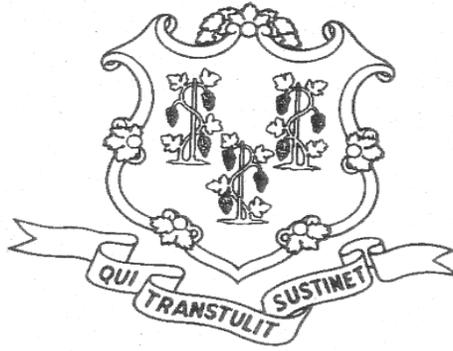


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) Mattatuck Health Care Facility, Inc.	
Address (No. & Street, City, State, Zip Code) 9 Cliff St., Waterbury, CT 06710	
Type of Facility <input type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) Rest Home with Nursing <input checked="" type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH	RHNS 144-RH	(Specify)	Medicare Provider 07-5432
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Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
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For Department Use Only

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

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General Information

Name of Facility (as licensed) Mattatuck Health Care Facility, Inc.	License No. 144-RH	Report for Year Ended 9/30/2021	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Mattatuck Health Care Facility, Inc. [facility name], for the cost report period beginning October 1, 2020 and ending September 30, 2021, 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) Allen V. Desena			Printed Name (Owner) Allen V. Desena		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Mattatuck Health Care Facility, Inc.		Period Covered:	From 10/1/2020	To 9/30/2021
Address of Facility 9 Cliff St., Waterbury, CT 06710				
Report Prepared By CJLC LLC		Phone Number 860-610-9009	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.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-573-9924		Report for Year Ended 9/30/2021	Page 2	of 37
Name of Facility (as shown on license) Mattatuck Health Care Facility, Inc.		Address (No. & Street, City, State, Zip) 9 Cliff St., Waterbury, CT 06710		
License Numbers:	CCNH 144-RH	RHNS (Specify)	Medicare Provider No. 07-5432	
Type of Facility (Check appropriate box(es))				
<input type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?				
<input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Allen V. Desena		Nursing Home Administrator's License No.:	000297	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

**General Information and Questionnaire
Related Parties***

Name of Facility Mattatuck Health Care Facility, Inc.	License No. 144-RH	Report for Year Ended 9/30/2021	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Allen V. Desena d/b/a Tricare Unlimited	9 Cliff St., Waterbury, CT 06710	<input type="radio"/>	<input checked="" type="radio"/>		Rental of Facility	22/9	483,000	483,000
RSC Insurance Brokerage, Inc.	15 Pacella Park Dr. Ste. 240, Randolph, MA 2368	<input type="radio"/>	<input checked="" type="radio"/>		Shared Property/Liability Insurance	27/14a	31,392	31,392
Carriage Manor LLC	157 Hillside Ave., Waterbury, CT 06710	<input type="radio"/>	<input checked="" type="radio"/>		Loans for Expenses	31/A8	346,619	346,619
Tricare LLC	Tricare LLC	<input type="radio"/>	<input checked="" type="radio"/>		Loans for Expenses	31/A8	323,772	323,772
Allen V. Desena d/b/a Geron	157 Hillside Ave., Waterbury, CT 06710	<input type="radio"/>	<input checked="" type="radio"/>		Loans of Funds	31/A8	358,247	358,247
William Mara	9 Cliff St., Waterbury, CT 06710	<input type="radio"/>	<input checked="" type="radio"/>		Maintenance/34 hours	16/m13	3,827	3,827
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

* Use additional sheets if necessary.

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

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility Mattatuck Health Care Facility, Inc.	License No. 144-RH	Report for Year Ended 9/30/2021	Page 5	of 37
If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:				
Item		Method of Allocation		
Dietary		Number of meals served to residents		
Laundry		Number of pounds processed		
Housekeeping		Number of square feet serviced		
Nursing		Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants		
Direct Resident Care Consultants		Number of hours of resident care provided by EACH specialist (<i>See listing page 13</i>)		
Maintenance and operation of plant		Square feet		
Property costs (depreciation)		Square feet		
Employee health and welfare		Gross salaries		
Management services		Appropriate cost center involved		
All other General Administrative expenses		Total of Direct and Allocated Costs		
The preparer of this report must answer the following questions applicable to the cost information provided.				
1. In the preparation of this Report, were all costs allocated as required? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				
2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.				
3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)				
<input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility			License No.	Report for Year Ended			Page	of
Mattatuck Health Care Facility, Inc.			144-RH	9/30/2021			6	37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease		Amount Claimed
	Yes	No						
Great America Financial Services Corp	<input type="radio"/>	<input checked="" type="radio"/>	Copier	02/28/20	63 months	1,769		1,769
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
							Total ***	1,769

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

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
 ** Attach copies of newly acquired leases.
 *** Amount should agree to Page 22, Line 6e.

General Information and Questionnaire
Accounting Basis

Name of Facility Mattatuck Health Care Facility, Inc	License No. 144-RH	Report for Year Ended 9/30/2021	Page 7	of 37
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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 1 CJLC LLC 2 3 4	Address (No. & Street, City, State, Zip Code) 225 Pitkin Street, East Hartford, CT 06108
--	---

Services Provided by This Firm (*describe fully*)

1 Medicaid Cost Report, Accounting Services, Tax Services, Financial Statements	\$ 9,600
2	\$
3	\$
4	\$
	Charge for Services Provided \$ 9,600

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No Pg 15/1d

Legal Services Information

Name of Legal Firm or Independent Attorney 1 Pullman & Comley 2 Murtha Cullina LLP 3 Broderick Law Firm 4 5	Telephone Number
--	------------------

Address (*No. & Street, City, State, Zip Code*)
 1
 2
 3
 4
 5

Services Provided by This Firm (*describe fully*)

1 Closing WDC Loan	\$ 2,025
2 Healthcare issues	\$ 1,851
3 Closing WDC Loan	\$ 2,395
4	\$
5	\$
	Charge for Services Provided \$ 6,271

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No Pg 15/1e

Schedule of Resident Statistics

Name of Facility Mattatuck Health Care Facility, Inc.		License No. 144-RH			Report for Year Ended 9/30/2021				Page 8		of 37	
	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	43		43		43		43		43		43	
B. On last day of THIS report period	43		43		43		43		43		43	
2. Number of Residents												
A. As of midnight of PREVIOUS report period	41		41		41		41		39		39	
B. As of midnight of THIS report period	37		37		39		39		37		37	
3. Total Number of Days Care Provided During Period												
A. Medicare	145		145		140		140		5		5	
B. Medicaid (Conn.)	11,564		11,564		8,409		8,409		3,155		3,155	
C. Medicaid (other states)												
D. Private Pay	721		721		453		453		268		268	
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	12,430		12,430		9,002		9,002		3,428		3,428	
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	8		8		8		8					
B. Other Bed Reserve Days	35		35		27		27		8		8	
5. Total Resident Days (3G + 4A + 4B)	12,473		12,473		9,037		9,037		3,436		3,436	

Schedule of Resident Statistics (Cont'd)

Name of Facility Mattatuck Health Care Facility, Inc.			License No. 144-RH			Report for Year Ended 9/30/2021			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	(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	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents				34		3							
Per Diem Rate													
a. One bed rm.				153.11		200.00							
b. Two bed rms.						195.00							
c. Three or more bed rms.						190.00							
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									173		173		
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									49		49		
C. Other													
D. Total Physical Therapy Treatments									222		222		
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B													
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other													
D. Total Speech Therapy Treatments													
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B													
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other													
D. Total Occupational Therapy Treatments													

Report of Expenditures - Salaries & Wages

Name of Facility Mattatuck Health Care Facility, Inc.	License No. 144-RH	Report for Year Ended 9/30/2021	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(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)			44,381	1,040		
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)			49,063	1,248		
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor			82,256	4,346		
c. Dietary Workers			27,129	2,166		
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers			25,364	1,780		
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers			54,253	2,472		
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers			31,769	2,151		
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses			70,579	2,003		
b. RN						
1. Direct Care			197,373	7,355		
2. Administrative**						
c. LPN						
1. Direct Care			5,957	238		
2. Administrative**						
d. Aides and Attendants			195,075	14,544		
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers			48,783	2,080		
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			12,196	520		
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>			844,177	41,943		

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

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

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

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

Name of Facility			License No.	Report for Year Ended			Page	of		
Mattatuck Health Care Facility, Inc.			144-RH	9/30/2021			11	37		
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Allen V. Desena		44,381		Group Ins (15/1a5 Life Ins)	Administrator	1,040	A2	Carriage Manor, 157 Hillside Ave., Waterbury, CT 06720	1,040	44,381
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.

**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
Mattatuck Health Care Facility, Inc.				144-RH	9/30/2021				12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Mattatuck Health Care Facility, Inc.	144-RH	9/30/2021	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			1,400	35		
2. Dentist			4,670	Fee for Svc		
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care			989	Fee for Svc		
b. Other						
6. Social Worker			1,200	48		
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)			5,200	96		
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)			12,415	122		
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries			25,873	301		

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

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

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

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

Name of Facility Mattatuck Health Care Facility, Inc.		License No. 144-RH		Report for Year Ended 9/30/2021	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Carolyn Hogrefe, RD, Woodbury, CT 06798	Dietician	<input type="radio"/>	<input checked="" type="radio"/>			
Kimberly Smead	Physical Therapist	<input type="radio"/>	<input checked="" type="radio"/>			
Therapeutic Pathways, LLC	Social Workers	<input type="radio"/>	<input checked="" type="radio"/>			
C. Marc N. Raad, MD	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
HealthDrive, 888 Worcester St, Wellesley, MA 02482	Dentist	<input type="radio"/>	<input checked="" type="radio"/>			
Melissa Thiede	Infection Preventist	<input type="radio"/>	<input checked="" type="radio"/>			
Cristina Freimuth	Physical Therapist	<input type="radio"/>	<input checked="" type="radio"/>			
Karen Petrucelli	Infection Preventist	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
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		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Mattatuck Health Care Facility, Inc.	144-RH	9/30/2021	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 16,221		16,221	
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 8,600		8,600	
4. Social Security (F.I.C.A.)	\$ 65,660		65,660	
5. Health Insurance	\$ 12,121		12,121	
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$			
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$			
d. Accounting and Auditing	\$ 9,600		9,600	
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 6,271		6,271	
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$ 14,570		14,570	
g. Office Supplies	\$ 3,424		3,424	
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 4,285		4,285	
2. Cellular Phones	\$			
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$			
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$ 44,467		44,467	
2. Other (<i>Specify</i>) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 264,653		264,653	
Subtotal	\$ 449,870		449,870	

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Mattatuck Health Care Facility, Inc.	144-RH	9/30/2021	16	37
Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	449,870		449,870	
i. Travel and Entertainment				
1. Resident Travel and Entertainment \$				
2. Holiday Parties for Staff \$				
3. Gifts to Staff and Residents \$				
4. Employee Travel \$				
5. Education Expenses Related to Seminars and Conventions \$				
6. Automobile Expense (<i>not purchase or depreciation</i>) \$				
7. Other (<i>Specify</i>) \$ See Attached Schedule				
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>) \$				
2. Advertising Telephone Directory (<i>all such expenses</i>)*** \$				
3. Advertising Other (<i>Specify</i>)*** \$ See Attached Schedule	85		85	
4. Fund-Raising*** \$				
5. Medical Records \$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)*** \$				
7. Postage \$	377		377	
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule \$				
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.*** \$	556		556	
9. Subscriptions \$				
10. Contributions*** \$ See Attached Schedule				
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>) \$				
12. Administrative Management Services** \$				
13. Other (<i>Specify</i>) \$ See Attached Schedule	20,895		20,895	
C-14 Total Administrative & General Expenditures	\$ 471,782		471,782	

* 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)
Advertising		\$ 85	
Total Other Advertising	\$ -	\$ 85	\$ -

Schedule of Dues

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

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Late Fees		\$ 487	
PR Processing		\$ 7,083	
Auto -Fuel		\$ 76	
Licenses and Permits		\$ 755	
MDS Support Service		\$ 3,905	
Fees & Permits		\$ 3,210	
Bank Service Charges		\$ 52	
Casual labor		\$ 3,827	
Miscellaneous		\$ 1,080	
Lions Club of Waterbury		\$ 300	
Costco Membership		\$ 120	
Total Other Administrative and General	\$ -	\$ 20,895	\$ -

Schedule C-1 - Management Services*

Name of Facility Mattatuck Health Care Facility, Inc.	License No. 144-RH	Report for Year Ended 9/30/2021	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
N/A			

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

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

Name of Facility Mattatuck Health Care Facility, Inc.		License No. 144-RH	Report for Year Ended 9/30/2021	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$	76,503		76,503	
2. Non-Food Supplies	\$	10,613		10,613	
3. Other (Specify) _____	\$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)					
c. Other (Specify) _____					
2D. Total Dietary Expenditures (2a + b + c + d)		\$	87,116	87,116	
2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F. Resident Meals:	Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D?	<input type="radio"/> Yes		<input checked="" type="radio"/> No		
H. Did you receive revenue from employees?	<input type="radio"/> Yes		<input checked="" type="radio"/> No		If yes, specify amt.
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes		<input checked="" type="radio"/> No		If yes, specify cost.
K. Is any revenue collected from these people?	<input type="radio"/> Yes		<input checked="" type="radio"/> No		If yes, specify amt.
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes		<input checked="" type="radio"/> No		If yes, specify cost.
N. Is any revenue collected from employees?	<input type="radio"/> Yes		<input checked="" type="radio"/> 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.

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

Name of Facility Mattatuck Health Care Facility, Inc.		License No. 144-RH	Report for Year Ended 9/30/2021	Page 19	of 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. \$	606		606	
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. \$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$	2,964		2,964	
c. Other (Specify)	\$				
3D. Total Laundry Expenditures (3a + b + c)	\$	3,570		3,570	
3E. Laundry Questionnaire					
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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.

**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
Mattatuck Health Care Facility, Inc.		144-RH	9/30/2021	20	37
Item		Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel			
a.	In-House Care				
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	13,225		13,225
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel			
		Amt. \$			
C. Other (<i>Specify</i>)		\$			
4D. Total Housekeeping Expenditures (4a + b + c)		\$	13,225		13,225
5.	Resident Care (Supplies)**				
a.	Prescription Drugs***				
	1. Own Pharmacy	\$			
	2. Purchased from	\$	5,170		5,170
b.	Medicine Cabinet Drugs	\$			
c.	Medical and Therapeutic Supplies	\$	41,435		41,435
d.	Ambulance/Limousine***	\$			
e.	Oxygen				
	1. For Emergency Use	\$			
	2. Other***	\$			
f.	X-rays and Related Radiological Procedures***	\$			
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$			
h.	Laboratory***	\$			
i.	Recreation	\$	12,316		12,316
j.	Direct Management Services*	\$			
k.	Indirect Management Services*	\$			
l.	Other (Specify)**** See Attached Schedule	\$	1,891		1,891
5M. Total Resident Care Expenditures (5a - 5j)		\$	60,811		60,811

* 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.

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

Name of Facility Mattatuck Health Care Facility, Inc.			License No. 144-RH		Report for Year Ended 9/30/2021			Page of 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
N/A		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

* List all contracted services over \$10,000. Use additional sheets if necessary.
 ** Refer to Page 4 for definition of related.
 *** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended			Page	of
Mattatuck Health Care Facility, Inc.	144-RH	9/30/2021			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 42,687		42,687			
b. Heat	\$ 21,861		21,861			
c. Light & Power	\$ 17,041		17,041			
d. Water	\$ 10,420		10,420			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 1,769		1,769			
f. Other (<i>itemize</i>)	\$					
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 93,779		93,779			
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$ 23,393		23,393			
c. Non-Movable Equipment	\$ 13,270		13,270			
d. Movable Equipment	\$ 9,917		9,917			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 46,580		46,580			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 483,000		483,000			
10. Property Taxes						
a. Real estate taxes paid by owner	\$ 27,367		27,367			
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$ 1,758		1,758			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 558,704		558,704			

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

Mattatuck Health Care Facility, Inc.
9/30/2021

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
9/21/2021	Painting	\$ 22,707	5	\$ 4,541
4/23/2021	Driveway repairs	\$ 35,284	5	\$ 7,057
8/25/2021	Handrails/Door Guards	\$ 12,470	5	\$ 2,494
9/13/2021	Handrails/Kick Plates/Door Protectors	\$ 13,147	5	\$ 2,629
Total additions for Building Improvements		\$ 83,609		\$ 16,722 *
Deletions:				
Total deletions for Building Improvements		\$ -		\$ - **

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
8/13/2021	Generator	\$ 82,312	20	\$ 4,116
7/15/2021	Washer Machine	\$ 11,543	5	\$ 2,309
7/28/2021	Rooftop	\$ 12,571	5	\$ 2,514
Total additions for Non-Movable Equipment		\$ 106,425		\$ 8,938 *
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
5/26/2021	Freezer	\$ 3,422	5	\$ 684
4/8/2021	Chairs/Cubicle Curtains	\$ 22,974	5	\$ 4,595
8/1/2021	Chairs/Furniture	\$ 6,333	5	\$ 1,267
10/29/2020	Charis	\$ 2,169	5	\$ 434
Total additions for Movable Equipment		\$ 34,898		\$ 6,980 *
Deletions:				
Total deletions for Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

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

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility Mattatuck Health Care Facility, Inc.			License No. 144-RH		Report for Year Ended 9/30/2021			Page 24	of 37
Item	Date of Acquisition		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
	Month	Year							
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									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									

* 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 Mattatuck Health Care Facility, Inc.	License No. 144-RH	Report for Year Ended 9/30/2021	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description	Total				
1. Date Land Purchased	07/06/78				
2. Date Structure Completed					
3. If NOT Original Owner, Date of Purchase	07/06/78				
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	43				
6. Square Footage	16,186				
7. Acquisition Cost					
a. Land					
b. Building					
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)					
b. Date Mortgage Obtained					
c. Interest Rate for the Cost Year					
d. Term of Mortgage (number of years)					
e. Amount of Principal Borrowed					
f. Principal balance outstanding as of					
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.

CT DSS AR 2018
2.0.0 LTC/DSS AR 2018
12/31/2018 01:23AM

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

Name of Facility		License No.	Report for Year Ended			Page	of
Mattatuck Health Care Facility, Inc.		144-RH	9/30/2021			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)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Mattatuck Health Care Facility, Inc		144-RH		9/30/2021		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$			
12. D. Other Interest Expense (Specify)				\$	5,404	5,404	
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	5,404	5,404	
14. Insurance							
a. Insurance on Property (buildings only)				\$	31,392	31,392	
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$			
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. Total Insurance Expenditures (14a + b + c)				\$	31,392	31,392	
15. Total All Expenditures (A-13 thru C-14)				\$	2,195,834	2,195,834	

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Mattatuck Health Care Facility, Inc.				144-RH	9/30/2021	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	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.			Accounting	\$			
10a.			Legal	\$ 4,420		4,420	
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.	15	1f	Life insurance premiums on the life of Owners, Partners, Operators	\$ 14,570		14,570	
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m3	Unallowable Advertising *	\$ 85		85	
19.	15	1k	Income Tax / Corporate Business Tax	\$ 44,467		44,467	
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 2,423		2,423	
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)				\$ 65,965		65,965	

* 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)
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

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	m13	Late Fees		\$ 487	
16	m13	Lions Club		\$ 300	
16	m13	Miscellaneous		\$ 1,080	
16	8a	Chamber of Commerce		\$ 556	
Total Other A&G Adjustments			\$ -	\$ 2,423	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Mattatuck Health Care Facility, Inc.			144-RH	9/30/2021	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 65,965		65,965	
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$			
28.			Ambulance/Limousine	\$			
29.			X-rays, etc	\$			
30.			Laboratory	\$			
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 1,891		1,891	
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.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
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)				\$ 67,856		67,856	

*** 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.

Mattatuck Health Care Facility, Inc.
9/30/2021

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Part A Expense:8140 · Medicare Transmission		\$ 1,891	
Total Other Ancillary Costs			\$ -	\$ 1,891	\$ -

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			\$ -	\$ -	\$ -

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			\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Mattatuck Health Care Facility, Inc.	144-RH	9/30/2021			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 1,612,844		1,612,844			
b. Medicaid Room and Board Contractual Allowance **	\$					
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 122,343		122,343			
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$ 126,933		126,933			
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$					
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$					
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$					
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$					
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$					
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$					
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$					
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$					
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$ 4,670		4,670			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 1,866,789		1,866,789			
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 (<i>Specify</i>)	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$					
V. Total Other Revenue (1 thru 8)	\$					
VI. Total All Revenue (III +V)	\$ 1,866,789		1,866,789			

* 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)
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30/II6b	Medicare - Part B		\$ 4,670	
Total Other Resident Revenue		\$ -	\$ 4,670	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Total Interest Income			\$ -	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
Total Other Revenue		\$ -	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Mattatuck Health Care Facility, Inc.	144-RH	9/30/2021	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	929,782
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	158,395
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	1,720
5. Prepaid Expenses			\$	(10,116)
a. _____				
b. _____				
c. _____				
d. See Schedule		(10,116)		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	1,037,914

See Schedule		1,037,914		
A-9. Total Current Assets (Lines A1 thru 8)			\$	2,117,694
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	149,113	\$	
	Accum. Depreciation	149,113		Net
3. Buildings	*Historical Cost	209,601	\$	112,660
	Accum. Depreciation	96,941		Net
4. Leasehold Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		Net
5. Non-Movable Equipment	*Historical Cost	165,171	\$	123,115
	Accum. Depreciation	42,056		Net
6. Movable Equipment	*Historical Cost	141,612	\$	41,714
	Accum. Depreciation	99,898		Net
7. Motor Vehicles	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	54,805

See Schedule		54,805		
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	332,293

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Mattatuck Health Care Facility, Inc.	144-RH	9/30/2021	32	37
Account			Amount	
Total Brought Forward:			\$	2,449,987
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements		*Historical Cost _____ Accum. Depreciation _____ Net	\$	
3. Buildings		*Historical Cost _____ Accum. Depreciation _____ Net	\$	
4. Non-Movable Equipment		*Historical Cost _____ Accum. Depreciation _____ Net	\$	
5. Movable Equipment		*Historical Cost _____ Accum. Depreciation _____ Net	\$	
6. Motor Vehicles		*Historical Cost _____ Accum. Depreciation _____ Net	\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense		*Historical Cost _____ Accum. Depreciation _____ Net	\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	(2,597)
Name and Address		Amount	Loan Date	
Loans from Related Party		(2,597)		
7. Other Assets (<i>itemize</i>)			\$	

See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	(2,597)
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	2,447,391

* 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
Mattatuck Health Care Facility, Inc.	144-RH	9/30/2021	33	37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable			\$	52,974
2. Notes Payable (<i>itemize</i>)			\$	

See Schedule				
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)			\$	
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)			\$	32,529
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$	
6. Accrued Payroll Taxes Payable			\$	(4,003)
7. Medicare Final Settlement Payable			\$	
8. Medicare Current Financing Payable			\$	
9. Mortgage Payable (<i>Current Portion</i>)			\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)			\$	
11. Accrued Income Taxes*			\$	(1,590)
12. Other Current Liabilities (<i>itemize</i>)			\$	1,931,871

See Schedule				1,931,871
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	2,011,781

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Mattatuck Health Care Facility, Inc.	License No. 144-RH	Report for Year Ended 9/30/2021	Page 34	of 37
Account				Amount
Total Brought Forward:				2,011,781
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				
				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 144,256

See Schedule				144,256
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 144,256
C. Total All Liabilities (Lines A-13 + B-5)				\$ 2,156,037

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

Name of Facility	License No.	Report for Year Ended	Page	of
Mattatuck Health Care Facility, Inc.	144-RH	9/30/2021	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	45,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	(138,391)
5. Cumulated Earnings			\$	713,789
6. Gain or Loss for Period			\$	(329,045)
	10/1/2020	thru 9/30/2021		
7. Total Net Worth			\$	291,353
C. Total Reserves and Net Worth			\$	291,353
D. Total Liabilities, Reserves, and Net Worth			\$	2,447,391

H. Changes in Total Net Worth

Name of Facility Mattatuck Health Care Facility, Inc.	License No. 144-RH	Report for Year Ended 9/30/2021	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2020			\$	708,738
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	1,866,789
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	2,195,834
D. Net Income or Deficit			\$	(329,045)
E. Balance			\$	379,693
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount	
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period			\$	379,693

I. Preparer's/Reviewer's Certification

Name of Facility Mattatuck Health Care Facility, Inc.	License No. 144-RH	Report for Year Ended 9/30/2021	Page 37	of 37
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<i>Check appropriate category</i>		
<input type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)

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

Printed Name of Preparer

CJLC LLC

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