State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2019

Name of Facility (as licensed) FILOSA FOR NURSING AND REHABILITATION		
Address (No. & Street, City, State, Zip Code) 13 HAKIM STREET, DANBURY, CT. 06810		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	461-C			07-5074

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	4614		

For Department Use Only

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

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CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2019	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 FILOSA FOR NURSING AND REHABILITATION [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, 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) MICHAEL D. MALONE			Printed Name (Owner) BARBARA A. MALONE	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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Department of Social Services
55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility FILOSA FOR NURSING AND REHABILITATION	Period Covered:		From 10/1/2018	To 9/30/2019
Address of Facility 13 HAKIM STREET, DANBURY, CT. 06810				
Report Prepared By	Phone Number		Date	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$				
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$				
5. All other wages paid	$				
6. ***Total Wages Paid***	$				
7. Total salaries paid	$				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-744-3666	9/30/2019	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
FILOSA FOR NURSING AND REHABILITATION	13 HAKIM STREET, DANBURY, CT. 06810

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	461-C			07-5074

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Type of Ownership (Check appropriate box)

○ Proprietorship ○ LLC ○ Partnership ◉ Profit Corp. ○ Non-Profit Corp. ○ Government ○ 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? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
MICHAEL D. MALONE	001685

Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILIT	461-C	9/30/2019	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
FILOSA CONVALESCENT HOME, INC	13 HAKIM STREET, DANBURY, CT 06810	CONNECTIC UT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
FRANK D. MALONE	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	TREASURER	122
BARBARA A. MALONE	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	SECRETARY	491
JENNIFER MALONE-SEIXAS	592 MANVILLE ROAD, PLEASANTVILLE, NY 10570	PRESIDENT	125
MICHAEL D. MALONE	197 GUINEA ROAD, MONROE, CT 06468	ICE-PRESIDEN	129
JOHN M. MALONE	22 NORTH DUTCHER STREET, IRVINGTON, NY 10533	DIRECTOR	119
Names of Stockholders Owning at Least 10% of Shares			
FRANK D. MALONE	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	TREASURER	122
BARBARA A. MALONE	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	SECRETARY	491
JENNIFER MALONE-SEIXAS	592 MANVILLE ROAD, PLEASANTVILLE, NY 10570	PRESIDENT	125
MICHAEL D. MALONE	197 GUINEA ROAD, MONROE, CT 06468	ICE-PRESIDEN	129
JOHN M. MALONE	22 NORTH DUTCHER STREET, IRVINGTON, NY 10533	DIRECTOR	119

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATIC	461-C	9/30/2019	3B	37

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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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	%**				
FILOSA CARE CENTER DBA HANCOCK HALL	31 STAPLES ST., DANBURY, CT 06811	○	⊙		SHARED EXPENSES	SEE ATTACHED	SEE ATTACI	SEE ATTACHED
BARBARA A. MALONE (BAMCO, LLC)	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	○	⊙		BUILDING RENTAL/DEPRECIATION	22/9 22/7b	780,000	780,000
SPACE PANTS, LLC	197 GUINEA ROAD, MONROE, CT 06468	○	⊙		PARKING LOT RENTAL	22/9	7,800	7,800
SPACE PANTS, LLC	197 GUINEA ROAD, MONROE, CT 06468	○	⊙		OFF SITE STORAGE	22/9	6,240	6,240
MICHAEL MALONE	197 GUINEA ROAD, MONROE, CT 06468	○	⊙		ADMINISTRATOR	10/A2	79,824	79,824
FILOSA CARE CENTER DBA HANCOCK HALL	31 STAPLES ST., DANBURY, CT 06811	○	⊙		ADVANCED FUNDS	34/B3	128,601	128,601
		○	⊙					
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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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 (*See listing page 13*)
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.

SEE ATTACHED

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

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

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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
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
WELLS FARGO/RICOH USA , PO BOX 41554, PHILADELPHIA, PA 19101	○	⊙	COPIER MACHINE LEASE	08/01/18	60 MONTH LEASE	8,160	8,160
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total** *** 8,160

* 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	of
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The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

Is the accounting basis for this period the same as for the previous period? ⊙ Yes ○ No — If "No," explain.

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 CLIFTON LARSON ALLEN, LLP	300 CROWN COLONY DRIVE, STE 310, QUINCY MA 02169
2 CLIFTON LARSON ALLEN, LLP	300 CROWN COLONY DRIVE, STE 310, QUINCY MA 02169
3	
4	

Services Provided by This Firm (*describe fully*)

1	FINANCIAL STATEMENT REVIEW	$ 12,600
2	PREPARATION OF ANNUAL PROPERTY TAX DECLARATION REPORT	$ 2,800
3		$
4		$

Charge for Services Provided: $ 15,400

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

⊙ Yes ○ No 15/1/D

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 MICHALIK, BAUER, SILVIA & CICCARILLO, LLP	860-225-8403
2	
3	
4	
5	

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

1 35 PEARL STREET, SUITE 300, NEW BRITAIN, CT, 06051-2645
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	COLLECTIONS	$ 2,335
2		$
3		$
4		$
5		$

Charge for Services Provided: $ 2,335

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

⊙ Yes ○ No 15/1/E

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	64	64			64	64			64	64		
B. On last day of THIS report period	64	64			64	64			64	64		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	58	58			58	58			58	58		
B. As of midnight of THIS report period	59	59			58	58			59	59		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,080	1,080			791	791			289	289		
B. Medicaid (Conn.)	15,320	15,320			11,349	11,349			3,971	3,971		
C. Medicaid (other states)												
D. Private Pay	4,671	4,671			3,651	3,651			1,020	1,020		
E. State SSI for RCH												
F. Other (Specify) Medicare Advantage	286	286			192	192			94	94		
G. Total Care Days During Period (3A thru F)	21,357	21,357			15,983	15,983			5,374	5,374		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	1	1			1	1						
B. Other Bed Reserve Days	4	4			4	4						
5. ***Total Resident Days*** **(3G + 4A + 4B)**	21,362	21,362			15,988	15,988			5,374	5,374		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

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

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	(Specify)
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	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	4	45		10				
Per Diem Rate								
a. One bed rm.	637.00			510.00				
b. Two bed rms.	578.85	261.71		480.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	1,826	1,826		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	3,268	3,268		
D. ***Total Physical Therapy Treatments***	5,094	5,094		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	422	422		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	168	168		
D. ***Total Speech Therapy Treatments***	590	590		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,319	1,319		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	3,375	3,375		
D. ***Total Occupational Therapy Treatments***	4,694	4,694		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	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)	79,824	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	106,619	5,423				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	30,757	832				
c. Dietary Workers	303,234	17,386				
6. Housekeeping Service						
a. Head Housekeeper	34,277	852				
b. Other Housekeeping Workers	159,685	12,195				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	45,210	852				
b. Other Maintenance Workers	72,144	2,373				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	74,595	4,626				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant	49,023	832				
b. Other Accountants	66,505	2,260				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	181,606	3,834				
b. RN						
1. Direct Care	639,401	19,449				
2. Administrative**	183,002	4,818				
c. LPN						
1. Direct Care	458,038	16,357				
2. Administrative**	18,256	473				
d. Aides and Attendants	1,064,650	62,215				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	130,839	5,578				
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	64,464	1,911				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	3,762,127	164,346				

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
RELIGIOUS SERVICES	$ 1,200	24				
Total	$ 1,200	24	$ -	-	$ -	-

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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
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
JENNIFER MALONE-SEIXAS				SAMES AS OTHER EMPLOYEES	PRESIDENT			HANCOCK HALL 31 STAPLES ST DANBURY CT	2,080	181,555
MICHAEL MALONE					VICE-PRESIDENT			HANCOCK HALL 31 STAPLES ST DANBURY CT		119,043
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.

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
MICHAEL MALONE	79,824			SAMES AS OTHER EMPLOYEES	ADMINISTRATIVE STAFF RESPONSIBLE FOR	2,080				
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.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATIOI	461-C	9/30/2019	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian	24,255	539				
2. Dentist	7,163	20				
3. Pharmacist	7,333	126				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	103,617	1,570				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	27,600	166				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)	880	5				
2. Pharmaceutical Committee (Quarterly meetings)	880	5				
3. Staff Development Committee (Once annually)	740	4				
e. Other (Specify)						
PSYCHIATRIC EVALUATIONS	11,200	63				
9. Speech Therapist						
a. Resident Care	21,748	288				
b. Other						
10. Occupational Therapist						
a. Resident Care	94,771	1,591				
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	1,200	24				
B-13 Total Fees Paid in Lieu of Salaries	301,387	4,402				

* 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2019	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
GRACE AHERN, R.D. 4 WESTMINSTER ROAD, DANBURY, CT, 06811	DIETICIAN - DIETARY NEEDS AND REPORTS	○	⊙	
SERAFIMA GLOUZGAL,MD, 388 GROVE ST, RIDGEFIELD, CT 06877	COORDINATION OF MEDICAL CARE FOR RESIDENTS	○	⊙	
DANIEL WOLLMAN,MD, 580 LONG HILL AVE, SHELTON, CT 06474	COORDINATION OF MEDICAL CARE FOR RESIDENTS	○	⊙	
HEALTH DRIVE DENTAL GROUP, 888 WORCHESTER ST, WELLESLEY, MA	EVALUATION AND DENTAL GROUP	○	⊙	
SYMBRIA REHAB, 28100 TORCH PARKWAY, WARRENVILLE, IL 60555	PT, OT AND SPEECH EVALUATIONS AND TREATMENT	○	⊙	
ORESTES ARCUNI, MD , 4 BARTRAM DRIVE, WEST REDDING, CT 06896	PSYCHIATRIC EVALUATIONS AND SERVICES	○	⊙	
REV. DAVID FRANKLIN, ST. JOSEPH'S ROMAN CATHOLIC CHURCH, 8 ROBINSON	MASS AND CLERGY VISITS TO FACILITY RESIDENTS	○	⊙	
OMNICARE PHARMACY, 525 KNOTTER DRIVE, CHESHIRE, CT	INFECTION CONTROL REVIEW, PHARMACEUTICAL REVIEW,	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITAT	461-C	9/30/2019	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	96,107	96,107		
2. Disability Insurance	$	23,910	23,910		
3. Unemployment Insurance	$	43,288	43,288		
4. Social Security (F.I.C.A.)	$	281,348	281,348		
5. Health Insurance	$	327,735	327,735		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	16,175	16,175		
(not-owners and not-operators)					
8. Uniform Allowance	$	3,875	3,875		
9. Other (*Specify*)	$	11,122	11,122		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	18,966	18,966		
d. Accounting and Auditing	$	15,400	15,400		
e. Legal (*Services should be fully described on Page 7)*	$	2,335	2,335		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	18,799	18,799		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	12,007	12,007		
2. Cellular Phones	$	1,888	1,888		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$	250	250		
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$	27,065	27,065		
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	421,784	421,784		
Subtotal	$	1,322,055	1,322,055		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
EMPLOYEE PHYSICALS	$ 11,122		
Total	$ 11,122	$ -	$ -

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2019	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,322,055	1,322,055		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	5,070	5,070		
2. Holiday Parties for Staff	$	933	933		
3. Gifts to Staff and Residents	$	6,833	6,833		
4. Employee Travel	$	96	96		
5. Education Expenses Related to Seminars and Conventions	$	3,271	3,271		
6. Automobile Expense (*not purchase or depreciation*)	$	2,117	2,117		
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	6,628	6,628		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	1,325	1,325		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$	3,004	3,004		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	2,020	2,020		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	5,701	5,701		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	687	687		
10. Contributions***	$	200	200		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	7,585	7,585		
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	91,521	91,521		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	1,459,046	1,459,046		

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

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
PROMOTION-PUBLIC RELATIONS	$ 1,325		
Total Other Advertising	$ 1,325	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 4,967		
AANAC RAC CT CERTIFICATION	$ 218		
AANAC	$ 124		
ACHCA	$ 310		
APIC	$ 82		
Total Dues	$ 5,701	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
HENRY ABBOTT TECHNICAL HIGH SCHOOL	$ 200		
Total Contributions	$ 200	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
EQUIPMENT RENTAL	$ 4,692		
CABLE TV EXPENSE	$ 14,373		
SOFTWARE LICENSE AND MAINTENACE	$ 32,776		
COMPUTER HOSTING AND SERVICES	$ 13,950		
PAYROLL SERVICE	$ 18,486		
FACILITY LICENSES AND FEES	$ 3,092		
MISCELLANEOUS EXPENSE	$ (30)		
BANK SERVICE CHARGES	$ 2,673		
RESIDENT RELATED MISC EXP	$ 240		
LOSS ON DISPOSED EQUIPMENT	$ 1,269		
Total Other Administrative and General	$ 91,521	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABI	461-C	9/30/2019	17 | 37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

*** 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.**

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2019	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	165,117	165,117		
2. Non-Food Supplies	$	24,631	24,631		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____	$	2,539	2,539		
DIETARY EQUIPMENT REPAIR AND SMALL EQUIP					
DIETARY EQUIPMENT RENTAL					
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	192,287	192,287		

2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F. Resident Meals:	Total no. of meals served per day:*	176	176		

G.	Is cost of employee meals included in 2D?	○ Yes	⊙ No	
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 Item)			
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	○ Yes	⊙ No	If yes, specify cost.
K.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	○ Yes	⊙ No	If yes, specify cost.
N.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

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

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2019	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	7,620	7,620		
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. $	15,617	15,617		
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) EQUIPMENT RENTAL AND REPAIR	$	8,714	8,714		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	31,951	31,951		

3E.	Laundry Questionnaire			
F.	Is cost of employee laundry included in 3D?	○ Yes	⊙ No	If yes, specify cost.
G.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
H.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	
I.	Is Cost of laundry provided to persons other than employees or residents included in 3D?	○ Yes	⊙ No	If yes, specify cost.
J.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
K.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	

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

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

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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
FILOSA FOR NURSING AND REHABILITA	461-C	9/30/2019	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel		39,605	39,605		
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	28,201	28,201		
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	28,201	28,201		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from OMNICARE		$	29,413	29,413		
b. Medicine Cabinet Drugs		$	1,069	1,069		
c. Medical and Therapeutic Supplies		$	122,844	122,844		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	4,603	4,603		
f. X-rays and Related Radiological Procedures***		$				
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	772	772		
i. Recreation		$	2,933	2,933		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	2,892	2,892		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	164,526	164,526		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
SMALL EQUIPMENT NURSING	$ 1,012		
TECH. COMPONENT PART A CHARGES	$ 1,880		
Total Other Resident Care	$ 2,892	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2019	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
ORESTES J. ARCUNI	WEST REDDING, CT 06896	○	⊙		EVALUATIONS AND SERVICES	11,200			13	B8E
GRACE AHERN, R.D.	ROAD, DANBURY, CT 06811	○	⊙		DIETICIAN - DIETARY NEEDS AND REPORTS	24,255			13	B1
SYMBRIA REHAB	PARKWAY, WARRENVILLE, IL	○	⊙		EVALUATIONS AND TREATMENT	220,136			13	VARI
SERAFIMA M. GLOUZGAL	RIDGEFIELD, CT 06877	○	⊙		MEDICAL DIRECTOR	27,600			13	B8A
CELTIC CONSULTING LLC	TORRINGTON, CT 06790	○	⊙		MDS COMPILANCE	4,127			16	M11
CLIFTON LARSON ALLEN LLP	DRIVE, STE 310, QUINCY MA 02169	○	⊙		ACCOUNTING SERVICES	15,400			15	1D
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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).

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABILIT	461-C	9/30/2019	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	78,648	78,648		
b. Heat	$	40,003	40,003		
c. Light & Power	$	59,844	59,844		
d. Water	$	24,534	24,534		
e. Equipment Lease (*Provide detail on page 6*)	$	8,161	8,161		
f. Other (*itemize*)	$	41,064	41,064		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	252,254	252,254		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	120,877	120,877		
c. Non-Movable Equipment	$	6,954	6,954		
d. Movable Equipment	$	59,821	59,821		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	187,652	187,652		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	84,210	84,210		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	84,210	84,210		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	673,163	673,163		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	9,782	9,782		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	954,807	954,807		

* 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	(Specify)
OUTSIDE SERVICE-GROUNDS	$ 10,731		
REFUSE REMOVAL	$ 26,528		
EXTERMINATING	$ 3,806		
Total Other Repairs and Maintenance	$ 41,064	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2019	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	4,835,483		4,835,483	3,044,596	SL	40	120,877	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								120,877
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	87,054		87,054	1,452	SL	20	4,353	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	40,229						2,601	
C-4. Subtotal								6,954

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. 2015 FORD F250 PICKUP	X		10	2015	44,463		44,463	33,346	SL	4	11,117	
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					624,778		624,778	357,987	SL	VARIOUS	47,683	
b. Disposals (attach schedule)					(17,818)		(17,818)	(16,389)	SL	VARIOUS	689	
c. Acquired during this report period (attach schedule)					5,264		5,264		SL	VARIOUS	332	
D-3. Subtotal												59,821
E. ***Total Depreciation***												187,652

Schedule of Land Improvements Acquired during this report period

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

***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:					
Total additions for Building Improvement		$ -		$ -	*
Deletions:					
Total deletions for Building Improvement		$ -		$ -	**

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

****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
11/14/2018	AIR CONDITIONER	$ 17,773	10	$ 1,703	
10/14/2018	PATIO/ROOF REPAIR	$ 22,456	25	$ 898	
Total additions for Non-Movable Equipmen		$ 40,229		$ 2,601	*
Deletions:					
Total deletions for Non-Movable Equipmen		$ -		$ -	**

***Ties to Page 23, Line C3**

****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
1/16/2019	KITCHEN FURNITURE	$ 1,237.07	10	$ 93	
3/1/2019	KITCHEN FURNITURE	$ 1,176.87	10	$ 69	
7/7/2019	SAFAVIEH HOME - RUG FOR FILOSA LOBBY	$ 2,850.18	7	170	
Total additions for Movable Equipmen		$ 5,264		$ 332	*
Deletions:					
	SEE ATTACHED	$ (17,818)	VARIOUS	$ 689	
Total deletions for Movable Equipmen		$ (17,818)		$ 689	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
12/1/2018	COMMERCIAL DOOR AND HARDWARE	$ 3,962	10	$ 330	
4/1/2019	REPLACE FAILED BOILER CONTROL	$ 5,177	15	$ 173	
7/1/2019	23K PATENT GOLD LEAF REFURBISH SIGN	$ 1,303	5	$ 109	
8/1/2019	SUPPLY AND INSTALL 19 REPLACEMENT INSULATED UNITS	$ 4,627	10	$ 77	
Total additions for Leasehold Improvemer		$ 15,069		$ 688	*
Deletions:					
Total deletions for Leasehold Improvemer		$ -		$ -	**

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2019	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period			VARIOUS	840,669	438,299	SL	VARI	83,522	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)			VARIOUS	15,069				688	
C-4. Subtotal									84,210
D. ***Total Amortization***									84,210

* 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.

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CSP-25 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHA	461-C	9/30/2019	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ⊙ Yes ○ No

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	1995 MAJOR RENOVATION
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	1947
5. Total Licensed Bed Capacity	64
6. Square Footage	39,605
7. Acquisition Cost	
a. Land	398,123
b. Building	4,835,483

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	FIXED			
b. Date Mortgage Obtained	12/22/16			
c. Interest Rate for the Cost Year	3.31%			
d. Term of Mortgage (number of years)	10			
e. Amount of Principal Borrowed	2,476,000			
f. Principal balance outstanding as of 9/30/2019				
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.

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REH	461-C	9/30/2019	26 | 37

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

(*Carry Subtotals forward to next page*)

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CSP-27 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND RE	461-C	9/30/2019	27 | 37

Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		$	226	226		
A. Item	Rate	Amount				
MAINTENANCE VEHICLE	6.00%	35,813				
Lender						
FORD MOTOR CREDIT						
Address of Lender						
PO BOX 220564PITTSBURGH, PA 15257						
2. Other (*Specify*)		$	6,878	6,878		
A. Item	Rate	Amount				
SEE ATTACHED						
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		$	7,104	7,104		
12. D. Other Interest Expense (*Specify*)		$	9,488	9,488		
SEE ATTACHED						
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)		$	16,592	16,592		
14. Insurance						
a. Insurance on Property (buildings only)		$	799	799		
b. Insurance on Automobiles		$	2,932	2,932		
c. Insurance other than Property (as specified above)						
1. Umbrella (*Blanket Coverage*)		$	7,379	7,379		
2. Fire and Extended Coverage		$	23,977	23,977		
3. Other (*Specify*)		$	7,384	7,384		
SEE ATTACHED						
14d. ***Total Insurance Expenditures (14a + b + c)***		$	42,471	42,471		
15. ***Total All Expenditures (A-13 thru C-14)***		$	7,205,649	7,205,649		

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CSP-28 Rev. 9/2018

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2019	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $	2,268	2,268		
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.	15	1c	Bad Debts $	18,966	18,966		
10.			Accounting $				
10a.			Legal $	2,335	2,335		
11.			Telephone $				
12.	15	1h2	Cellular Telephone $	808	808		
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.	16	L3	Gifts, flowers and coffee shops $	6,833	6,833		
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 * $	1,325	1,325		
19.	15	K1	Income Tax / Corporate Business Tax $	27,065	27,065		
20.	16	10	Fund Raising / Contributions $	200	200		
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	1,097	1,097		
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) $	60,897	60,897		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	A2	ADMINISTRATOR ALLOWANCE ADJUSTMENT	$ 2,268		
Total Other Salaries Adjustment			$ 2,268	$ -	$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M/13	MISCELLANEOUS EXPENSE	$ (30)		
16	M/13	BANK SERVICE CHARGES	$ 2,673		
16	M/13	RESIDENT RELATED MISC EXP	$ 240		
16	M/13	LOSS ON DISPOSED EQUIPMENT	$ 1,269		
15	1/A/4	FICA ON DISALLOWED SALARIES	$ 174		
15	1/A/1	WORKMENS COMPENSATION REFUND	$ (3,229)		
Total Other A&G Adjustments			$ 1,097	$ -	$ -

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CSP-29 Rev. 9/2018

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2019	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	60,897	60,897		
Page 20 - Resident Care Supplies***								
27.	20	5a2	Prescription Drugs	$	29,413	29,413		
28.			Ambulance/Limousine	$				
29.			X-rays, etc	$				
30.	20	5h	Laboratory	$	772	772		
31.	20	5c	Medical Supplies	$	6,952	6,952		
32.	20	5e2	Oxygen (non emergency)	$	4,603	4,603		
33.	13		Occupational Therapy	$				
34.			Other - See Attached Schedule	$	549	549		
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$				
36.			Depreciation on Unallowable Motor Vehicles	$				
37.			Unallowable Property and Real Estate Taxes	$				
38.			Rental of Building Space or Rooms	$				
39.			Other - See Attached Schedule	$				
Page 27 - Insurance								
40.			Mortgage Insurance	$				
41.	27		Property Insurance	$	4,839	4,839		
Other - Miscellaneous								
42.			Other - Indirect	$				
43.			Interest Income on Account Rec.	$				
44.			Other - Miscellaneous Administrative	$	586	586		
45.			Management Fees Direct	$				
46.			Management Fees Indirect	$				
47.			Other - Direct	$				
Not For Profit Providers Only								
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	$				
49.	***Total Amount of Decrease (Items 1 - 48)***			$	108,611	108,611		

*** 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.

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5/L	TECH. COMPONENT PART A CHARGES	$ 549		
Total Other Ancillary Costs			$ 549	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)

Total Other Adjustments			$ -	$ -	$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	12d	FINANCE CHARGES	$ 586		
Total Other Adjustments			$ 586	$ -	$ -

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABI	461-C	9/30/2019	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	7,403,670	7,403,670		
b. Medicaid Room and Board Contractual Allowance **	$	(3,469,145)	(3,469,145)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	518,400	518,400		
b. Medicare Room and Board Contractual Allowance **	$	202,734	202,734		
4. a. Private-Pay Residents and Other	$	2,491,500	2,491,500		
b. Private-Pay Room and Board Contractual Allowance **	$	(56,524)	(56,524)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	64,033	64,033		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(56,865)	(56,865)		
c. Prescription Drugs - Non-Medicare	$	17,990	17,990		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(17,990)	(17,990)		
2. a. Medical Supplies - Medicare	$	4,877	4,877		
b. Medical Supplies - Medicare Contractual Allowance **	$	(4,877)	(4,877)		
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	167,324	167,324		
b. Physical Therapy - Medicare Contractual Allowance **	$	(117,665)	(117,665)		
c. Physical Therapy - Non-Medicare	$	16,057	16,057		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(16,057)	(16,057)		
4. a. Speech Therapy - Medicare	$	30,907	30,907		
b. Speech Therapy - Medicare Contractual Allowance **	$	(11,332)	(11,332)		
c. Speech Therapy - Non-Medicare	$	6,104	6,104		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(6,104)	(6,104)		
5. a. Occupational Therapy - Medicare	$	158,441	158,441		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(121,605)	(121,605)		
c. Occupational Therapy - Non-Medicare	$	17,753	17,753		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(17,753)	(17,753)		
6. a. Other *(Specify)* - Medicare	$	(746)	(746)		
b. Other *(Specify)* - Non-Medicare	$	(2,975)	(2,975)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	7,200,155	7,200,155		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	1,593	1,593		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	4,720	4,720		
V. Total Other Revenue (1 thru 8)	$	6,313	6,313		
VI. Total All Revenue (III +V)	$	7,206,468	7,206,468		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30	SEQUESTER REDUCTION MEDICARE B	$ (3,819)		
30	PRIOR YEAR ADJUSTMENT	$ 3,073		
Total Other Resident Revenue - Medicare		$ (746)	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30/II6b	PRIOR YEAR ADJUSTMENT	$ (2,975)		
Total Other Resident Revenue		$ (2,975)	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30/IV5	BANK INTEREST		$ 145		
30/IV5	INTEREST ON ACCOUNTS RECEIVABLE	-	$ 1,448		
Total Interest Income			$ 1,593	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30/IV8	NON EMERGENCY FACILITY VAN TRANSPORT	$ 1,735		
30/IV8	CREDIT CARD CASH REWARDS	$ 2,985		
Total Other Revenue		$ 4,720	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHAI	461-C	9/30/2019	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 13,452
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 478,815
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 64,043
a. INSURANCE		40,665		
b. CORPORATE INCOME TAX		864		
c.				
d. See Schedule		22,514		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 556,310
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	855,738		$ 333,229
	Accum. Depreciation	522,509	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	612,224		$ 221,922
	Accum. Depreciation	390,302	Net	
7. Motor Vehicles	*Historical Cost	44,463		$
	Accum. Depreciation	44,463	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 555,151

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	5d	MAINTENANCE	$ 9,465
31	5d	HEALTH INS	$ 9,260
31	5d	OFFICE	$ 3,788
Total Prepaid Expenses			$ 22,514

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

Page Ref	Line Ref	Description	
Total Other Current Assets (Itemize)			$ -

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

Page Ref	Line Ref	Description	
Total Other Other Fixed Assets (Itemize)			$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHA	461-C	9/30/2019	32	37

Account				Amount
		Total Brought Forward:	$	1,111,460
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			$	
2. Land Improvements	*Historical Cost			
	Accum. Depreciation	Net	$	
3. Buildings	*Historical Cost	4,835,483		
	Accum. Depreciation	3,165,473 Net	$	1,670,010
4. Non-Movable Equipment	*Historical Cost	127,283		
	Accum. Depreciation	8,406 Net	$	118,877
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)			$	1,788,887
D. Investment and Other Assets				
1. Deferred Deposits			$	
2. Escrow Deposits			$	
3. Organization Expense	*Historical Cost			
	Accum. Depreciation	Net	$	
4. Goodwill (Purchased Only)			$	
5. Investments Related to Resident Care (*itemize*)			$	
6. Loans to Owners or Related Parties (*itemize*)			$	
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)			$	96,701
BED LICENSES		48,001		
DEFERRED TAXES		48,700		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)			$	96,701
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$	2,997,049

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITA	461-C	9/30/2019	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 352,260
2. Notes Payable (*itemize*)					$
See Schedule					
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$ 70,971
	Name of Lender	Purpose	Amount	Date Due	
	SEE ATTACHED		70,971		
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)					$ 1,925
5. Accrued Payroll (*Owners and/or Stockholders only*)					$ 186,742
6. Accrued Payroll Taxes Payable					$ 14,562
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 149,859
LINE OF CREDIT 134,771					
ACCRUED EXPENSES 15,088					
See Schedule					
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 776,318

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILI	461-C	9/30/2019	34	37

Account	Amount
Total Brought Forward:	776,318
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$ 44,808

Name of Lender	Purpose	Amount	Date Due
SEE ATTACHED		44,808	

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ 128,601

Name and Address of Lender	Amount	Loan Date
HANCOCK HALL, 31 STAPLES ST, DANBURY, CT	128,601	

4. Other Long-Term Liabilities (*itemize*)	$
See Schedule	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 173,409
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 949,727

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHA	461-C	9/30/2019	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	$ 1,795,841
3.	Reserve for depreciation value of leased personal property (*Equity)*	$
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	$ 1,795,841
B.	**Net Worth**	
1.	Owner's Capital	$
2.	Capital Stock	$ 90,310
3.	Paid-in Surplus	$ 183,510
4.	Treasury Stock	$
5.	Cumulated Earnings	$ (23,158)
6.	Gain or Loss for Period 10/1/2018 thru 9/30/2019	$ 819
7.	Total Net Worth	$ 251,481
C.	***Total Reserves and Net Worth***	$ 2,047,322
D.	***Total Liabilities, Reserves, and Net Worth***	$ 2,997,049

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHAB	461-C	9/30/2019	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2018			$ 250,662
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 7,206,468
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 7,205,649
D.	Net Income or Deficit			$ 819
E.	Balance			$ 251,481
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period*** 09/30/19			$ 251,481

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND	461-C	9/30/2019	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
BENJAMIN CHIANESE, CPA

Addres Address	Phone Number
31 STAPLES STREET	203-794-9466

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
BENJAMIN CHIANESE, CPA	203-794-9466

Contact Email Address
Bchianese@filosa.com