedule) 7. Acquired during this report period (attach schedule) 8. Acquired during this report period (attach schedule) 9. Acquired during this	 Acquired prior to this report period 										
3. Acquired during this report period (attach schedule) 2. Disposals (attach schedule) 2. Disposals (attach schedule) 2. Disposals (attach schedule) 3. Acquired prior to this report period (attach schedule) 3. Acquired during this report period (attach schedule) 3. Acquired during this report period (attach schedule) 3. Acquired during this report period (attach schedule) 3. Acquired during this report period (attach schedule) 3. Acquired during this report period (attach schedule) 3. Acquired during this report period (attach schedule) 3. Acquired during this report period (attach schedule) 4.885	2. Disposals (attach schedule)	-									
Subtotal Building Improvements		1 schedule)									
Building and Building Improvements	A-4. Subtotal	:									
1. Acquired prior to this report period											
2. Disposals (attach schedule) Subroral I. Acquired during this report period (attach schedule) Subtoral I. Acquired fairly this report period (attach schedule) 2. Disposals (attach schedule) 3. Acquired fairly this report period (attach schedule) Subtoral I. Acquired during this report period (attach schedule) 3. Acquired during this report period (attach schedule) Subtoral I. Acquired during this report period (attach schedule) Subtoral I. Morable Equipment II. Morable E	1. Acquired prior to this report period										
Subtoral											
Non-Movable Equipment	1	schedule)									
1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) 3. Acquired during this report period (attach schedule) 3. Acquired during this report period (attach schedule) 3. Acquired during this report period (attach schedule) 4. Acquired during this report period (attach schedule) 5. Acquired during this report period (attach schedule) 5. Acquired during this report period (attach schedule) 6. Acquired during this report period (attach schedule) 7. Acquired during this report period (attach schedule) 8. Disposals (attach schedule) 9. Disposals (attach schedu	S										
1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) 3. Acquired during this report period (attach schedule) 3. Acquired prior to this report period (attach schedule) 3. Acquired puring this report period (attach schedule) 3. Acquired puring this report period (attach schedule) 4. Acquired prior to this report period (attach schedule) 5. Disposals (attach schedule) 5. Disposals (attach schedule) 6. Disposals (attach schedule) 6. Acquired during this report period (attach schedule) 7. Acquired prior to this report period (attach schedule) 8. Disposals (attach schedule) 9. Dispos	1										
2. Disposals (attach schedule) Subtoral Subtoral Is a mileage logbook Date of Historical Less Depreciation to Method of Movable Equipment Nor Vehicles (Specify name, model and year of each vehicle) X No Month Year Land Value Depreciation Depreciation Depreciation a. 2000 Dodge Caravan X 9 2015 3,728 3,728 4,885 SL 3 b. 2000 Dodge Caravan (Disposed) X 10 2008 (4,885) (4,885) (4,885) SL 3 c. 2000 Dodge Caravan (Disposed) X 10 2008 (4,885) (4,885) (4,885) SL 3 c. Acquired during this report period Var Var 31,635 31,635 27,433 SL Var Var Depreciation Subtonal Subtonal c. Acquired during this report period (4,885) Subtonal Subto	-									465	
3. Acquired during this report period (attach schedule)											
Subtotal		(elifeditie)									
Stantileage	5	, serice and									
Salvage Date of Cost Less Accumulated Accumulated Depreciation to Method of Cost Less Accumulated Method of Cost Land Value Depreciation Deprec											
Movable Equipment Yes No Month Year Var		s a mileage logbook	Date of	Historical			Accumulated				
Movable Equipment Yes No Month Year Exclusive of Land Salvage Depreciated Cost to Be Depreciated Beginning of Vear's Operations Computing Depreciation I. Motor Vehicles (Specify name, model and year of each vehicle) x 10 2008 4,885 4,885 S.L 3 a. 2000 Dodge Caravan x 10 2008 4,885 3,728 4,885 S.L 3 b. 2006 Dodge Caravan (Disposed) x 10 2008 (4,885) (4,885) S.L 3 c. 2000 Dodge Caravan (Disposed) x 10 2008 (4,885) (4,885) S.L 3 d. a. Acquired prior to this report period var va	<u> </u>	naintained?	Acquisition	Cost	Less		Depreciation to	Method of			
Movable Equipment 4,885 4,885 4,885 1 1. Motor Vehicles (Specify name, model and year of each vehicle) x 10,2008 4,885 4,885 1 3,728 4,885 1 3 a. 2000 Dodge Caravan x 9,2015 3,728 3,728 5L 3 b. 2006 Dodge Caravan (Disposed) x 10,2008 (4,885) (4,885) 2L 3 d. 2. Movable Equipment a. Acquired prior to this report period Var Var 31,635 27,433 SL V b. Disposals (attach schedule) c. Acquired during this report period (attach schedule) 2. Movable Equipment 2. Movable Equipment 2. Movable Equipment 2. Movable Equipment 31,635 27,433 SL V					Salvage Value	Cost to Be Depreciated	Beginning of Year's Operations	Computing	Useful	Depreciation for This Year	Totale
1. Motor Vehicles (Specify name, model and year of each vehicle) x 10 2008 4,885 4,885 SL a. 2000 Dodge Caravan x 9 2015 3,728 4,885 SL b. 2006 Dodge Caravan (Disposed) x 9 2015 3,728 (4,885) SL d. c. 2000 Dodge Caravan (Disposed) x 10 2008 (4,885) SL (4,885) SL d. Acquired Equipment a. Acquired prior to this report period Var Var Var 31,635 27,433 SL b. Disposals (attach schedule) c. Acquired during this report period (attach schedule) 33.50 total Actual Dancialists	Movable Equipment	2000					T.				
and year of each vehicle) a. 2000 Dodge Caravan x b. 2006 Dodge Caravan x c. 2000 Dodge Caravan (Disposed) x d. 2. Movable Equipment a. Acquired prior to this report period b. Disposals (attach schedule) c. Acquired during this report period (attach schedule) 3. Subtotal 3. Subtotal	 Motor Vehicles (Specify name, model 										
a. 2000 Dodge Caravan	and year of each vehicle)										
b. 2006 Dodge Caravan c. 2000 Dodge Caravan (Disposed) d. 2. Movable Equipment a. Acquired prior to this report period b. Disposals (attach schedule) c. Acquired during this report period (attach schedule) 3. Subtotal 3. Subtotal			10 2008	4,885		4,885	4,885		3 years		
c. 2000 Dodge Caravan (Disposed) x 10 2008 (4,885) (4,885) Lissos d. 2. Movable Equipment Var Var Var 31,635 27,433 SL b. Disposals (attach schedule) c. Acquired during this report period (attach schedule) (attach schedule) 2. Acquired during this report period (attach schedule) 2. Acquired			9 2015	3,728		3,728			3 years		
d. 2. Movable Equipment a. Acquired prior to this report period Var Var Var 31,635 31,635 27,433 SL b. Disposals (attach schedule) c. Acquired during this report period (attach schedule) manual sch	<u> </u>		10 2008	(4,885)		(4,885)	(4,885)		3 years		
2. Movable Equipment a. Acquired prior to this report period b. Disposals (attach schedule) c. Acquired during this report period (attach schedule) 3. Subtotal Total Dissolution	ď.										
a. Acquired prior to this report period b. Disposals (attach schedule) c. Acquired during this report period (attach schedule) 3. Subtotal Total Disposals (attach period) (attach schedule) 3. Subtotal											
3. Suk				31,635		31,635			Var	442	
3. Suk	b. Disposals (attach schedule)										
3. Subtot	c. Acquired during this report period										
က္ပါ	(attach schedule)										
	હા										442
	E. Total Depreciation										442

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
		0.00		
		1000 000 000 000 00	10 10 10 10 10	
		00.00 0 00	90.000000000000000000000000000000000000	0.000 000 000 000
		40.00 (5.00)	0.00000	
		\$ 70 O S	31 32 32 33	
(0) (2) (1)		(465 UH), QUI NS (361	26.0500000000000000000000000000000000000	
Fotal additions for L	and Improvements	\$ -		\$ -
Deletions:				
0.0000000000000000000000000000000000000		1050,000,000,000,000,00	2 News 20 At 122	
		Mary Control		6.0000000000000000000000000000000000000
			5 (8 (6) 10)	
(2) 50 (B) 01 (2) (B)		95.700 30 30		
19-280 Dec (20-20) (20-20)			10.000000000000000000000000000000000000	1 70 10 10 10
		7000000	(A) (15) (E) (A)	
Total deletions for La	and 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:	•			
		100000	50 (50 (50)	
DELCO RECUES OF THE		100 No. 100 No. 100 No. 100 No. 100 No. 100 No. 100 No. 100 No. 100 No. 100 No. 100 No. 100 No. 100 No. 100 No	G (0)	
	and the state of t		8), 1(<u>6), alignoù 10</u> , 10	100000000000000000000000000000000000000
0.00			90 (50 (61 (64 (65)	0.000
		100000000000000000000000000000000000000		
		100 000 000 000	57 (19 (5) (5) (6)	14.00
Fotal additions for B	uilding Improvements	\$ -	15 280 (480) 5 (15)	\$ -
Deletions:				
		50 AST 175 (1)	G. Goden III. do.	(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)
0.30000		(6) (6) (1)		100 100 100 100 10
		40.00	6.000	
1.00		The second of the second		
		and a second second second	Missing and the	
Fotal deletions for Bu	ilding Improvements	\$ -		\$ -

^{*}Tics to Page 23, Line B3

Schedule of Non-Movable Equipment Acquired during this report period

			Usetui	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:	· .			
		162.00.00	10.000.000.00	20 20 20 20 20 20
			194 42 00 144	
		100 10 10 10 10	10.00 30.00	2000
Total additions for	Non-Movable Equipment	\$ -		\$ -
Deletions:				
		6.000000		0.000 SE 965 450 SE
		0.000	2 0 2 0 0	
		10.00		
		1 (5) (5) (6) (6)		100
				substance and action of the
	The state of the s			
Total deletions for I	Non-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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
2. 10. 10. 10. 10. 10. 10.				
10 100 000 00 00 00 00		300 000 000 000	1000 0800000000000000000000000000000000	
	The state of the s			
		4		
Total additions for	Movable Equipment	\$ -		\$ -
Deletions:				
		96.000.000.000	0.000	34 (2) (3)
		100	100000000000000000000000000000000000000	
		60 C C C C C C C C C C C C C C C C C C C	- 00 00 00 00 00 00	
	and the second s			
		25, 32,75		5.00
Total deletions for l	Movable Equipment	\$ -	333000000000000000000000000000000000000	\$ -

Schedule of Leasehold Improvements Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
			0.00	100 100 100 100
			9.000.0002000000000	200720100000000000000000000000000000000
the section of the section of		80 00 100 00		100
	10 Million and 10 Mil		Si Seni Si	100 100 100 100 100 100 100 100 100 100
	(1977) 1885 (1989) (1986) (1986) (1986) (1986) (1986) (1986) (1986) (1986) (1986) (1986) (1986) (1986) (1986)	980 22 22 22		AND RESIDENCE
Total additions for	Leasehold Improvement	\$ -		\$ -
Deletions:				
01.50.000.000.000			7 (10)	0010 051 151 151 151 151 151 151 151 151
		360 completes on	Se Consessi Administrativ	
			3 200000	
Tatal dalakana fan	Leasehold Improvement	S -		\$ -
TOTAL GETECHOUS TOT	Leasenoia Improvement	9 -		Φ -

^{*}Ties to Page 24, Line C3

^{*}Ties to Page 23, Line D2c **Ties to Page 23, Line D2b

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

Annual Report of Long-Term Care Facility CSP-24 Rev. 10/2006 State of Connecticut

Amortization Schedule*

Name of Facility	Facility			License No.		Report for Year Ended	r Ended		Page	of
Shailervi	Shailerville Manor LLC			1882		9/30/2015			24	37
						Accumulated				
		Date of	e of			Amort. to				
		Acquisition	sition			Beginning of	Basis for			
				Length of	Cost to Be	Year's	Computing	Rate /	Rate Amortization	
	Item	Month	Year	Amortization	Amortized	Operations	Amortization**	¥ %	for This Year	Totals
A. Or	Organization Expense									
].	1. Organization Expense	Var	Var		29,212	29,212	•			
2.										
3.										
A-4. Subtotal	btotal									
B. Mo	Mortgage Expense								12/49.00 10/10/10/10/10/10/10/10/10/10/10/10/10/1	
<u></u>										
2.										
3.	-									
B-4. Sul	Subtotal									
C. Le	Leasehold Improvements and Other									
	1. Acquired prior to this report period	Var	Var	Various	35,163	9,447	$S\Gamma$		3,726	
2.	2. Disposals (attach schedule)									
3.	3. Acquired during this report period									
	(attach schedule)									
C-4. Sul	Subtotal									3,726
D. To	Total Amortization									3,726
*	* Chaight line mathod must be used									

* 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	License No.	Report for Year E	nded		Page of
Shailerville Manor LLC	1882	9/30/2015			25 37
11. Property Questionnaire					
Part A					
Is the property either owned by the	ne Facility	A **	^		If "Yes," complete Part B.
or leased from a Related Party?*	-	O Yes	•	No	If "No," complete Part C.
*If any owner or operator of this far	cility is related by famil	y, marriage, ownership, ab	ility to control or		
business association to any person	or organization from wh	nom buildings are leased, th	nen it is considered		
a related party transaction. Description		Total			
1. Date Land Purchased		01/25/07	7	100	
2. Date Structure Completed		01723707			
3. If NOT Original Owner, Date	e of Purchase	01/25/07	7		
4. Date of Initial Licensure		01/25/07	7		
5. Total Licensed Bed Capacity		15	5		
6. Square Footage		Charles Aller Carles Annual Carles Commission (Carles Commission Carles Commission C			
7. Acquisition Cost					
a. Land					
b. Building	41	1,11	0.114	2-124-4	441. N
Part B - Owner and Related Pa	rties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
 Financing Type of Financing (e.g., financing) 	ived variable)	SBA		Maria de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de	
b. Date Mortgage Obtained	ixed, variable)	01/25/07	,		want to
c. Interest Rate for the Cost	Year	Various			
d. Term of Mortgage (number		20			
e. Amount of Principal Borro	owed	600,000			
f. Principal balance outstand	ling as of				
Complete if Mortgage was I					
During Current Cost Ye					
g. Type of Financing (e.g., fi	ixed, variable)				
h. Date of Refinancing i. New Interest Rate			•		
j. Term of Mortgage (number	er of years)				
k. Amount of Principal Borre					
Principal Outstanding on 1					
Part C - Arms-Length Lease	es for Real Propert	y Improvements Onl	y		
Name and Address of Lesso	r F	Property 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 Ye	ar Ended		Page of
Shailerville Manor LLC	1882		9/30/2015			26 37
						Residential Care
Item			Total	CCNH	RHNS	Home
12. Interest						
A. Building, Land Improvem Equipment	ent & Non-Movable	;				
1. First Mortgage		\$				
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage		\$		100000000000000000000000000000000000000		
Name of Lender		Rate				
Address of Lender				ing land and the second		
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 Expen	se					
12 B7. Total Building Interest Expen		\$				
<u> </u>			(7	Subtotals	C	

(Carry Subtotals forward to next page)

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

Name of Facility Shailerville Manor LLC	License No. 1882		Report for Y 9/30/2015	ear Ended		Page 0: 27 37
SMATIOI VIIIO IMAIIOI EEC	1002		7/30/2013			Residential
Ĭ te	em		Total	CCNH	RHNS	Care Home
	Subtotals Brow	ught Forward:		COLUI	KIIIKO	Care Home
12. C. Movable Equipment	Daototalo Bro	agiit i oi maid.				
1. Automotive Equipme	ent	\$				
A. Item	Rate	Amount				
		1				
Lender						
Lit Cr 1						
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
		<u> </u>				
Lender						
A 1.1 CT 1						
Address of Lender						
12. C. 3. Total Movable Equip	ment Interest				***************************************	
Expense $(C1 + 2)$	Alexander de la companya de la companya de la companya de la companya de la companya de la companya de la comp	\$				
12. D. Other Interest Expense (Specify)	\$	367			36
Credit card interest						
13. Total All Interest Expense (12B7 + 12C3 + 12D) \$	367			36
14. Insurance						
a. Insurance on Property (t		\$				9,93
b. Insurance on Automobil		\$	1,141			1,14
c. Insurance other than Pro						
1. Umbrella (Blanket C		\$ \$				
2. Fire and Extended Co	overage	\$				
3. Other (Specify)		\$				
14d. Total Insurance Expenditur	uas (11a ± b ± a)	\$	11.070			11.02
15. Total All Expenditures (A-1		\$				11,07 522,51
15. гош га ехрепшиев (А-1	3 unu (-14)	Ψ	344,310			344,31

D. Adjustments to Statement of Expenditures

Name				Lie	cense No.	Report for Ye	ar Ended	Page	of
Shaile	erville	Mane	or LLC	<u> </u>	1882	9/30/2015		28	37
	_				Total			L	
	Page				Amount of	COM	DIDIO		ntial Care
	No.		Item Description		Decrease	CCNH	RHNS	J. J.	ome
Page	10 - S	Salarie	es and Wages						
1.	•••		Outpatient Service Costs	\$					
2.			Salaries not related to Resident Care	\$					
3.			Occupational Therapy	\$					
4.			Other - See attached Schedule	\$					
	13 - H	rofes	sional 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.			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.			Unallowable Advertising *	\$					
19.			Income Tax / Corporate Business Tax	\$					
20.			Fund Raising / Contributions	\$!			
21.			Unallowable Management Fees	\$					
22.			Barber and Beauty	\$				-	
23.			Other - See attached Schedule	 \$					
	18 - 1)ietar	y Expenditures	_					
24.	10 1		Meals to employees, guests and others						
21.			who are not residents	\$					
Page	10 _ 1	annd	lry Expenditures	Ψ					
25.	17 - L		Laundry services to employees, guests						
25.			and others who are not residents	\$					
Page	20 - 1	Iouea	keeping Expenditures	Ψ					
26.	20 - I	i ouse	Housekeeping services to employees, guests						
20.			and others who are not residents	\$					
		<u> </u>	Subtotal (Items 1 - 26)					-	
			Subibiai (Items 1 - 20)	φ		 arry Subtotal f		<u> </u>	****

^{*} 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

				Francisk kantalister open words og	
			and a second second second		
200					40 G C C C C
SI SI			754 (35) (37)		
Total Other S	alaries Ad	ljustment	\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
				6 (6 (3 (4 (3 (3 (4 (4 (4 (4 (4 (4 (4 (4 (4 (4 (4 (4 (4	25 (3.16) (2.16) (3.16)
9514333333333	70 Sin (30 Si)				
	165 GF GF GF				
		The second secon	0.00		
				7 307 324 374 374 374	
		The state of the s			
			110 100 100 100 100 100 100 100 100 100		
120 001 30 001		The second secon			
Total Othe	r Fees Adi	ustments	\$ -	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref		Description	CCNH	RHNS	Care Home
					the contract of the second of the contract of
(i) (i) (ii) (ii)					36.00.03 (5.00.03)
Total Other	A&G Ad	justments	\$ -	\$ -	\$ -

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

NT	- CE	•1•4	D. Adjustments to Statemen					Daga	o.f
	e of Fa			LIC	ense No.	Report for Y	ear Ended	Page	of
Snaii	erville	Man	or LLC		1882	9/30/2015		29	37
 -,	n	т.			Total			Danidaa	4: a1 Caus
	Page		r 5 ·		Amount of	CONTI	DIDIC		tial Care
No.	No.	No.	Item Description	ф.	Decrease	CCNH	RHNS	HC	me
<u> </u>	20 7		Subtotals Brought Forward	\$					
	20 - K	<i>tesiae</i>	nt Care Supplies***	ф					
27.			Prescription Drugs	\$			•		
28.			Ambulance/Limousine	\$					
29.			X-rays, etc	\$					
30.			Laboratory	\$					
31.			Medical Supplies	\$					
32.			Oxygen (non emergency)	\$					
33. 34.			Occupational Therapy	_	055				055
	22 3	W. T 4	Other - See Attached Schedule	\$	955				955
-	22 - 11	gainte	enance and Property						
35.			Excess Movable Equipment Depreciation	φ					
2.0			See Attached Schedule	\$					
36.			Depreciation on Unallowable Motor Vehicles	đ			10		
37.				\$					
37.			Unallowable Property and Real Estate Taxes	Φ					
38.			Rental of Building Space or Rooms	\$ \$					
39.			Other - See Attached Schedule	\$					
	27 - I	M61140		Φ.					
40.	2/-1		Mortgage Insurance	\$				100	
41.	27		Property Insurance	\$	331				331
	r - Mis			ψ	331				331
42.	- 177.15	cenu	Research or Experimental Activities	\$					
43.			Radio and Television Revenue	\$					
44.			Vending Machine Revenue	\$					
44. 45.			Purchase Discounts and Allowances	\$					
46.			Duplications of functions or services	\$					
47.			Expenditures made for the protection,	Ψ					
т/.			enhancement or promotion of the						
			providers interest	\$					
48.			Interest Income on Accounts Rec	\$					
49			Other (include personnel and other	Ψ					
T 771			costs unrelated to resident care) - See						
			Attached Schedule	\$	367				367
Not 1	Tor Pr	ofit P	roviders Only	Ψ.	307				507
50.		· j · · · ·	Building/Non Movable Eq. Depreciation						
50.			Unallowable Building Interest -		0.00				
			See Attached Schedule	\$					
51	Total	Amo	unt of Decrease (Items 1 - 50)	\$	1,653				1,653
J.1.	A VIIII		on of Decrease trems I - 50)	Ψ	1,000	<u> </u>		L	-,000

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

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
20	5j	Excess cable			\$ 955
			the party of the same	30 (800 S0) (50 S0 S0 S0	
100 100 100 100			50 02 03 03 05 05 05		1,000,050,000,000,000
70 Ga Ga G				55,2501,052,052,053	
60 00 00 00					
60,450,000				3 (0)	
Total Othe	r Ancillary	Costs	\$ -	\$ -	\$ 955

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
					All on the second
8 3 9 6				principal control of	0.00
			55 (00 05) or 55	20,000,000,000	
			li di di di di di di di		
196 (13) (15)	11 (15) 195				
			110		
				0.0000000000000000000000000000000000000	5 9 6 5 6
5 5 35 36	\$4.95 (G) (G) (G				0.00
Total Exce	ss Movable	e Equipment Depreciation	\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
	7 40 60		0.0000000000000000000000000000000000000	0.00	
0.000	100000				
	4 (CO 10) (CO 10)				
6.3	55 12 12 1		10 (a) (b) (b) (b)		
				5 (0.0)	
					6 6 6
80 M S					
Total Othe	r Property	Adjustments	\$ -	\$ -	\$ -

				DITTIO	Residential
Page Ref	Line Ref	Description	CCNH	RHNS	Care Home
27	12 D	Credit card interest			\$ 367
	100 000 000 00				
	1/4/21 10/21/20/20		a delivering		
					0.0000000000000000000000000000000000000
			6 (6 5 9 8 8		
2.52.60.69	V 004/05/07/50 +3		60,000,000,000,000	10 07 Mg 90 05	17 Uroša roge per Uleanes na
	1005-00-00-0				
9.30 8.30					
Total Othe	r Adjustm	ents	\$ -	\$ -	\$ 367

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
	7 00 000 150 110			11 Gr (20 12 03 03	
				0.000.000.000.000.000	
	200820000000000000000000000000000000000		2 2 6 6 6 6 6	(1)	
				2 (2) (2) (2) (3)	
					000
			5 40 65 65 65 65	100 100 100 100	
50 000 000 000 0 51 000 000 000 000			100		
			55 SC 88 SS 82 (4)	0.0000000000000000000000000000000000000	
SSVACALOVANA			0.000	10.00	
Total Unal	lowable Bu	nilding Interest	\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility Shailerville Manor LLC	License No.		Report for Y 9/30/2015	ear Ended		Page of 30 37
						Residential Care
	Item		Total	CCNH	RHNS	Home
I. Resident Room, Board & Routine	Care Revenue					
1. a. Medicaid Residents (CT onl.	ν)	\$	518,513			518,513
b. Medicaid Room and Board		\$		<u> </u>		
2. a. Medicaid (All other states)		\$		J		
b. Other States Room and Boar	d Contractual Allowance **	\$				
3. a. Medicare Residents (all incl		\$				
b. Medicare Room and Board (Contractual Allowance **	\$				
4. a. Private-Pay Residents and O		\$				
b. Private-Pay Room and Board		\$				
II. Other Resident Revenue		·				
1. a. Prescription Drugs - Medica	re	\$				
b. Prescription Drugs - Medica		\$				
c. Prescription Drugs - Non-M		\$				
	edicare Contractual Allowance **	\$	*****			
a. Medical Supplies - Medicare		\$		*		
b. Medical Supplies - Medicare		\$				
c. Medical Supplies - Non-Med		\$,
	dicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare		\$				
b. Physical Therapy - Medicare	***************************************	\$				
c. Physical Therapy - Non-Med		\$				
d. Physical Therapy - Non-Med		\$				
4. a. Speech Therapy - Medicare	mode Contractad 7 mo wanto	\$				
b. Speech Therapy - Medicare	Contractual Allowance **	\$				
c. Speech Therapy - Non-Medi	· · · ·	\$			•	
d. Speech Therapy - Non-Medi		\$		MICT II V		
5. a. Occupational Therapy - Med		\$				
L	dicare Contractual Allowance **	\$				
c. Occupational Therapy - Nor	****	\$			·········	
	n-Medicare Contractual Allowance **	\$			·	
6. a. Other (Specify) - Medicare	1 1/10didate Continuouda 1 xmo maxee	\$				
b. Other (Specify) - Non-Medic	care	\$				
III. Total Resident Revenue (Section		\$	518,513			518,513
IV. Other Revenue*			310,313			310,313
Meals sold to guests, employees	2 & others	\$				
Rental of rooms to non-resident		\$				
3. Telephone	5	\$				****
4. Rental of Television and Cable	Sarvines	\$				
5. Interest Income (Specify)	DOI 41009	\$				
6. Private Duty Nurses' Fees		\$				
7. Barber, Coffee, Beauty and Gift	shons	\$				
8. Other (Specify)	ысро	\$				
V. Total Other Revenue (1 thru 8)		\$				
	L MAN ANNAMA - THE TE					
VI. Total All Revenue (III +V)		\$	518,513			518,513

^{*} 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.

		Description	7	CCNH	RHNS	Residential Care Home
27	12 D	Credit card interest	i de la companya de la companya de la companya de la companya de la companya de la companya de la companya de			\$ 367
		4 10	-Sica			100000000000000000000000000000000000000
	600 60 60 6	1963				5 (0.5) (0.5)
						0.0000000
97 (17 (27 (28)						
	0.000					
	e sy militare				(5) (22 (23) (6) (6) (6)	0.00
Total Othe	r Adjustme	ents		\$ -	\$ -	\$ 367

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
	6 32 65 65		3 10 10 10 10 10	30 (6) (6) (6) (6)	VIC. 10. 10. 10. 10. 10. 10. 10. 10. 10. 10
(a) (b) (a) (a)	5 65 65 66 66 F				
			(1) (1) (1) (1) (1)		8 60 2 6 70 1
41,000,00					0.00
12.00				11.0	
100000000000000000000000000000000000000					10 (00 (01) (02) (03)
30.000		A Company of the Comp			
Total Unall	owable Bu	ilding Interest	\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility Shailerville Manor LLC	License No.	<u> </u>	Report for Y	ear Ended		Page	of
			9/30/2015			30	37
	Item		Total	CCNH	RHNS	Resident Ho	
I. Resident Room, Board & Ro	outine Care Revenue	·			AGII (O	110	IIIC
1. a. Medicaid Residents (C	T only)	\$	518,513				518,513
b. Medicaid Room and B	oard Contractual Allowance **	\$	2 - 0,0 12			<u> </u>	210,213
2. a. Medicaid (All other sto	ntes)	\$	7,			<u> </u>	
b. Other States Room and	Board Contractual Allowance **	\$		-		 	
3. a. Medicare Residents (ai	ll inclusive)	\$		***			
b. Medicare Room and B	oard Contractual Allowance **	\$,	***	 		-
4. a. Private-Pay Residents a		\$	"				44
b. Private-Pay Room and	Board Contractual Allowance **	\$	· · · · · · · · · · · · · · · · · · ·		**	<u> </u>	
II. Other Resident Revenue							
1. a. Prescription Drugs - M	edicare	\$					
	edicare Contractual Allowance **	\$		***			
c. Prescription Drugs - No		\$			<u></u> -		
	on-Medicare Contractual Allowance **	\$					
2. a. Medical Supplies - Med		\$					
	licare Contractual Allowance **	\$					
c. Medical Supplies - Non		\$				**	
	-Medicare Contractual Allowance **	\$				**	
3. a. Physical Therapy - Med		\$					
	licare Contractual Allowance **	\$		* **		**-	
c. Physical Therapy - Non-		\$		*		٨.	
	-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medic		\$			*		
· · · · · · · · · · · · · · · · · · ·	care Contractual Allowance **	\$					
c. Speech Therapy - Non-N		\$					
	Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy -	Medicare	\$	* -				
	Medicare Contractual Allowance **	\$					-
c. Occupational Therapy -	Non-Medicare	\$					
	Non-Medicare Contractual Allowance **	\$					
6. a. Other (Specify) - Medica	are	\$				"	
b. Other (Specify) - Non-M	ledicare	\$				*	
II. Total Resident Revenue (Sec		\$	519.512				
V. Other Revenue*		Ψ	518,513			51	8,513
1. Meals sold to guests, emplo	vees & others	ø					
2. Rental of rooms to non-resid		\$					
3. Telephone	donto	\$					
4. Rental of Television and Ca	hle Services	\$					
5. Interest Income (Specify)		\$		 +		**	
6. Private Duty Nurses' Fees	-	\$ \$				7411	
7. Barber, Coffee, Beauty and	Gift shops	\$			 - -		
8. Other (Specify)							
. Total Other Revenue (1 thru 8)		\$	— -				
I. Total All Revenue (III+V)	,	\$.	 				
- Zom Zii Acrente (III TV)		\$	518,513			518	8,513

^{*} 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

Daga Daf	Description	CCNH	RHNS	Care Home
Page Rei	Description	(0)	Sec. 403 (354) 1581	all christings at
		100	201000	- 01 - 05 AS 15 M
	and the second s	-	50 SA 10 SA 100	
				025 032 030 032 55
100 000 000 000 000 000 000 000 000 000				
12 12 12 12 12		100	12 (12 (12 (12 (12 (12 (12 (12 (12 (12 (diameter in
73. (Sp.)45912	I compared to the second secon	· ·	q	\$ -
Total Oth	er Resident Revenue - Medicare	Ψ -	Ψ	1.9

Schedule of Other Non-Medicare Resident Revenue

Related Exp

		CCNH	RHNS	Care Home
Page Ref	Description	Togga (SSEZICE CORRUSTO)	2020 (SO) (CO) (SO) (SO) (SO) (SO)	1955-1985/0987/0987/0987
			15 15 15 16 16 16 16 16 16 16 16 16 16 16 16 16	
	Property of the second		l se se se se se se se se	
	100 mg/s			
		(0.00 C) (0.00 C) (0.00 C)	351 PRO 1980 STATE OF THE STATE	
200 of threshold				
200000000000000000000000000000000000000		1021 50 70 00 00	person set vin 25, 0	
***//g#///jab/j/s		1023 923 335 339 000		
Contract of			201003000000000000000000000000000000000	- 162114 (401 Hall Hall Hall Hall Hall Hall Hall Hal
Total Oth	er Resident Revenue	\$ -	\$ -	3 -
TOTAL OTH	C AMARCO AN CONTROL OF THE CONTROL O			

Interest Income

Account

				Residential
Barra Daf Account	Balance	CCNH	RHNS	Care Home
Page Ref Account			1 (0.18) (0.20)	
The state of the		100	organical designation of the second	
And the second s		and the second second second		
	100,000			Section 1997
		e	s -	\$ -
Total Interest Income		O. W. Contraction of Section Section Co.	THE MONTHS COURSE WAS A COURSE	1 -

Schedule of Other Revenue

Description	CCNII	RHNS	Residential Care Home
Page Ref Description	1		6.00 (2.00)
Section 1 Control of the Control of		0.00	
Additional Control of the Control of			
	(48) E. C. C. C. S. S. S. C. C.		Section 12
			0.04.00.00.00
		(8) (8) (8)	
		200 00 00 00 00	9 9 9 9
Agricultural de la companya del companya del companya de la compan	4. 0. 0. 0. 0.		
	50 St. Ct. (\$0.05)		
			<u> </u>
Total Other Revenue	\$ -	\$ -	\$ -

G. Balance Sheet

Asse A.	ts Cu 1.	rille Manor LLC Burrent Assets Cash (on hand and in banks	Account	9/30/2015	31 At	nount 37
	Cu 1. 2. 3.	Cash (on hand and in banks	Account		Ar	nount
	Cu 1. 2. 3.	Cash (on hand and in banks				
A. 	1. 2. 3.	Cash (on hand and in banks				
	2. 3.		1		e e	10 504
	3.	Resident Accounts Receivab		Pod Dobto	\$ \$	10,596
		Other Accounts Receivable			\$	39,765
		Inventories	(Excluding Owners of 1	Related Farties)	\$	1,500
		Prepaid Expenses			\$	3,900
	٥.	a. Prepaid Insurance		3,047	Φ	3,900
		b. Prepaid pension		853		
				033	_	
		c. d.				
	6.	Interest Receivable			\$	
		Medicare Final Settlement R	eceivable		\$	
		Other Current Assets (itemiz			\$	5,100
	٠.	Security Deposit		5,100	Ψ	3,100
A-9.	To	tal Current Assets (Lines A1	thru 8)		\$	60,861
		xed Assets			-	
	1.	Land			\$	
	2.	Land Improvements	*Historical Cost		\$	
		1	Accum. Depreciation	Net	Ì	
	3.	Buildings	*Historical Cost		\$	
		C	Accum. Depreciation	Net		
	4.	Leasehold Improvements	*Historical Cost	35,163	\$	21,990
		•	Accum. Depreciation	13,173 Net		
	5.	Non-Movable Equipment	*Historical Cost		\$	
		, -	Accum. Depreciation	Net		
	6.	Movable Equipment	*Historical Cost	31,635	\$	3,760
			Accum. Depreciation	27,875 Net		
	7.	Motor Vehicles	*Historical Cost	3,728	\$	3,728
			Accum. Depreciation	Net		
	8.	Minor Equipment-Not Depre	eciable	, ,	\$	
	9.	Other Fixed Assets (itemize)			\$	
3-10.		Total Fixed Assets (Lines B	1 thru 9)		\$	29,478

^{*} 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
Shailerville Manor LLC		ille Manor LLC	1882	9/30/2015		32		37
Account					An	noun		
	Total Brought Forward							90,339
C.	Le	asehold or like property record	ed for Equity Purpose	S.				
	1.	. Land			\$			
	2.	Land Improvements	*Historical Cost	<u></u>				
			Accum. Depreciation	n Net	\$			
	3.	Buildings	*Historical Cost					
÷			Accum. Depreciation	n Net	\$			
	4.	Non-Movable Equipment	*Historical Cost					
			Accum. Depreciation	n Net	\$			
	5.	Movable Equipment	*Historical Cost					
			Accum. Depreciation	n Net	\$			
	6.	Motor Vehicles	*Historical Cost					
			Accum. Depreciation	n Net	\$			
		Minor Equipment-Not Depre			\$			·
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	29,212				
			Accum. Depreciation	29,212 Net	\$ \$			
	7)							
	5.	Investments Related to Reside	ent Care (itemize)		\$			
	6.	Loans to Owners or Related I	T		\$			
	Name and Address Amount Loan Date							
				<u> </u>	6			
	7. Other Assets (itemize)				D.			
D. O. Water I. L. and L. and A. and C. C. C. C. D. L. A. D. C.					\$			
	D-8. Total Investments and Other Assets (Lines D1 thru 7)							00.220
D-9.	O-9. Total All Assets (Lines A9 + B10 + C8 + D8)							90,339

^{*} 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		Ended	Page	of	
Shailerville Manor LLC		1882	9/30/2015		33	37	
Account					Am	ount	
Liabilities							
Α.	Cu	rrent Liabilities					
	1.	Trade Accounts Payable					7,490
	2.	Notes Payable (itemize)			9	3	
				, u .			
	3.	Loans Payable for Equipn	ant (Carrent noution	n) (itamira)		,	
	٥,	Name of Lender	Purpose	Amount	Date Due)	
		Name of Lender	rurpose	Allount	Date Due		
	4.	Accrued Payroll (Exclusive	e of Owners and/or s	Stockholders only)	\$	i)	6,222
	5.	Accrued Payroll (Owners	and/or Stockholders	only)	\$)	
	6.	Accrued Payroll Taxes Pa	yable		\$)	
	7.	Medicare Final Settlement	t Payable		\$)	
	8.	Medicare Current Financi	ng Payable		\$)	
	9.	Mortgage Payable (Currer	nt Portion)		\$,	
	10.	Interest Payable (Exclusive	e of Owner and/or R	elated Parties)	\$	\$	
11. Accrued Income Taxes*					\$		
	12.	Other Current Liabilities (itemize)		\$		36,176
		Due to DSS	36,	176			
					<u></u>		
	787	4. 3. 6T 4 Y * 3. 124.4 /Y *	A 1 (1 10)				46.005
A-13	. 10	tal Current Liabilities (Lin	es A1 thru 12)			<u> </u>	49,888

^{*} 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			Ended	Page	of
Shailerville Manor LLC				34	37
A	Account				unt
	ht Forward:		49,888		
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment			\$		
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable			\$		200 ANOTHER PROPERTY AND ADDRESS OF THE PARTY OF THE PART
3. Loans from Owners or Rela	ated Parties (itemize)		\$		119,811
Name and Address of Lender	Amount	Loan D	ate		
William Boisvert	119,811	Open			
·					
4. Other Long-Term Liabilities (itemize)					
					110 011
B-5. Total Long-Term Liabilities (I	<u>\$</u>		119,811 169,699		
C. Total All Liabilities (Lines A-	<u>4</u>		102,023		

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

1		License No.	Report for Year Ended	f	Page	of
Shai	lerville Manor LLC	Account	9/30/2015		35	37
			Amou	ınt		
A.	Reserves					
	1. Reserve for value of leased	l land		\$		
	2. Reserve for depreciation v					
	to be amortized	\$				
	3. Reserve for depreciation v	alue of leased perso	onal property (<i>Equity)</i>	\$		
	4. Reserve for leasehold real	properties on whicl	n fair rental value is based	\$		
	5. Reserve for funds set aside	as donor restricted		\$		
	6. Total Reserves			\$		
В.	Net Worth					
<u> </u>	1. Owner's Capital			\$_		
	2. Capital Stock			\$		
	3. Paid-in Surplus			\$		
	4. Treasury Stock			\$		
	5. Cumulated Earnings			\$		(75,357)
	6. Gain or Loss for Period	10/1/2	014 thru 9/30/2	2015 \$		(4,003)
,	7. Total Net Worth			\$		(79,360)
C.	Total Reserves and Net Wort	h		\$		(79,360)
D.	Total Liabilities, Reserves, ar	nd Net Worth		\$		90,339

H. Changes in Total Net Worth

		License No.	Report for Year	Ended	Page	of
Shailerville Manor LLC		1882	9/30/2015		36	37
Account					I	Amount
A.	Balance at End of Prior Period as s	hown on Report of 0	9/30/2014		\$	(75,357)
B.	Total Revenue (From Statement of				\$	518,513
C.	Total Expenditures (From Statemen	nt of Expenditures P	age 27)		\$	522,516
D.	Net Income or Deficit				\$	(4,003)
E.	Balance				\$	(79,360)
F.	Additions					
	1. Additional Capital Contributed	(itemize)				
	2 Other (itemia)				-	
	2. Other (itemize)					
					W.	
F-3.	Total Additions				\$	
G.	Deductions				1	
	Drawings of Owners/Operators	/Partners (Specify)			 \$	
	Name and Address (No., City,	1 2 11 1	Title	Amount		
	2. Other Withdrawings (Specify)					
Purpose Amount					\$	
	100					
	3. Total Deductions		_l		\$	
Н.	Balance at End of Period	09/30/1	5		\$	(79,360)
		02/20/1	• · · · · · · · · · · · · · · · · · · ·		17	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,

I. Preparer's/Reviewer's Certification

Name of Facility		License No.		of				
Shaile	rville Manor LLC	1882	9/30/2015 37 3	7				
	Check appropriate category							
	Chronic and Convalescent Nursing Home only (CCNH)	T I I I I I I I I I I I I I I I I I I I						
		Preparer/Reviewer Certifica	tion					
	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	Printed Name of Preparer							
Davis,	Davis, Mascola & Phillips, LLC							
Addres Address			Phone Number					
1062 I	1062 Barnes Rd, Ste. 203, Wallingford CT, 06492 203-265-0488							

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