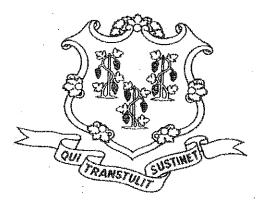
### **State of Connecticut**





DEC 1.5 2015

### Annual Report of Long-Term Care Facility MYERS & STAUFFER LC

Cost Year 2015

		C,	ost i vai 2	UIJ				
				Γ	PE	CEIVE	()	!
Name of Facility (as I	icensed)						- A F	
TERESA REST HON	Æ INC				DE	c 7 21	)15	
Address (No. & Stree				ļ		_		
57 MAIN ST. EAST	HAVEN, CT 0	6512			L	OF SOCIAL S	SERVIC	TTINGS
Type of Facility					OFFICE OF	CON AND IT	A11 1.2	
Chronic and C	onvalescent		Rest Home wit	h Nursing				
☐ Nursing Home	only		Supervision on	ly	V	Residenti	al Ca	re Home
(CCNH)			(RHNS)					
Report for Year Begin	nning		Report for Yea	r Ending				
10/1/2014	Ü		9/30/2015					
License Numbers:		CCNH 1767	RHNS	Reside	ential Care	Home	Ме	dicare Provider
Medicaid Provider N	umbers:	CC	NH	RI	INS		IC	F-IID
For Department Use	e Only							
Sequence Number	Signed and	Date	Sequence N		Signed a	ınd Notari	zeđ	Date Received
Assigned	Notarized	Received	Assign	ed	Digited	mig i (Vill)		240 110001104

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### **Annual Report of Long-Term Care Facility**

CSP-1 Rev.9/2002

### **General Information**

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
TERESA REST HOME INC	1767	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 TERESA REST HOME INC [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)		Date	Signed (Owner)	Date
Noveen Espas	ito	24-15	Josephin Hanto	13-4-15
Printed Name (Administrator) DOREEEN ESPOSITO			Printed Name (Owner) JOSEPHINE SANTINO	
Subscribed and Sworn to before me:	State of Connecticut	Date (2 · Y - 15	Signed (Notary Public)	Comm. Expires SHOW EXPIRES APRIL 30
Address of Notary Public	Have Co	71105	7.2	

(Notary Seal)

2020

### State of Connecticut Department of Social Services

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	tm	ent		Page 1A	of 37
Name of Facility		Period Cov	ered:	From	То
TERESA REST HOME INC				10/1/2014	9/30/2015
Address of Facility 57 MAIN ST. EAST HAVEN, CT 06512					
Report Prepared By		Phone Num		Date	
PETER SANTINO		203-824-13	31	11/25/2015	
			COMM	DIDIG	Residentia 1 Care
Item		Total	CCNH	RHNS	Home
1. Dietary wages paid	\$	32,251			32,251
2. Laundry wages paid	\$	2,953			2,953
3. Housekeeping wages paid	\$	28,344			28,344
4. Nursing wages paid	\$				
5. All other wages paid	\$	206,570			206,570
6. Total Wages Paid	\$	270,118			270,118
7. Total salaries paid	\$				
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$	#VALUE!			]]/////////////////////////////////////

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

·	Di-	na No af Eas	ility	Report for Yea	ar Ended	Page	of
		ne No. of Fac -467-0836	mity	9/30/2015	ai Liided	2	37
AT CD - 124 (co. d	203		R	Street, City, Sta	te, Zin		
Name of Facility (as shown on license) TERESA REST HOME INC				AST HAVEN,		2	
TERESA REST HOME INC CCNH				dential Care Ho		Medicare I	Provider No.
License Numbers: 176	57						
Type of Facility (Check appropriate box(es))							
Chronic and Convalescent  Nursing Home only (CCNH)		t Home with ervision only			Resident	ial Care Hor	ne
Type of Ownership (Check appropriate box)		<del></del>					
O Proprietorship O LLC O Partnership	•	Profit Corp.	0	Non-Profit Cor		Government	O Trust
			Date	e Opened	Date Clo	sed	
If this facility opened or closed during report year prov	ride:						
Has there been any change in ownership				N	TEUSZ: "	Lorrelain C.11	1.,
or operation during this report year?		Yes	<u> </u>	No	it "Yes,'	explain full	ıy.
Administrator	<del></del>						
Name of Administrator				Nursing H			
DOREEN ESPOSITO				Administra	į.		
				License	No.:		
Other Operators/Owners who are assistant administrat	ors (fu	ll or part time	e) of	this facility.	No :		
Name				License 1	110.:		
						<u>.</u>	

### General Information and Questionnaire Partners/Members

Name of Facility TERESA REST HOME INC		License No. 1767	Report for Y 9/30/2015		Page of 3 37
Legal Name of Partr	nership/LLC	Business A	Address	State(s) and/o Which R	or Town(s) in egistered
Name of Partners/Members	Business A	ddress	,	Title	% Owned

### General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year E	nded	Page	of
TERESA REST HOME INC	1767	9/30/2015		3A	37
If this facility is owned or operated as a corp	poration, provide	the following informa	ation:		
Legal Name of Corporation		ness Address	State(s) in Which	ch Incorp	orated
TERESA REST HOME INC.	57 MAIN ST		CT. 06512		
	, .		m'u	No. Sl	hares
Name of Directors, Officers	Busii	ness Address	Title	Held by	/ Each
JOSEPHINE SANTINO	57 MAIN ST F	EAST HAVEN, CT	PRESIDENT	5(	)
JOSEPHINE SANTINO	06512	MOT IMATELLA, CI	TRUSTBERT	,	
PETER SANTINO	67 TOWNSEN		TREASURER		
	HAVEN CT. 0	90312			
DOREEN ESPOSITO	57 MAIN ST.	EAST HAVEN, CT	SECTY		
	06512				
Names of Stockholders Owning at Least					
10% of Shares					
JOSEPHINE SANTINO	57 MAIN ST I	EAST HAVEN, CT		5	0
JOSEI III (E SPECIAL)	06512	,			
			·		
			-		
					<del></del>

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

### General Information and Questionnaire Individual Proprietorship

Name of Facility TERESA REST HOME INC	License No. 1767	Report for Year Ended 9/30/2015	Page of 3B 37
If this facility is owned or operated as an individu	al proprietorship	provide the following informa	
1) this facility is owned of operated as an individual	vner(s) of Facility		
	viier(b) of x definey		
			,
·			

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

### General Information and Questionnaire Related Parties\*

Name of Facility TERESA REST HOME INC		License No	No. 1767	Report for Year Ended 9/30/2015		Page 4	of 37
	And the second s						7
Are any individuals receirmarriage, ability to contro	Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?	cility re	ated through	Yes O No	If "Yes," provide the Name/Address and complete the information on Page 11 of the report.	e Name/Add	ress and ge 11 of the report.
Are any individuals or co	Are any individuals or companies which provide goods or services,	or servi	es,				
including the rental of prorelated through family as	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?	to this fa , control of this fi	cility, or business cility?	• Yes O No	If "Yes," provide the following information:	e following i	nformation:
association to any or any	T Comment						
		Als	Also Provides		Indicate Where Costs are Included		
Name of Related	Business	Non-R	Non-Related Parties	Descriptic	in Annual Report	Cost	Actual Cost to the
any	Address	Yes	No %**	Provided	Page # / Line #	Keported	Neialed I any
	67 TOWNSEND AVE NEW HAVEN, CT 06512	0	0	ACCTG, TAXES & COST REPORT	15/37D	5,000	5,000
OSFPH SANTINO	63 MAIN ST EAST HAVEN, CT 06512	•	0	LAWN AND GENERAL MAINT	22/6A	1,765	1,765
		0	0				
		0	0				
		0	0				
		0	0				
		0	0				
		0	0				
		0	0				
	,						

<sup>\*</sup> Use additional sheets if necessary.

<sup>\*\*</sup> 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
TERESA REST HOME INC	1767		9/30/2015	5	37
If the facility is licensed as CDH and/or RCH of	or provides A	AIDS or TB	I services with special Medic	caid rates,	costs
must be allocated to CCNH and RHNS as follo	ows:				
Item			Method of Allocation	on	
Dietary		Number of	f meals served to residents		
Laundry		Number o	f pounds processed		
Housekeeping			f square feet serviced		
Troubertoop		Number o	f hours of routine care provide	led by EAC	CH
Nursing		employee	classification, i.e., Director (	or Charge	Nurse),
, , , , , , , , , , , , , , , , , , ,		Registered	Nurses, Licensed Practical	Nurses, Ai	des and
		Attendant			
Direct Resident Care Consultants		Number o	f hours of resident care provi	ided by EA	CH
			(See listing page 13)		
Maintenance and operation of plant		Square fee	et		100
Property costs (depreciation)		Square fee	et		
Employee health and welfare		Gross sala			
Management services			ite cost center involved		
All other General Administrative expenses			Direct and Allocated Costs		
The preparer of this report must answer the fo	llowing ques	stions appli	cable to the cost information	provided.	
1. In the preparation of this Report, were all		O No	If "No," explain fully why	such alloca	ition was
costs allocated as required?		O No	not made.		
2. Explain the allocation of related company of	expenses and	l attach cor	y of appropriate supporting	data.	
a, baptan at			<del></del>		
3. Did the Facility appropriately allocate and	self-disallov	v direct and	I indirect costs to non-nursin	g home cos	st centers?
(e.g., Assisted Living, Home Health, Outpo	atient Servic	es, Adult I	Day Care Services, etc.)		
(0,8., 165)5664 Elimb, 175			If "No," explain fully why	such alloc	ation was
	O Yes	O No	not made.		
	<u>.</u>		not maue.		
		<del></del>			

Annual Report of Long-Term Care Facility State of Connecticut CSP-6 Rev. 9/2002

### General Information and Questionnaire Leases (Excluding Real Property)

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

should not be included in these amounts.					,		
Name of Facility			License No.	Report for Year Ended	ear Ended		_ (1)
TERESA REST HOME INC			1767	9/30/2015			6   37
	Related * to	d * to					
	Owners,	ers,				,	
	Operators, Officers	itors,		Date of	Term of	Amount	Amount
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	ofLease	Claimed
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
Is a Mileage Log Book Maintained for All Leased Vehicles?	Leased V	ehicles	? O Yes		O No	Total ***	

Is a Mileage Log Book Maintained for All Leased Vehicles?

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

<sup>\*\*</sup> Attach copies of newly acquired leases.

<sup>\*\*\*</sup> Amount should agree to Page 22, Line 6e.

### Annual Report of Long-Term Care Facility

CSP-7 Rev. 6/95

### General Information and Questionnaire Accounting Basis

ama of Engility	icense No.	Report for Year Ended	Page o
EDESA REST HOME INC	1767	9/30/2015	7 3
he records of this facility for the per	iod covered by this re	port were maintained on the following bas	is:
_	Modified Cash		
	TOUTHEU CASH		
the accounting basis for this	Ina	If "No," explain.	
eriod the same as for the O Y		n 140, oaptani	_
revious period? O N	10		
ndependent Accounting Firm			
lame of Accounting Firm	<del></del>	Address (No. & Street, City, State, 2	Zip Code)
ACCTG & FINANCIAL SVS		67 TOWNSEND AVE NEW H	AVEN, C1 00312
·			
Services Provided by This Firm (desc			d C.000
P/R TAXES, FORMS, COST REPOR	RT & TAX RETURNS		\$ 5,000
			\$
			\$
			\$
			Charge for Services Provid
			_
			\$ 5,000
are These Charges Reflected in the Expend	liture Portion of This Repo	ort? If Yes, Specify Expense Classification and Line	\$ 5,000
⊙ Yes O No	liture Portion of This Repo 15/37D	ort? If Yes, Specify Expense Classification and Line	\$ 5,000
	15/37D	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.
	15/37D	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.  Telephone Number
	15/37D	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.
	15/37D	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.  Telephone Number
<ul> <li></li></ul>	15/37D	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.  Telephone Number
<ul> <li>         O No</li></ul>	15/37D	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.  Telephone Number
<ul> <li>Yes O No</li> <li>Legal Services Information</li> <li>Name of Legal Firm or Independent</li> <li>ALFRED ZULLO</li> <li>3</li> <li>4</li> <li>5</li> </ul>	Attorney	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.  Telephone Number
O Yes O No  Legal Services Information  Name of Legal Firm or Independent  ALFRED ZULLO  2  3  4  5  Address (No. & Street, City, State, 2	Attorney  Zip Code)	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.  Telephone Number
O Yes O No  Legal Services Information  Name of Legal Firm or Independent  ALFRED ZULLO  2  3  4  5  Address (No. & Street, City, State, 2  1 83 MAIN ST EAST HAVEN, 0	Attorney  Zip Code)	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.  Telephone Number
<ul> <li>Yes O No</li> <li>Legal Services Information</li> <li>Name of Legal Firm or Independent</li> <li>ALFRED ZULLO</li> <li>3</li> <li>4</li> <li>5</li> <li>Address (No. &amp; Street, City, State, Z</li> <li>1 83 MAIN ST EAST HAVEN, C</li> </ul>	Attorney  Zip Code)	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.  Telephone Number
<ul> <li>Yes O No</li> <li>Legal Services Information</li> <li>Name of Legal Firm or Independent</li> <li>1 ALFRED ZULLO</li> <li>2</li> <li>3</li> <li>4</li> <li>5</li> <li>Address (No. &amp; Street, City, State, Z</li> <li>1 83 MAIN ST EAST HAVEN, C</li> <li>2</li> <li>3</li> </ul>	Attorney  Zip Code)	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.  Telephone Number
<ul> <li>Yes O No</li> <li>Legal Services Information</li> <li>Name of Legal Firm or Independent</li> <li>ALFRED ZULLO</li> <li>3</li> <li>4</li> <li>5</li> <li>Address (No. &amp; Street, City, State, Z</li> <li>1 83 MAIN ST EAST HAVEN, C</li> <li>2</li> <li>3</li> <li>4</li> <li>5</li> </ul>	Attorney  Zip Code ) CT	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.  Telephone Number
<ul> <li>Yes O No</li> <li>Legal Services Information</li> <li>Name of Legal Firm or Independent</li> <li>ALFRED ZULLO</li> <li>3</li> <li>4</li> <li>5</li> <li>Address (No. &amp; Street, City, State, Z</li> <li>1 83 MAIN ST EAST HAVEN, C</li> <li>2</li> <li>3</li> <li>4</li> <li>5</li> </ul>	Attorney  Zip Code ) CT	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.  Telephone Number 206-467-1411
<ul> <li>Yes O No</li> <li>Legal Services Information</li> <li>Name of Legal Firm or Independent</li> <li>1 ALFRED ZULLO</li> <li>2</li> <li>3</li> <li>4</li> <li>5</li> <li>Address (No. &amp; Street, City, State, Z</li> <li>1 83 MAIN ST EAST HAVEN, C</li> <li>2</li> <li>3</li> <li>4</li> <li>5</li> </ul>	Attorney  Zip Code ) CT	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.  Telephone Number 206-467-1411
<ul> <li>Yes O No</li> <li>Legal Services Information</li> <li>Name of Legal Firm or Independent</li> <li>1 ALFRED ZULLO</li> <li>2</li> <li>3</li> <li>4</li> <li>5</li> <li>Address (No. &amp; Street, City, State, Z</li> <li>1 83 MAIN ST EAST HAVEN, C</li> <li>2</li> <li>3</li> <li>4</li> <li>5</li> <li>Services Provided by This Firm (de</li> </ul>	Attorney  Zip Code ) CT	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.  Telephone Number 206-467-1411
O Yes O No  Legal Services Information  Name of Legal Firm or Independent  ALFRED ZULLO  2 3 4 5 Address (No. & Street, City, State, 2 1 83 MAIN ST EAST HAVEN, 0 2 3 4 5 Services Provided by This Firm (de 1 ALL LEGAL MATTERS	Attorney  Zip Code ) CT	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.  Telephone Number 206-467-1411  \$ \$ \$ \$ \$
<ul> <li></li></ul>	Attorney  Zip Code ) CT	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.  Telephone Number 206-467-1411  \$ \$ \$ \$ \$ \$ \$ \$
<ul> <li></li></ul>	Attorney  Zip Code ) CT	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.  Telephone Number 206-467-1411  \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
<ul> <li></li></ul>	Attorney  Zip Code ) CT	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.  Telephone Number 206-467-1411  \$ \$ \$ \$ \$ \$ \$ \$
<ul> <li></li></ul>	Attorney  Zip Code ) CT	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.  Telephone Number 206-467-1411  \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
O Yes O No  Legal Services Information  Name of Legal Firm or Independent  ALFRED ZULLO  3  4  5  Address (No. & Street, City, State, 2  1 83 MAIN ST EAST HAVEN, 0  2  3  4  5  Services Provided by This Firm (de  1 ALL LEGAL MATTERS  2 COURT APPEARANCES  3  4  5	Attorney  Zip Code)  CT  scribe fully)		\$ 5,000 e No.  Telephone Number 206-467-1411  \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
O Yes O No  Legal Services Information  Name of Legal Firm or Independent  ALFRED ZULLO  3  4  5  Address (No. & Street, City, State, 2  1 83 MAIN ST EAST HAVEN, 0  2  3  4  5  Services Provided by This Firm (de  1 ALL LEGAL MATTERS  2 COURT APPEARANCES  3  4  5	Attorney  Zip Code)  CT  scribe fully)	ort? If Yes, Specify Expense Classification and Line	\$ 5,000 e No.  Telephone Number 206-467-1411  \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 9/2002

## Schedule of Resident Statistics

Total All CCNH RHNS Residential CCNH RHNS Residential Levels Level Level Care Home Total Officential Levels Level Level Care Home Total Officential CCNH RHNS Residential CCNH RHNS Residential CCNH Capacity asy of PREVIOUS report period 22 22 22 22 22 22 22 22 22 22 22 22 22	Name of Facility			License No.	<u>7</u> 0.			Report fo	Report for Year Ended	ģ		Page	jo
Total All CCNH RHNS Residential Level Care Home	TERESA REST HOME INC			_	191			9/30/201:	10			8	37
Certified Bed Capacity         Total All CCNH         RHNS         Residential Residential Total Auru Floor period         22 </th <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th>Period 10,</th> <th>/1 Thru 6/</th> <th>30</th> <th></th> <th>Period 7/</th> <th>Period 7/1 Thru 9/30</th> <th>0</th>							Period 10,	/1 Thru 6/	30		Period 7/	Period 7/1 Thru 9/30	0
Certiffed Bed Capacity         22         22         22           A. On last day of PREVIOUS report period         22         22         22           B. On last day of THIS report period         22         22         22           Number of Residents         22         22         22           A. As of midnight of PREVIOUS report period         22         22         22           B. As of midnight of PREVIOUS report period         22         22         22           A. As of midnight of PREVIOUS report period         22         22         22           B. As of midnight of PREVIOUS report period         22         22         22           A. As of midnight of PREVIOUS report period         22         22         22           B. As of midnight of THIS report period         22         22         22           A. Medicare         B. Medicare         B. Medicare         B. Medicare         B. Medicare           B. Medicare         B. Medicare         A45         A45         A45         A45           C. Medicald (other states)         A45         A45         A45         A45         A45           E. State SSI for RCH         B. A34         B. A34         B. A34         B. A34         A304         A45			Total CCNH Level	Total RHNS Level	Total Residential Care Home	Total	CCNH	RHNS	Residential Care Home	Total	CCNH	RHNS	Residential Care Home
B. On last day of THIS report period       22       22       22         Number of Residents       22       22       22         A. As of midnight of PREVIOUS report period       22       22       22         B. As of midnight of THIS report period       22       22       22         Total Number of Days Care Provided During Period       22       22       22         B. As of midnight of THIS report period       22       22       22         Cotal Number of Days Care Provided During Period       445       27       22         B. Medicaid (Conn.)       445       274       274         C. Medicaid (other states)       445       574       274         D. Private Pay       445       574       274         E. State SSI for RCH       7,589       6,030       27         F. Other (Specify)       6. Total Care Days During Period (3A thru F)       8,034       6,304       6,304         Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved       8,034       8,034       8,034       8,304	Certified Bed Capacity     A. On last day of PREVIOUS report period	22			22	22			22	22			22
Number of Residents         22         22         22           A. As of midnight of PREVIOUS report period         22         22         22           B. As of midnight of THIS report period         22         22         22           Total Number of Days Care Provided During Period         22         22         22           A. Medicare         A. Medicare         22         22         22           B. Medicare         A. Medicare         23         24         24         24           C. Medicaid (other states)         445         445         274	B. On last day of THIS report period	22			22	22			22	22			22
B. As of midnight of THIS report period       22       22       22         Total Number of Days Care Provided During Period       22       22       22         A. Medicare       3       42       42       42         B. Medicaid (Conn.)       445       445       445       445         C. Medicaid (other states)       445       445       274       445         D. Private Pay       445       445       574       445         E. State SSI for RCH       7,589       6,030       6,030       6,030         F. Other (Specify)       G. Total Care Days During Period (3A thru F)       8,034       6,304       6,304       6,304         Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved       6,304       6,304       6,304       6,304	1	22			22	22			22	22			22
Total Number of Days Care Provided During Period       A. Medicare         A. Medicare       B. Medicaid (Conn.)         C. Medicaid (other states)       445         D. Private Pay       445         E. State SSI for RCH       7,589         F. Other (Specify)       6,030         G. Total Care Days During Period (3A thru F)       8,034         Total Number of Days Not Included in Figures in Total Number of Days Not Included in Figures in Total Number of Days Not Included in Reserved	B. As of midnight of THIS report period	22			22	22			22	22			22
A. Medicare	1												
B. Medicaid (Conn.)       Addicaid (Conn.)       Addicaid (other states)       Addicaid (other states)       Addicaid (other states)         C. Medicaid (other states)       445       274       Addicaid (other states)         D. Private Pay       7,589       6,030       Addicaid (other states)         F. Other (Specify)       8,034       8,034       6,304         G. Total Care Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved       3G for Which Revenue Was Received for Reserved	A. Medicare												
C. Medicaid (other states)       445       274       8030       445       274       445       445	B. Medicaid (Conn.)												
D. Private Pay       445       445       274         E. State SSI for RCH       7,589       6,030       Private SSI for RCH         F. Other (Specify)       8,034       8,034       6,304         G. Total Care Days During Period (3A thru F)       8,034       6,304       Private Single Sing	ı												
E. State SSI for RCH         7,589         6,030           F. Other (Specify)         6.334         6,304           G. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved         8,034         6,304	ı	445			445	274			274	171			171
F. Other (Specify)  G. Total Care Days During Period (3A thru F) 8,034 6,304  Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved	l	685,7			7,589	6,030			6,030	1,559			1,559
G. Total Care Days During Period (3A thru F) 8,034 6,304  Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved													
1	G. Total Care Days During Period (3A thru F)	8,034			8,034	6,304			6,304	1,730			1,730
	1								1188				
Beds	Beds						<b></b>						
- 1	A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days	- 1												
5. Total Resident Days (3G + 4A + 4B) 8,034 6,304 6,304 6,304		8,034			8,034	6,304			6,304	1,730			1,730

### CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Facil	lity			Licer	ise No.				Report	for Year		ļ	Page	of
TERESA RES	ST HOM	1E INC		1	1767					9/30/201	5		9	37
			in the certified b		pacity du	ring tl	he repo	rt yea	r?	0	Yes	•	No	
11 1175			Change		Ch	ange	in Bed	S		Car	pacity Afte	r Change		
		1 lace of	Residential											
Date of	CCNH	RHNS	Care Home		Lost		(	3aine	d					
Cit												Residential	_	
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Care Home	Reason fo	or Change
				<u> </u>										
								1						
5. If there v	was any	change	in certified bed	capac	ity during	the r	eport y	ear (a	s repor	ted in iter	n 4 aboye)	provide the nur	nber of	
RESIDI	ENT DA	YS for	90 days followii	ng the	change.									
														tial Care
[			Change in R	esider	nt Days					CC	CNH	RHNS	Нс	me
1st chan	ge													
2nd char														
3rd chan												<del></del>		
4th chan	ge	1	d Rates on Sept	amba	• 20 of Co	ot Va	or			<u> </u>				
6. Number	of Resi	uems an	Medicare	CITIOCI	Medi		aı	1		Se	elf-Pay		Other Sta	te Assisted
			Medicare		.,,,,,,,,	<u> </u>								
												Residential		
	Item		CCNH	(	CCNH	R	HNS	C	CNH	RI	HNS	Care Home	R.C.H.	ICF-MR
No. of R		s												
Per Dier	n Rate		4.5				11.11							
a. One	bed rm.					ļ								
b. Two	bed rms	S		ļ <u>-</u>		ļ <u>.</u>		ļ .						
c. Three		e												
bed	rms.		<u> </u>	ŀ		<u> </u>		<u> </u>						
														Residential
7 Total No	umber o	f Physic	al Therapy Trea	tment	· e					TC	TAL	CCNH	RHNS	Care Home
1		are - Pai												
			lusive of Part B	)										
			ce Treatments											
	2. Res	storative	Treatments											
	. Other													
			Therapy Treat								2211			
		if Speeci are - Pai	h Therapy Treat	ments										
			clusive of Part B	3										
, B			ce Treatments	,							-			
			Treatments											
C	. Other													
			Therapy Treatn							of many books a share a could be dead				
			ational Therapy	Treat	ments									
		are - Pa												
В			clusive of Part B	)								5 (F) (M		
			e Treatments							<del> </del>	·		-	
	2. Re	Siviative	110aunono											
		Оссира	tional Therapy	Treat	ments									

CSP-10 Rev. 9/2002

### Report of Expenditures - Salaries & Wages

Name of Facility	License No.		Report for Year		Page	of
TERESA REST HOME INC	1767		9/30/2015		10	37
Are time records maintained by all individuals receiving con	nensation?	•	Yes	0	No	
The time records internal and of			Total Cost a	nd Hours		
			7000	1101110		
					Residential	
Item	CCNH	Hours	RHNS	Hours	Care Home	Hours
A. Salaries and Wages*	to a contract of					
Operators/Owners (Complete also Sec. I					11,550	920
of Schedule A1)  2. Administrator(s) (Complete also Sec. III					11,550	920
of Schedule A1)					54,000	2,000
3. Assistant Administrator (Complete also Sec. IV						_,,
of Schedule A1)					*****************	100000000000000000000000000000000000000
4. Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)		WARRANT AND				
5. Dietary Service						
a. Head Dictition	-				21,245	1,300
b. Food Service Supervisor c. Dietary Workers		-			11,006	802
6. Housekeeping Service					11,500	002
a. Head Housekeeper		Santa S			22,102	1,473
b. Other Housekeeping Workers					6,242	567
7. Repairs & Maintenance Services		Tarring Co.				
a. Engineer or Chief of Maintenance						ļ
b. Other Maintenance Workers						
Laundry Service     a. Supervisor					2,953	211
b. Other Laundry Workers		<u> </u>			2,,500	
Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant			<del> </del> -	<u> </u>		
b. Other Accountants  12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses						
b. RN						
1. Direct Care		and the second s				
2. Administrative**						
c. LPN						
I. Direct Care		ļ				
2. Administrative** d. Aides and Attendants				1	124,101	8,715
e. Physical Therapists			<del></del>		124,101	0,713
f. Speech Therapists				1		
g. Occupational Therapists						
h. Recreation Workers					16,919	1,400
i. Physicians						
1. Medical Director	-	<u> </u>				
2. Utilization Review 3. Resident Care***		<del> </del>		<b>-</b>		
4. Other (Specify)						
j. Dentists		<b> </b>				
k. Pharmacists				-		
Podiatrists     M. Social Workers/Case Management		-		-		-
n. Marketing		<del> </del>				
o. Other (Specify)						
See Attached Schedule	2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2					
A-13. Total Salary Expenditures					270,118	17,388

<sup>\*</sup> 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.

<sup>\*\*</sup> 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.

<sup>\*\*\*</sup> 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	NH	RH	NS	Residential C	Care Home
•••	S S	Hours	S	Hours	\$	Hours
osition						
		**				
Potal	\$ -		\$ -		\$	

### Schedule of Other Fees (Page 13)

	NH	IX.	HNS	Residentia, v	Care Home
S CC		\$	Hours	S	Hours
				vicus in Asia.	
		t sen vistorio vist.			
e _		s -	-	\$ -	
	\$				

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	Assistant	Walling of	Administrators and Outer resucces a accept	TATATA			f	4
Name of Facility			•	License No.		Report for Year Ended	Year Ended		rage 	27
TERESA REST HOME INC				1767		9/30/2015			ī	37
A CONTRACTOR OF THE PROPERTY O		Salary Paid	đ							•
		5	Residential	Fringe Benefits and/or Other Payments	Full Description of	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
Name	CCNH	KHNS	Саге ноше	(describe tuny)	מבו גורכי ואמיומרובית	now io	22.00.1	, T		
Section I - Operators/Owners	:									
JOSEPHINE SANTINO	·		11,550		P/R & BOOKKEEPER	920	A1	NONE		
							•			
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).										
in the sadditional sheets if feduired.	1 he conside	- sodian pom	fill information	on is provided [Js	e additional sheets if rec	ouired.				

<sup>\*</sup> No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

<sup>\*\*</sup> Include all employment worked during the cost year.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

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

Assistant Administrators and Other Related Parties\*

Name of Pacilly (as licensed)   License No.   Report for Year Ended   Copy   Pacilly (as licensed)   License No.   Report for Year Ended   Copy   License No.   Report for Year Ended   Copy   License No.   Residential   Pacill Description of Hours   Pacill Description of Moread   License No.   Page 10   Other Employment**   Moread   Page 10   Other Employment**   Moread   Page 10   Other Employment**   Moread   Residential   Pacill Description of Moread   Page 10   Other Employment**   Moread   Page 10   Other Employmen			Ψ,	SSIStall	Adminisha	Assistant Administrators and Cura				Dogs	J.
Salary Paid   Pringe Benefits   Andrew Paid   Pringe Benefits   Pringe Benefits   Pringe Benefits   Pringe Benefits   Paymor Other   Pull Description of   Hours   Claimed on   Name and Address of All   Paymor Paid   Paymor Paymor Paid   Paymor Paymor Paymor Paymor Paymor Paymor Paymor Paymor Page 10   Other Employment**    S4,000   S4,000   2,000   A2   Page 10   Other Employment**	V				License No.		Report for Y	ear Ended		rago	j t
Salary Paid  Finge Benefits and/or Other and/or Other Residential Psyments Services Rendered Worked Page 10 Other Employment**  S4,000  S4,000  S4,000  S4,000  S4,000  S4,000  S6,000  S6,000	Name of Facility (as licensed)				1751		9/30/2015			12	37
Salary Paid  Finge Benefits  CCNH RHNS Care Home (describe fully) Services Rendered Worked S4,000  54,000  2,000 A2  2,000 A2	TERESA REST HOME INC				1/0/						
CCNH RHNS Care Home (describe fully) Services Rendered Worked Page 10 Other Employment**  54,000 Services Rendered Services Rendered Worked Page 10 Other Employment**  2,000 A2	A STATE OF THE PARTY OF THE PAR		Salary Pai	d.	1					_	
CCNH RHNS Care Home (describe fully) Services Rendered Worked Page 10 Other Employment**  54,000 2,000 A2  54,000 100 100 100 100 100 100 100 100 100					Fringe Benefits and/or Other		Total	Line Where	11 6 30 mm and a m	Total	Compensation
54,000	Name	CCNH	RHINS	Residential Care Home		Full Description of Services Rendered	Hours Worked	Claimed on Page 10	Name and Address of Ant Other Employment**	Worked	Received
54,000	Section III - Administrators***										
DOU'TE				7			2.000	A2			
Section IV - Assistant Administrators	DOREEN ESPOSITO			24,000			,				
Section IV - Assistant Administrators											
Section IV - Assistant Administrators											
Section IV - Assistant Administrators											
Section IV - Assistant Administrators											
Administrators	Section IV - Assistant										
	Administrators										
										_	
Position 3: 100 of 1 - 1111											
11:1 11:1.											
Lasting 4, not 1 11.2 2.11 1							_				
The considered unless full information is provided. Use additional surfaces at required.		The concid	and nules	e fiull informs	tion is provided. U	Ise additional sheets if	required.				

\*No allowance for salaries will be considered unless full information is pro

<sup>\*\*</sup> 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 Facility TERESA REST HOME INC	License No. 176		Report for Y 9/30/2015	ear Ended	Page 13	of   37
TEXAST TEXAS			Total Cost	and Hours		7401-107
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
*B. Direct care consultants paid on a fee						
for service basis in lieu of salary	Tarantan a					
(For all such services complete Schedule B1)		100				
1. Dietitian						
2. Dentist						
3. Pharmacist						
4. Podiatrist						
<ol><li>Physical Therapy</li></ol>			10000			
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)						
Staff Development Committee						
(Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						<u> </u>
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care				-		
2. Administrative***				<u> </u>		<u> </u>
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries						

<sup>\*</sup> 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.

<sup>\*\*</sup> 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.

<sup>\*\*\*</sup> 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 TERESA REST HOME INC	License No. 1767		Report for Yea 9/30/2015	ır Ended	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** Operato Yes	to Owners, rs, Officers	Expla	nation of Rela	
		0	0			
		0	0			
		0	0			
		0	0		<i>19.110-1</i>	
		0	0			
		0	0			
		0	0			
		0	0			
		0	0	.,		
		0	0			
		0	0			
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		0	0			
		0	0		4400	
		0	0			
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		0	0			• ==•· • •
		0	0			
		0	0		80° 80° 90° 1	
		0	0			

<sup>\*</sup> Use additional sheets if necessary.

<sup>\*\*</sup> Refer to Page 4 for definition of related.

### **Annual Report of Long-Term Care Facility**

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### C. Expenditures Other Than Salaries - Administrative and General

C. Expenditures Other Tha	cense No.	R	eport for Ye		Page	of
ERESA REST HOME INC	1767	9	/30/2015		15	37
						D: d - máio
					DIDIG	Residentia
Item			Total	CCNH	RHNS	Care Home
. Administrative and General						
a. Employee Health & Welfare Benefits		ā				10.74
Workmen's Compensation		\$	10,747			10,747
2. Disability Insurance		\$				5.400
3. Unemployment Insurance		\$	5,402			5,402
4. Social Security (F.I.C.A.)		\$	20,547			20,547
5. Health Insurance		\$	16,490			16,490
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	<del></del>	\$				
Profit Sharing Plans for Owners and						
Operators (Discriminatory)*						
c. Bad Debts*		\$				5.00
d Accounting and Auditing		\$	5,000			5,00
e. Legal (Services should be fully described of	n Page 7)	\$				
f. Insurance on Lives of Owners and		\$				
Operators (Specify)*						1.71
g. Office Supplies		\$	1,715			1,71
h. Telephone and Cellular Phones						4.00
1. Telephone & Pagers		\$	4,032			4,03
2. Cellular Phones		\$	1,630	)		1,63
i. Appraisal (Specify purpose and		\$				
attach copy)*				100	0.000000	0.0000000000000000000000000000000000000
_					de la companya di sa	
j. Corporation Business Taxes (franchise tax	()	\$				
k. Other Taxes (Not related to property - See	Page 22)					
1. Income*		\$				
2. Other (Specify)		\$				
See Attached Schedule	•					
3. Resident Day User Fee		\$				(5.5
Subtotal		9	65,56	3	btotals forwa	65,5

<sup>\*</sup> Facility should self-disallow the expense on Page 28 of the Cost Report.

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

TERESA REST HOME INC 9/30/2015

Attachment Page 15

### **Schedule of Other Employee Benefits**

Description	CCNH	RHNS	Residential Care Home
Description			
		All and the second seco	
	.0	\$ -	\$ -
Total	\$	<b>S</b>	<b>-</b>

### **Schedule of Other Taxes**

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

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

Name of Facility Licer	ise No.	Report for Y	ear Ended	Page	of
ERESA REST HOME INC	1767	9/30/2015		16	37
					Residentia
. Item		Total	CCNH	RHNS	Care Home
	ught Forward:	65,563			65,56
I. Travel and Entertainment					
Resident Travel and Entertainment	\$	7,955			7,955
Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4 Employee Travel	\$				
5. Education Expenses Related to Seminars and Co	nventions \$				0.15
6. Automobile Expense (not purchase or depreciat	ion) \$	<del></del>			2,15
7. Other (Specify)	\$				
See Attached Schedule					
m. Other Administrative and General Expenses					-
1 Advertising Help Wanted (all such expenses)					21
2. Advertising Telephone Directory (all such expen	ses )*** \$		ļ		61
3. Advertising Other (Specify)***	4				
See Attached Schedule					
4. Fund-Raising***	9			<u> </u>	
5. Medical Records					
6. Barber and Beauty Supplies (if this service is su	pplied	5			
directly and not by contract or fee for service)**	·*	155			47
7. Postage		475			$\frac{1}{71}$
* 8. Dues and Membership Fees to Professional	:	717			
Associations (Specify)					
See Attached Schedule		005			22
8a. Dues to Chamber of Commerce & Other Non-Allow		\$ 225			
9. Subscriptions		\$			
10. Contributions***		\$			
See Attached Schedule		0			
11. Services Provided by Contract (Specify and Con	nplete	\$			
Schedule C-2, Page 21 for each firm or individ	ual)	<b>A</b>			
12. Administrative Management Services**		\$ 1.055			12
13. Other (Specify)		\$ 1,368			1,3
See Attached Schedule		d 50000			79,2
C-14 Total Administrative & General Expenditures		\$ 79,283	3		19,2

<sup>\*</sup> Do not include Subscriptions, which should go in item 9.

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*\*</sup> Facility should self-disallow the expense on Page 28 of the Cost Report.

### Schedule of Other Travel and Entertainment

	CCNH	RIINS	Residential Care Home
Description			
			gradulisis gradus.
			AND THE STATE
	14.1. Bet. 1.1. A.V		
Total Other Travel and Entertainment	\$ -	\$	S

### Schedule of Other Advertising

			Residential
	CCNH	RHNS	Care Home
Description		SANTE YEAR	
	The second of th		STARSON FIRMS
			2 - 10 - 10 - 10 - 10 - 10 - 10 - 10 - 1
	\$ -	\$	\$ -
Total Other Advertising			

### Schedule of Dues

			Residential
Description	CCNH	RHNS	Care Home
CARCH	(4) 新建筑		\$ 550
CARCH			\$ 100
SURETY BOND	389, 259, 14 July 200	20000000000000000000000000000000000000	\$ 67
MEETINGS & SEMINARS	Production of State	**************************************	urikus saidika
		VALUE (1997)	
		605 Y 63 U UW 123	
			Control State
		2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 -	A
Total Dues	\$ -	\$	\$ /1/

### Schedule of Contributions

			Kesidentiai
The state of the s	CCNII	RHNS	Care Home
Description	attiviti jiridaya oʻrsi	All the control of the control of	300 min 100 min 100 min
		Neverther by	A 200 CO STATE OF CO. 11.
	1. (4.16) Fr. Hugh (1.17) (4.17)	SELECTION OF SELEC	12000 - 101301 000000 0000
	35000 - November 1970 - 1970 - 1970 - 1970 - 1970 - 1970 - 1970 - 1970 - 1970 - 1970 - 1970 - 1970 - 1970 - 19		A CONTRACTOR OF THE PARTY OF TH
	•	· .	The transfer of the second
	2		<b>Ψ.</b>
Total Contributions			

### Schedule of Other Administrative and General

The control of the co	CCNH	RHNS	Residential Care Home
Description			\$ 762
DATA PROCESSING			s 96
BANK SERVICE CHARGES	Service Services		2.2
LICENSE RENEWAL		Tegerija Kalegol	\$ 510
	ALBOYS TO		
		es istranto	1.350 PS 11.30 P
	ACE SEVELS		
Total Other Administrative and General	\$ -	\$ -	\$ 1,368

### Schedule C-1 - Management Services\*

Name of Facility	License No.	Report for Year Ended	Page of
TERESA REST HOME INC	1767	9/30/2015	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 #
1 7 117 0			
	-		

<sup>\*</sup> 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)

				1 Page 5)				r	
Name of Facility			l l			eport for Ye	ar Ended	Page	of
TER	ESA REST HOME INC			1767	<u> </u>	9/30/2015		18	37
								Resident	
	Item			Total		CCNH	RHNS	Ho	ne
2.	Dietary								
	a. In-House Preparation & Service								
	1. Raw Food		\$	69,192	丄				69,192
	2. Non-Food Supplies		\$	1,635					1,635
	3. Other (Specify)		\$		200 200 400				70000000000000
								-0.00000	
					4				
	b. Purchased Services (by contract other		\$						
i	than through Management Services)								
	(Complete Schedule C-2 att. Page 21)			100000000000000000000000000000000000000					
	c. Management Services**		\$		+				
	d. Other (Specify)		\$						
	Tatal Distance França diturnos (20 ± b ± 0 ± d)			70,827	+				70,827
2E.	Total Dietary Expenditures $(2a + b + c + d)$			70,827	+				
							DYD IG	Residen	
2F.	Dietary Questionnaire			Total	$\bot$	CCNH	RHNS	Но	me
G.	Resident Meals: Total no. of meals served per	r day	y:*						
H.	Is cost of employee meals included in 2E?	0	Yes	•	N	1o			
I.	Did you receive revenue from employees?	0	Yes	•	N	10	If yes, specify amt.		
J.	Where is the revenue received reported in the	Co	st Repo	rt? (Page/Line	e Ito	em)			
H	Is cost of meals provided to persons other						If was appoint		
K.	than employees or residents (i.e., Board	0	Yes	•	N	No	If yes, specify		
112.	Members, Guests) included in 2E?						cost.		
$\vdash$						_	If yes, specify		
L.	Is any revenue collected from these people?	O	Yes	•	) N	<b>V</b> 0	amt.		
M.	Where is the revenue received reported in the	Co	st Repo	rt? (Page/Line	e It	tem)			
<b>—</b>	Is cost of food (other than meals, e.g.,								
	snacks at monthly staff meetings, board	_	<b>3</b> 7	_		.T.,	If yes, specify		
N.	meetings) provided to employees included	Θ	Yes	. 0	) N	NO	cost.		
	in 2E?								
-						T	If yes, specify		
0.	Is any revenue collected from employees?	O	Yes	•	1 (	NO	amt.		
l <sub>D</sub>	Where is the revenue received reported in the	· Co	et Reno	rt? (Page/Line	e It	tem)			
Р.	where is the revenue received reported in the	. VC	or rept	TO THEOLDIN	~ .t	····· <i>)</i>			

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

<sup>\*\*</sup> 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 No. 1767			eport for Y 9/30/2015	ear Ended	Page 19	of   37
ERESA REST HOME INC		<del></del>	1707	╁	7,30,2010		Resid	ential Care
Item			Total		CCNH	RHNS		Home
<ul> <li>Laundry</li> <li>a. In-House Processing*</li> <li>1. Bed linens, cubicle curtains, draperies, gowns and other resident care items</li> </ul>		Lbs. Amt. \$						
washed, ironed, and/or processed.***								
Employee items including uniforms, gowns, etc. washed, ironed and/or		Lbs.						
processed.***		Amt. \$						<u>.                                    </u>
3. Personal clothing of residents		Lbs.		_				<u> </u>
washed, ironed, and/or processed.***		Amt. \$		+	,			
4. Repair and/or purchase of linens.***		Lbs. Amt. \$						
b. Purchased Services (by contract other	$\dashv$	\$		$\top$	<u></u>			
than through Management Services)								
(Complete Schedule C-2 att. Page 21)	_	\$						
c. Management Services**		\$		28				2,4
d. Other (Specify)		4	2,40					
SUPPLIES  3E. Total Laundry Expenditures (3a + b + c + d)		9	2,48	38				2,4
		<u> </u>						
<ul><li>3F. Laundry Questionnaire</li><li>G. Is cost of employee laundry included in 3E?</li></ul>	0	Yes	•	) 1	No	If yes, specify cost		
H. Did you receive revenue from employees?		Yes		•		If yes, specify amt.		. <u></u>
I. Where is the revenue received reported in the C	ost	Report	?		(Page/Lin	e Item)		<u> </u>
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?		Yes		<b>9</b> 7	No	If yes, specify cost	•	
K. Did you receive revenue from these people?	0	Yes	(	Э :	No	If yes, specify amt		
L. Where is the revenue received reported in the C	Cost	Report	t?		(Page/Lin	e Item)		

<sup>\*</sup> 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.

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*\*</sup> 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	inded	Page	of
TERESA REST HOME INC 1767		1767	1767			20	37
	Item			Total	CCNH	RHNS	Residential Care Home
4.	Housekeeping	Sq. Ft. Serviced					
['	a. In-House Care	by Personnel					
l	1. Supplies - Cleaning ( <i>Mops</i> ,	Amt.	\$				
	pails, brooms, etc.)	1 11111.	*				
	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*		\$				
	d. Other (Specify)		\$	3,380			3,380
	SUPPLIES, CLEANING, MOPS, E	BROOMS					
4E.	Total Housekeeping Expenditures (4a +		\$	3,380			3,380
5.	Resident Care (Supplies)**						
	a. Prescription Drugs***					ONE OF SER	sanamini
	1. Own Pharmacy		\$				
	2. Purchased from		\$				
		e e		Service Control			
	b. Medicine Cabinet Drugs		\$				
	c. Medical and Therapeutic Supplies		\$				
	d. Ambulance/Limousine***		\$				
	e. Oxygen						
	1. For Emergency Use		\$				
	2. Other***		\$				
	f. X-rays and Related Radiological		\$				
	Procedures***						
	g. Dental (Not dentists who should be inc	luded under	\$				
	salaries or fees)			and the state of t			
	h. Laboratory***		\$				
	i. Recreation		\$				
	j. Other (Specify)****		\$				
	See Attached Schedule						
5K.	Total Resident Care Expenditures (5a - 5	5j)	\$				

<sup>\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

<sup>\*\*\*</sup> Facility should self-disallow the expense on Page 29 of the Cost Report.

<sup>\*\*\*\*</sup> ICFMR's should provide a detailed schedule of all Day Program Costs.

### TERESA REST HOME INC 9/30/2015

### Schedule of Other Resident Care

	CCNH	RHNS	Residential Care Home
Description			
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				License No.	Report for Year Ended 9/30/2015				Page (	of 37
TERESA REST HOME INC	TWEET THE TAXABLE PROPERTY.									
		Related ** to Owners,	o Owners,			<u>-</u>	Potal Cost/	Total Cost/Page Ref.***		
		Operators, Officers	Officers							
Name of Individual or Company	Address	Yes	Ν̈́	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	Residential Care Home	Pg I	Line
		0	0							
		0	0							
		0	0							Ī
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							

<sup>\*</sup> List all contracted services over \$10,000. Use additional sheets if necessary.

<sup>\*\*</sup> Refer to Page 4 for definition of related.

<sup>\*\*\*</sup> 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	icense No.		Report for Ye	ar Ended		Page	of
TERESA REST HOME INC	1767	S	0/30/2015			22	37
			<u> </u>				ntial Care
Item			Total	CCNH	RHNS	Н	ome
5. Maintenance & Operation of Plant		١					
a. Repairs & Maintenance		\$	58,287			<u> </u>	58,287
b. Heat	(	\$	6,669			<u>.                                    </u>	6,669
c. Light & Power		\$	15,318			<u> </u>	15,318
d. Water		\$	3,915				3,915
e. Equipment Lease (Provide detail on pa	ge 6)	\$				<u> </u>	
f. Other (itemize)		\$ [	6,489				6,489
See Attached Schedule							
6g. Total Maint. & Operating Expense (6a -	6f)	\$	90,678				90,678
7. Depreciation (complete schedule page 23*							
a. Land Improvements		\$				<u> </u>	
b. Building & Building Improvements		\$					
c. Non-Movable Equipment		\$	3,131			<u> </u>	3,13
d. Movable Equipment		\$	11,188				11,18
*7e. Total Depreciation Costs $(7a + b + c + d)$		\$	14,319				14,31
8. Amortization (Complete att. Schedule Pag	ge 24*)						
a. Organization Expense		\$					
b. Mortgage Expense		\$					
c. Leasehold Improvements		\$					
d. Other (Specify)		\$					<u>.                                 </u>
*8e. Total Amortization Costs (8a + b + c + d	)	\$					<del></del>
9. Rental payments on leased real property l							06.00
real estate taxes included in item 10b		\$	96,000				96,00
10. Property Taxes							
a. Real estate taxes paid by owner		\$					
b. Real estate taxes paid by lessor		\$					
c. Personal property taxes		\$		+		_	23
11. Total Property Expenses (7e + 8e + 9 +	10)	\$	110,553				110,55

<sup>\*</sup> 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

<b>Description</b>	CC	NH RHN	Residential S Care Home
WPCA			\$ 4,072
CONTRACT FIRE DRILLS			\$ 700
ALARM SYSTEM			\$ 1,717
Total Other Repairs and Maintenance	\$	- \$	- \$ 6,489

State of Connecticut Annual Report of Long-Term Care Facility CSP-23 Rev. 10/2006 Depreciation Schedule

			הפולפת	Depreciation Schedure	Į					
Name of Facility			License No.	İ		Report for Year Ended	nded		Page	oţ
TERESA REST HOME INC	•		1767			9/30/2015			23	37
		-	Historical Cost	Less		Accumulated Depreciation to	Method of			
Property Item			Exclusive of Land	Salvage Value	Cost to Be Depreciated	Beginning of Year's Operations	Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A Land Improvements										
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	h schedule)									
B. Building and Building Improvements										
<ol> <li>Acquired prior to this report period</li> </ol>										
	h schedule)									
ž					,	1			1010	
<ol> <li>Acquired prior to this report period</li> </ol>			62,629		62,629	27,138		SL	3,131	
2. Disposals (attach schedule)										
	h schedule)									1010
C-4. Subtotal										3,131
	Is a mileage					Accumulated	-			
	nogoook maintained?	Date of Acquisition	Historical Cost	Less		Depreciation to	Method of			
			Exclusive of	Salvage	Cost to Be	Beginning of		Useful	Depreciation	T.
	Yes No	Month Year	Land	Value	Depreciated	Year's Operations	Depreciation	Life	Tor This Year	1 Otalis
D. Movable Equipment 1. Motor Vehicles (Specify name, model and year of each vehicle)										
a.										
b,										
C.										
ď.										
2. Movable Equipment							0.063		00, 10	
a. Acquired prior to this report period			158,251			77,591	SL	VARIOU	11,188	
b. Disposals (attach schedule)		9 15	(2,021)			(1,407)				
c. Acquired during this report period										
(attach schedule)			156,230			76,184				
D-3. Subtotal										11,188
E. Total Depreciation										14,319

Useful

Useful

Schedule of Land Improvements Acqu	tired during this report period
------------------------------------	---------------------------------

Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:			- 4-1 Tuna - + 0 1 70 00.	mmidd vedmildeddel
. At the walk principle				
ang a samilyong pang terbelah di kabupat Managpanggapan ang Malaysia				
		RUSER AND AND AND AND		
		•		\$ -
Total additions for	r Land Improvements	3	P8, P41 (1975) 134-144-158	4
Deletions:				
				Highlighten (* 34)
			and Strained	
9:54,60,000,000,5966				
		: April 1800 kine september 1	lan Militaria de la	
				4 4040000000000000000000000000000000000
Total deletions for	r Land Improvements	\$ -	1600 Mg 660 g 64	\$ -

<sup>\*</sup>Ties to Page 23, Line A3

### Schedule of Building Improvements Acquired during this report period

Schedule of Buildin Acquisition Date	g Improvements Acquired during this report period  Description of Item	Cost	Useful Life	Depreciation
Additions:				
Kuurtions.				
		den sed Niche (C.).		
			Professional Company	
		\$ -		\$ -
Fotal additions for	Building Improvements	A COLORA DE COLO		
Deletions:		Transplación Seguidado		
and the second second	Building Improvements	s -		\$ -

<sup>\*</sup>Ties to Page 23, Line B3

### Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				7 1 1 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Cartifold Commence			managelinia.	éncuración.
		d.		\$ -
Total additions for	Non-Movable Equipment	- <b>3</b>		<b>Ψ</b> , η α χ. α α α α α α α α α α α α α α α α α
Deletions:			e e e e e e e e e e e e e e e e e e e	
Karakin (Managas)				
			100 100 100 100 100 100 100 100 100 100	
			Problem & Forest St.	
		d:		· e
Total deletions for	Non-Movable Equipment	\$ -		14 Sec. 22 (15 27 17 17 17 17 17 17 17 17 17 17 17 17 17

<sup>\*</sup>Ties to Page 23, Line C3

<sup>\*\*</sup>Ties to Page 23, Line A2

<sup>\*\*</sup>Ties to Page 23, Line B2

<sup>\*\*</sup>Ties to Page 23, Line C2

### Schedule of Movable Equipment Acquired during this report period

Schedule of Movad	le Equipment Acquired during this report period		Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:		6 No. 25 2 No. 27 No. 48 10 N	PARTON NAME OF THE BAD	re Water to August 1481 sa
			SOLA WILLIAM	
		164 (464) (471) (486)		
		\$ -	yese ayasara.	\$ -
Total additions for	Movable Equipment	4	Specification and the second	
Deletions:		PROPERTY.	CONT.	\$ 1,407
9/30/2015	ASSET DISPOSED, CANNOT INDICATE ACTUAL UNIT	\$ 2,021	S/L,	3 1,407
			hale consume	
using HIA QUASI NG MINING Lapter Art of the Page 1997 HIA				
		\$ 2.021		\$ 1,407
Total deletions for	Movable Equipment	\$ 2,021		\$

<sup>\*</sup>Ties to Page 23, Line D2c

### Schedule of Leasehold Improvements Acquired during this report period

Schedule of Leasen  Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:			**************************************	ar Pilingger er
ang mengalah mengalah dari Jeografian Maliferian dari				
				ofice Care
		\$		\$ -
Fotal additions for	Leasehold Improvement	Ψ	Lawreng was a spig	
Deletions:		O resident villige og gjeggen i	F1-650,188 F37-85100.	99 A S CONTO CA D 49
				A Company of the State of the Company of the Compan
		Percision and the		
			ROLL ARTES	
		\$ -		\$ -
Total deletions for	Leasehold Improvement	War district the file		

<sup>\*</sup>Ties to Page 24, Line C3

<sup>\*\*</sup>Ties to Page 23, Line D2b

<sup>\*\*</sup>Ties to Page 24, Line C2

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

## Amortization Schedule\*

Nisson of Envilley		License No.		Report for Year Ended	r Ended		Page	jo
INAME OF FACILITY THEREOF REST HOME INC		1767		9/30/2015			24	37
1 Linear Maria				Accumulated				
	Date of			Amort. to				
	Acquisition			Beginning of		ŗ		
		Length of	Cost to Be	Year's		Kate	Kate Amortization	ï
Item	Month Year	<	Amortized	Operations	Amortization**	%	for This Year	lotais
A. Organization Expense								
1.								
2.								
3.								
A-4. Subtotal								
B. Mortgage Expense								
1.								
2.								
3.								
B-4. Subtotal								
C. Leasehold Improvements and Other								
	70							
2. Disposals (attach schedule)								
3. Acquired during this report period								
(attach schedule)								
C-4. Subtotal								
D. Total Amortization								
* Straight_line method 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 End	ded		Page	of
TERESA REST HOME INC	1767		9/30/2015			25	37
11. Property Questionnaire							
Part A	<del></del>						
Is the property either owned by the	ne Facility			_		If "Yes," comple	ete Part B.
or leased from a Related Party?*	10 1 401111	•	Yes	0	No	If "No," comple	I
*If any owner or operator of this fa	oility is related by	/family m	arriage, ownership, abil	lity to control or		•	
business association to any person	or organization fr	om whom	buildings are leased, the	en it is considered			
a related party transaction.			*****				
Description			Total				
Date Land Purchased	···		08/31/79				
2. Date Structure Completed	- CD - I	**	01/31/06				
3. If <b>NOT</b> Original Owner, Dat	e of Purchase		00/21/20				
4. Date of Initial Licensure			08/31/79				
5. Total Licensed Bed Capacity			10,000				
<ul><li>6. Square Footage</li><li>7. Acquisition Cost</li></ul>			10,000				
a. Land			25,100				
b. Building			967,310				
Part B - Owner and Related Part	arties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mort	gage
1. Financing		•				and the comment	
a. Type of Financing (e.g.,	fixed, variable)	•	FIXED		310		
b. Date Mortgage Obtained			10/04/10				
c. Interest Rate for the Cost	Year		600.00%		· <del></del>		
d. Term of Mortgage (numb			20				
e. Amount of Principal Bor	rowed		800,000				
f. ##							
Complete if Mortgage was							
During Current Cost Y		*****					
g. Type of Financing (e.g.,	fixed, variable)	)					
h. Date of Refinancing i. New Interest Rate							
i. New Interest Rate i. Term of Mortgage (numl	or of vegre)						
k. Amount of Principal Bor	·						
l. Principal Outstanding on		<u> </u>			- ****		
Part C - Arms-Length Lea			Improvements Onl	y			
Name and Address of Less			perty Leased		Term of Lease	Annual Amour	nt of Lease
SANTINO REALTY			TATE & ALL		10 YEARS		96,000
67 TOWNSEND AVE NEW HAVEN		/PROVE	EMENTS				
CT. 06512							
							11.44
1							

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 Y	ear Ended		Page	of
TERESA REST HOME INC	1767		9/30/2015			26	37
					DIDIG	Residentia	
Iter	m		Total	CCNH	RHNS	Hom	ne
12. Interest	Or Non More	ahla					
A. Building, Land Impro Equipment	vement & Non-Mov	able					
1. First Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
2. Second Mortgage		\$				and Asserting Control of Control	
Name of Lender		Rate					
	······································						
Address of Lender							
3. Third Mortgage		\$	3				
Name of Lender		Rate				1000	
					10000		
Address of Lender							
4. Fourth Mortgage			3				
Name of Lender		Rate	The Health and the Con-				
				10 11			
Address of Lender							
B. CHEFA Loan Inform	nation				Section 1		
1. Original Loan Am		9	5				
2. Loan Origination	···					1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
3. Interest Rate %							
4. Term							
	Typonso						
5. CHEFA Interest F		n <i>s</i> :	ħ				
12 B7. Total Building Interest 1	expense (A1 - A4 + )	R) (	(Ca	rry Subtotals	forward to	nert page	

(Carry Subtotals forward to next page)

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

Name of Facility TERESA REST HOME INC	License No.		Report for Ye 9/30/2015	ear Ended		Page of 27   37
· Ite			Total	CCNH	RHNS	Residential Care Home
	Subtotals Brou	ught Forward:				
12. C. Movable Equipment						
1. Automotive Equipm	ent	\$				
A. Item	Rate	Amount				
Lender		-				
Address of Lender						
2. Other (Specify)		\$		k in the second		
A. Item	Rate	Amount				
Lender						Bull approximation of the property of the prop
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equi Expense (C1 + 2)	pment Interest		6			
12. D. Other Interest Expense	(Specify)		S .			
13. Total All Interest Expense	(12B7 + 12C3 + 12)	(D)	\$			
14. Insurance			1			15 100
a. Insurance on Property	(buildings only)		15,109			15,109
b. Insurance on Automob			\$		<del> </del>	-
c. Insurance other than P	roperty (as specified	a above)	ar I			
1. Umbrella (Blanket	Coverage)		\$ \$			
2. Fire and Extended	Coverage		\$			
3. Other (Specify)		1	Ψ			The state of the s
14d. Total Insurance Expendit	ures (14a + b + c)		\$ 15,109			15,109
15. Total All Expenditures (A			\$ 642,436			642,436

## D. Adjustments to Statement of Expenditures

	e of Fa		HOME INC	Lic	cense No. 1767	Report for Ye 9/30/2015	ar Ended	Page 28	of 37
TLIC					Total				
Item	Page	Line			Amount of			Resident	ial Care
	No.		Item Description		Decrease	CCNH	RHNS	Но	me
			es and Wages						
1.	10 ~		Outpatient Service Costs	\$					
2.			Salaries not related to Resident Care	\$					
3.		-	Occupational Therapy	\$					
4.	<b>-</b>		Other - See attached Schedule	\$	4,000				4,000
		Profes	sional Fees						
5.			Resident Care Physicians **	\$					
6.			Occupational Therapy	\$					
7.			Other - See attached Schedule	\$					
Page	s 15 d	k 16 -	Administrative and General			10.00			
8.	1		Discriminatory Benefits	\$					
9.			Bad Debts	\$					
10.			Accounting & Legal	\$					
11.			Telephone	\$					
12.			Cellular Telephone	\$	430				430
13			Life insurance premiums on the life	"					
			of Owners, Partners, Operators	\$					
14			Gifts, flowers and coffee shops	\$					
15			Education expenditures to colleges or				100000000000000000000000000000000000000		
``			universities for tuition and related costs						
			for owners and employees	\$					
16			Travel for purposes of attending						
		1	conferences or seminars outside the						
			continental U.S. Other out-of-state				0.0000000000000000000000000000000000000		
			travel in excess of one representative	\$					
17			Automobile Expense (e.g. personal use)	\$	2,151				2,151
18			Unallowable Advertising *	\$	612				612
19		1	Income Tax / Corporate Business Tax	\$	S				
20		<b>†</b>	Fund Raising / Contributions	9	S				
21		1	Unallowable Management Fees		6				
22		1	Barber and Beauty	Ş	5				
23		-	Other - See attached Schedule	5	Б				
		Dieta	ry Expenditures				0.00		
24		1	Meals to employees, guests and others			10 (10 (10 (10 (10 (10 (10 (10 (10 (10 (	10 (10 (10 (10 (10 (10 (10 (10 (10 (10 (		
	' <b>'</b>		who are not residents	5	6				
Pan	e 19 -	Laun	dry Expenditures		101000000000000000000000000000000000000				
25			Laundry services to employees, guests				the second second		
1			and others who are not residents	(	\$				
Pac	re 20 -	Hous	ekeeping Expenditures			in the second se			
26		11003	Housekeeping services to employees, guests						
20	<u>" </u>		and others who are not residents		\$				
			Subtotal (Items 1 - 26		\$ 7,193	3			7,193

<sup>\*</sup> All except "Help Wanted".

<sup>(</sup>Carry Subtotal forward to next page)

<sup>\*\*</sup> 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

ine Dof	Description	CCNH	RHNS	Care Home
				\$ 4,000
2	ADM SALARY OVER CAP			
Alachtiyi.				
			[60,73 types, [70][Unitarily	
11. 450 17.31.		reflecter vogs aveit o		
esarge Care				
		<b>6</b>	e de la company	\$ 4.000
The second of th	2		2 ADM SALARY OVER CAP	2 ADM SALARY OVER CAP

#### Schedule of Fees Adjustments

Dago Dof I in a H	ef Description	CCNH	RHNS	Residential Care Home
Page Ref Line R	er Description			
Total Other Fees		\$ -	s -	s -

Schedule of Other A&G Adjustments

Dage Def	I ina Daf	Description	CCNH	RHNS	Residential Care Home
Page Ref	Ellic Kei	Bescription			
Fotal Othe	r A&C Ac	ljustments	\$	\$ -	- \$

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

	_		D. Adjustments to Statemen	nt	oi Expend	mures (co	meu)	n-	
	e of Fa			Lic	ense No.	Report for Y	ear Ended	Page	of
TERI	ESA R	EST I	HOME INC		1767	9/30/2015		29	37
					Total			,	· 1.0
Item	Page	Line			Amount of			ŧ	ntial Care
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	H	ome
	·	<u></u>	Subtotals Brought Forward	\$	7,193				7,193
Page	20 - 1	Reside	nt Care Supplies***						
27.			Prescription Drugs	\$					
28.			Ambulance/Limousine	\$					
29.			X-rays, etc	\$					
30.			Laboratory	\$					
31.			Medical Supplies	\$					
32.			Oxygen (non emergency)	\$			<u> </u>	ļ	
33.			Occupational Therapy	\$				<u> </u>	
34.			Other - See Attached Schedule	\$					
Page	2 22 - 1	Maint	enance and Property			1000000			
35.			Excess Movable Equipment Depreciation						
			See Attached Schedule	\$	,				
36			Depreciation on Unallowable						
			Motor Vehicles	\$					
37			Unallowable Property and Real						
			Estate Taxes	\$			ļ		
38			Rental of Building Space or Rooms	\$			<u> </u>		
39			Other - See Attached Schedule	\$	3				
Pag	e 27 -	Insura	ance						
40			Mortgage Insurance	_ \$					
41		T	Property Insurance	. \$	8				
Oth	er - M	iscella	ineous						
42			Research or Experimental Activities	9					
43			Radio and Television Revenue		<u> </u>				
44			Vending Machine Revenue		5				
45	i.		Purchase Discounts and Allowances		B				
46	<u>5.</u>		Duplications of functions or services		<b>S</b>				
47	_		Expenditures made for the protection,						
			enhancement or promotion of the		and the second				
			providers interest		\$				
48	3.		Interest Income on Accounts Rec	:	\$				
49			Other (include personnel and other						
			costs unrelated to resident care) - See						
	1		Attached Schedule		\$				200
Not	For I	Profit	Providers Only						
50			Building/Non Movable Eq. Depreciation						0.02
			Unallowable Building Interest -						
			See Attached Schedule		\$				
5	1 Tot	al Am	ount of Decrease (Items 1 - 50)		\$ 7,19	3			7,193

<sup>\*\*\*</sup> 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

D D 0	Vissa Baf	Description	CCNII	RHNS	Residential Care Home
Page Ref	Line Kei	Description			
	The second of th				
			6	\$ -	\$ -
Total Otho	er Ancillar	y Costs	<b>a</b>	<u> </u>	· [. Ψ. respective T. see

Schedule of Excess Movable Equipment Depreciation

D - D-6	Line Dof	Description	CCNH	RHNS	Residential Care Home
Page Ref	Line Kei	Description			
TALL SAME				Service of the servic	A CONTROL OF THE STAR
1900 S. 11 (1904)					
Million Civile					
	1000				3. Y. C. C. Sandari, S. C. C. C.
	为《节》2014年		The surgery of the control of		
ang	Gertler 1988 services				
\$7.00 m	w. http://www.		•	\$	S
Total Exce	ss Movabl	e Equipment Depreciation	144 C C C C C C C C C C C C C C C C C C	1. 4.	1

Schedule of Other Property Adjustments

Page Ref	Lina Daf	Description	CCNH_	RHNS	Residential Care Home
rage Nei	Line Ive	<b>Description</b>			
	D	2 Protes on fo	\$ -	\$ -	\$ +
Lotal Othe	er Property	y Adjustments			***

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
1 age Rei	Zinc Rei				
Total Othe	r Adinetm		\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
	valiet ser ter				
				100000000000000000000000000000000000000	
erijanguyan yali. Garaktin (Kara					
				0.0000000000000000000000000000000000000	
		Luilding Interest	\$ -	8 -	s -

F. Statement of Revenue

	F. Statement of Key		Report for Ye	ar Ended		Page	of
ame of Facility	License No.		9/30/2015	ai Liidea		30	37
ERESA REST HOME INC	1767	-		<del></del>		Resider	ntial Care
	Tr		Total	CCNH	RHNS	ı	ome
- 10 P	Item	-	Total				
Resident Room, Board & Routing		\$	605,583		I company		605,583
1. a. Medicaid Residents (CT only	v)		003,363			1	
b. Medicaid Room and Board (	Contractual Allowance **	\$					
2. a. Medicaid (All other states)		\$		<del></del>		<del>                                     </del>	<del></del>
b. Other States Room and Boar		\$				╂──~	
3. a. Medicare Residents (all incl	usive)	\$		· · · · · · · · · · · · · · · · · · ·	<del>                                     </del>	1	
b. Medicare Room and Board		. \$		un.		+	37,800
4. a. Private-Pay Residents and C	Other	\$	37,800		<del> </del>	╁-	37,000
b. Private-Pay Room and Boar	d Contractual Allowance **	\$	#VALUE!				
I. Other Resident Revenue							
1. a. Prescription Drugs - Medica	are	\$		<del></del>	<del> </del>	<del> </del>	
b. Prescription Drugs - Medica	are Contractual Allowance **	\$					
c. Prescription Drugs - Non-M		\$					
d. Prescription Drugs - Non-M	fedicare Contractual Allowance **	\$					
2. a. Medical Supplies - Medical		\$					
b. Medical Supplies - Medical	e Contractual Allowance **	\$		<u> </u>			
c. Medical Supplies - Non-Me		\$				<b>_</b>	
d Medical Supplies - Non-Me	edicare Contractual Allowance **	\$		,,,,			
3. a. Physical Therapy - Medica		\$					
b. Physical Therapy - Medica	re Contractual Allowance **	\$					
c. Physical Therapy - Non-Mo		\$					
d. Physical Therapy - Non-Me	edicare Contractual Allowance **	\$					4.1
4. a. Speech Therapy - Medicard		\$					
b. Speech Therapy - Medicare	Contractual Allowance **	\$					
c. Speech Therapy - Non-Me		9	<del></del>				
c. Speech Therapy - Non-Mo-	dicare Contractual Allowance **	9					
		9			-		
5. a. Occupational Therapy - M	Adjourn Contractual Allowance **			·			
	ledicare Contractual Allowance **						
c. Occupational Therapy - N	On-Ivicuitate						
	on-Medicare Contractual Allowance **		<b>B</b>	<u> </u>			
6. a. Other (Specify) - Medicare			\$	<u> </u>			**
b. Other (Specify) - Non-Med				┼───			643,38
III. Total Resident Revenue (Secti	on I. thru Section II.)		643,383				010,50
IV. Other Revenue*							
<ol> <li>Meals sold to guests, employed</li> </ol>	ees & others		\$	<del> </del>	<del> </del>		<del>.</del>
2. Rental of rooms to non-reside	ents		\$				•••
3. Telephone			\$	<u> </u>		-	
4. Rental of Television and Cab	le Services		\$	<del> </del>			
5. Interest Income (Specify)			\$			-	
6. Private Duty Nurses' Fees			\$	<del> </del>			<del></del>
7. Barber, Coffee, Beauty and C	ift shops		\$			_	· · ·
8. Other (Specify)			\$			_	
V. Total Other Revenue (1 thru 8)			\$				**
VI. Total All Revenue (III+V)			\$ 643,383	,			643,3

<sup>\*</sup> Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

<sup>\*\*</sup> Facility should report all contractual allowances and/or payer discounts.

#### Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref Description	CCNH	RHNS	Residential Care Home
	The second contract the second contract to th		
Total Other Resident Revenue	\$ -	\$	\$ -

Interest Income

Account

				Residential
Page Ref Account	Balance	CCNH	RHNS	Care Home
		*******		
		\$ -	\$ -	\$ ,

Schedule of Other Revenue

				Residential
Page Ref	Description	CCNH	RHNS	Care Home
				V
etano, en e Hanna				
Catal Othe	г Кеуепие	\$ -	\$ -	\$ -

### G. Balance Sheet

		Facility	License No.	1 -	ort for Year	Ended	Pag	-	of
LER.	ESA	REST HOME INC	1767	9/30/	/2015		31		37
1			Account					Amour	<u>1t</u>
Asse									
A.		rrent Assets	`				\$		16,731
		Cash (on hand and in banks Resident Accounts Receivab		for Rad	Debtel		\$		34,700
		Other Accounts Receivable					\$		34,700
		Inventories	Excluding Owners	oi Keiate	u i artics)		\$		2,000
		Prepaid Expenses					\$		2,000
	٦.	- "					ų.		
		ab.							
		d.						4444	
	6	Interest Receivable					\$		
		Medicare Final Settlement R	eceivable				\$		
,		Other Current Assets (itemiz					\$		
	0,	omer carrent index (i.e	~ )						
								16.5	
A-9	To	tal Current Assets (Lines A1	thru 8)				\$		53,431
B.		ked Assets	<u> </u>			·	1		,
٠,		Land					\$		
		Land Improvements	*Historical Cost				\$		
	٠.	Edita Improvementa	Accum. Deprecia	tion		Net			
	3.	Buildings	*Historical Cost				\$		
	•		Accum. Deprecia	tion ——		Net			
	4.	Leasehold Improvements	*Historical Cost			<u></u>	\$		
		r ·	Accum. Deprecia	tion		Net			
	5.	Non-Movable Equipment	*Historical Cost		62,629		\$		32,360
		1 1	Accum. Deprecia	tion	30,269	Net			-
	6.	Movable Equipment	*Historical Cost		156,230		\$		68,858
			Accum. Deprecia	tion	87,372	Net			
	7.	Motor Vehicles	*Historical Cost				\$		
			Accum. Deprecia	tion		Net			
	8.	Minor Equipment-Not Depr	eciable				\$		
	9.	Other Fixed Assets (itemize	)				\$		
B-10	).	Total Fixed Assets (Lines B	31 thru 9)				\$	· ·	101,218

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

## G. Balance Sheet (cont'd)

•		Facility	License No.	Report for Year Ended	Page	
TER	TERESA REST HOME INC		1767	9/30/2015	32	37
			Account			Amount
				Total Brought Forward:	\$	154,649
C.	Lea	asehold or like property record	ded for Equity Purpose	S.		
		Land	.,		\$	
	2.	Land Improvements	*Historical Cost		_	
			Accum. Depreciation	n Net	\$	
1	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 Proper	ties (C1 thru 7)		\$	annanca
D.	Inv	vestment and Other Assets				
	1.	Deferred Deposits			\$	
	2.	Escrow Deposits			\$	
	3.	Organization Expense	*Historical Cost			
			Accum. Depreciation	n Net	\$	
		Goodwill (Purchased Only)			\$	
	5.	Investments Related to Resid	dent Care (itemize)		\$	
					10051	
	6.	Loans to Owners or Related	Parties (itemize)		\$	
		Name and Address	Amount	Loan Date		
1						
	7.	Other Assets (itemize)			\$	
1						
		otal Investments and Other A			\$	
D-9	. To	otal All Assets (Lines A9 + B	10 + C8 + D8		\$	154,649

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

## G. Balance Sheet (cont'd)

Name of Facility			License No.	Report for Year	Ended	Page	of
TERESA REST HOME INC			1767	9/30/2015		33	37
		10 1000 1000 1000 1 1 1 1	Account			Am	ount
Liabilities	~						
A.		rrent Liabilities			<b>6</b>		10.760
	1.	Trade Accounts Payable			\$ \$		12,768
	2.	Notes Payable (itemize)			Φ		
		MATERIAL STATES		1001		10000	
	3.	Loans Payable for Equipm	nent (Current portio	n)(itemize)	\$		
		Name of Lender	Purpose	Amount	Date Due		
	*						
						60000	
		A samued Desmall (English		Standard and and	<u> </u>		
	4.	Accrued Payroll (Exclusive			\$		
<u> </u>	5.	Accrued Payroll (Owners	*****	s only)	\$		750
	6.	Accrued Payroll Taxes Pa	7		\$ \$		752
	7.	Medicare Final Settlemen			\$		
	8. 9.	Medicare Current Financi Mortgage Payable (Current			\$		
		. Interest Payable (Exclusiv	<u></u>	Polated Parties	\$		
			e oj Owner ana/or 1	Netatea Larties )	\$		
		<ul><li>Accrued Income Taxes*</li><li>Other Current Liabilities (</li></ul>	itamiza)		¢.		7,590
	12	PROFESSIONAL FEES PAYABL		5,500	) D		7,370
		EMPLOYEE CLUB FUNDS PAY		,090			
		ENH NOTED COORTORDS IAI					
A-13	. To	<i>tal Current Liabilities</i> (Lir	nes A1 thru 12)		\$		21,110

<sup>\*</sup> 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
TERESA REST HOME INC	1767	767 9/30/2015		34	37
	Account			Amoı	ınt
		Total Brough	ıt Forward:		21,110
Liabilities (cont'd)					
B. Long-Term Liabilities					
<ol> <li>Loans Payable-Equipment</li> </ol>	t (itemize )		\$		
Name of Lender	Purpose	Amount	Date Due		
			3.		
2. Mortgages Payable			\$		
<ol><li>Loans from Owners or Re</li></ol>	lated Parties (itemiz	e)	\$		3,189
Name and Address of Lender	Amount	Loan D	ate		
			<u>                                   </u>		
4. Other Long-Term Liabilit	iec (itamiza)		\$		
4. Other Long-Term Liability	ics (tiemize)		J		
		<u> </u>			
B-5. Total Long-Term Liabilities	(Lines R1 thru 4)		\$		3,189
C. Total All Liabilities (Lines A	-13 + B-5)		\$		24,299
C. Tour Mit Pinounces (Pinos V	. 10 , 10 0)		14		47,477

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

	ne of Facility	License No.	Report for Yo	ear Ended	Page	of
TER	RESA REST HOME INC	1767	9/30/2015		35 Am	ount 37
Α.	Reserves	Account			Alli	Ount
	Reserve for value of leased	₹ land			\$	
	2. Reserve for depreciation v		lings and appurter	nances		
	to be amortized	arde or reased barre	ings and appares		\$	
	3. Reserve for depreciation v	alue of leased person	onal property (Equ	uity)	\$	
	4. Reserve for leasehold real	properties on whic	h fair rental value	is based	\$	
	5. Reserve for funds set aside	e as donor restricted	d		\$	
	6. Total Reserves				\$	
B.	Net Worth					
<u> </u>	1. Owner's Capital				\$	
	2. Capital Stock				\$	
	3. Paid-in Surplus				\$	
	4. Treasury Stock				\$	
	5. Cumulated Earnings				\$	129,403
	6. Gain or Loss for Period	10/1/2	014 thru	9/30/2015	\$	947
	7. Total Net Worth				\$	130,350
C.	Total Reserves and Net Wort	h			\$	130,350
D.	Total Liabilities, Reserves, ar	nd Net Worth			\$	154,649

## H. Changes in Total Net Worth

	ne of Facility	License No.	Report for Year	r Ended	Page	of
TER	ESA REST HOME INC	1767	9/30/2015		36	37
		Account				nount
A.	Balance at End of Prior Period as s				\$	129,403
B.	Total Revenue (From Statement of		\$	643,383		
C.	Total Expenditures (From Stateme	ent of Expenditures	Page 27)		\$	642,436
D.	Net Income or Deficit				\$	947
E.	Balance				\$	130,350
F.	Additions  1. Additional Capital Contributed  2. Other (itemize)	l (itemize)				
E 2	Total Additions	· -			\$	
G.	Deductions				φ	
.	Drawings of Owners/Operators	s/Partners ( <i>Specify</i> )			\$	
	Name and Address (No., City)		Title	Amount	Ψ	
		, 4.7			Manager Comments of the Comme	
<u> </u>	2. Other Withdrawings (Specify)				\$	
	Purpose		Amo	ount		
   T   T   T   T   T   T   T   T   T	3. Total Deductions  Balance at End of Period	00/20/	11.5		\$	120.250
H.	Datance at Ena of Perioa	09/30/	13		\$	130,350

## I. Preparer's/Reviewer's Certification

Name of Facility		License No.	Report for Year Ended	Page	of	
TERESA REST HOME INC		1767	9/30/2015	37	37	
Check appropriate category						
	Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)	☑ Residential Care Home			
Preparer/Reviewer Certification						
I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.						
Signature of Preparer		Title	Date Signed			
X	the faction	TREASUR ER	12-1-15			
Printed Name of Preparer						
PETER SANTINO						
Addres Address			Phone Number			
67 TOWNSELD AVE NEW HAVEN, CT. 06512			208-469-245	208-469-2453		