

# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2016

Name of Facility (as licensed) <b>HANCOCK HALL</b>	
Address (No. & Street, City, State, Zip Code) <b>31 STAPLES STREET, DANBURY, CT . 06810</b>	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> ICF Mental Retardation	
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016

License Numbers:	CCNH 2185-C	RHNS	ICF Mental Retardation	Medicare Provider 07-5414
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Medicaid Provider Numbers:	CCNH 2185	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

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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 HANCOCK HALL [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 2016, 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) Jennifer Malone-Seixas			Printed Name (Owner) Frank D. Malone		
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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility HANCOCK HALL		Period Covered:	From 10/1/2015	To 9/30/2016
Address of Facility 31 STAPLES STREET, DANBURY, CT . 06810				
Report Prepared By CLIFTONLARSONALLEN LLP		Phone Number 617-984-8100	Date 3/9/2017	
Item	Total	CCNH	RHNS	Mental Retardatio n
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (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 203-794-9466		Report for Year Ended 9/30/2016		Page 2	of 37
Name of Facility (as shown on license) HANCOCK HALL			Address (No. & Street, City, State, Zip) 31 STAPLES STREET, DANBURY, CT . 06810		
License Numbers:		CCNH 2185-C	RHNS	ICF Mental Retardation	Medicare Provider No. 07-5414
Type of Facility (Check appropriate box(es))					
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input type="checkbox"/> ICF Mental Retardation	
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 type="radio"/> No   If "Yes," explain fully.					
<b>Administrator</b>					
Name of Administrator Jennifer Malone-Seixas			Nursing Home Administrator's License No.:	00-1928	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		



**General Information and Questionnaire**  
**Corporate Owners**

Name of Facility HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2016	Page 3A	of 37
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
FILOSA CARE CENTER, INC	31 STAPLES STREET, DANBURY, CT . 06810	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Frank D. Malone	105 Middle River Rd., Danbury, CT 06811	Treasurer	2100
Barbara A. Malone	105 Middle River Rd., Danbury, CT 06811	Secretary	2250
Michael D. Malone	197 Guinea Road, Monroe, CT 06468	President	250
Jennifer Malone-Seixas	592 Manville Road, Pleasantville, NY 10570	Vice-President	200

Names of Stockholders Owning at Least 10% of Shares	Business Address	Title	No. Shares Held by Each
Frank D. Malone	105 Middle River Rd., Danbury, CT 06811	Treasurer	2100
Barbara A. Malone	105 Middle River Rd., Danbury, CT 06811	Secretary	2250





**General Information and Questionnaire  
 Related Parties\***

Name of Facility HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2016	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	%**				
Staples Realty, LLC	105 Middle River Rd., Danbury, CT 06811	<input type="radio"/>	<input checked="" type="radio"/>		Rental of Building	Page 22 / Line 9	566,748	566,748
Filosa Convalescent Home, Inc	13 Hakim St., Danbury, CT 06810	<input checked="" type="radio"/>	<input type="radio"/>		Shared Expenses	See Attached	See Attached	See Attached
Space Pants, LLC	197 Guinea Road, Monroe, CT 06468	<input type="radio"/>	<input checked="" type="radio"/>		Rent Expense - Off Site Storage	Page 22 / Line 9	7,400	7,400
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					

\* 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 HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2016	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.  
 Allocation of Related Company expenses based on the number of beds in each facility as follows: Hancock Hall 96 Beds / 60% and Filosa for Nursing & Rehab 64 Beds / 40%. Maintenance and housekeeping shared expenses allocated based on square feet. (Hancock Hall 59% and Filosa for Nursing & Rehab 41%)

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

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

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

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

Name of Facility HANCOCK HALL			License No. 2185-C	Report for Year Ended 9/30/2016			Page 6	of 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							
GE Capital/Ricoh USA, PO Box 41554, Philadelphia, PA 19101	<input type="radio"/>	<input checked="" type="radio"/>	Copier Machine Lease	07/29/15	60 Month Lease	7,345		7,345	
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
<b>Is a Mileage Log Book Maintained for All Leased Vehicles ?</b>							<input type="radio"/> Yes <input type="radio"/> No	<b>Total ***</b>	7,345

\* 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 HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2016	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	Address (No. & Street, City, State, Zip Code)
1 CLIFTONLARSONALLEN LLP	300 CROWN COLONY DR., STE 310, QUINCY, MA 02169
2 EQUALE & CIRONE, LLP	24 STONY HILL RD, BETHEL, CT 06801
3	
4	

Services Provided by This Firm (*describe fully*)

1 Financial Statement Review and Preparation of Cost Reports and Tax Return	\$ 21,255
2 Preparation of annual personal property tax return	\$ 2,475
3	\$
4	\$
	Charge for Services Provided
	\$ 23,730

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

- Yes     No    Page 15, Line 1.d

**Legal Services Information**

Name of Legal Firm or Independent Attorney	Telephone Number
1 N/A	
2	
3	
4	
5	

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	\$
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided
	\$

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

- Yes     No

## Schedule of Resident Statistics

Name of Facility HANCOCK HALL			License No. 2185-C			Report for Year Ended 9/30/2016				Page 8		of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total ICF Mental Retardation	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	ICF Mental Retardation	Total	CCNH	RHNS	ICF Mental Retardation	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	96	96			96	96			96	96			
B. On last day of THIS report period	96	96			96	96			96	96			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	85	85			85	85			90	90			
B. As of midnight of THIS report period	94	94			85	85			94	94			
3. Total Number of Days Care Provided During Period													
A. Medicare	2,907	2,907			2,132	2,132			775	775			
B. Medicaid (Conn.)	22,965	22,965			17,568	17,568			5,397	5,397			
C. Medicaid (other states)													
D. Private Pay	5,676	5,676			3,830	3,830			1,846	1,846			
E. State SSI for RCH													
F. Other (Specify) Commercial Ins/Medicare Advant	467	467			365	365			102	102			
G. Total Care Days During Period (3A thru F)	32,015	32,015			23,895	23,895			8,120	8,120			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days	4	4							4	4			
B. Other Bed Reserve Days	29	29			22	22			7	7			
5. <b>Total Resident Days (3G + 4A + 4B)</b>	32,048	32,048			23,917	23,917			8,131	8,131			

### Schedule of Resident Statistics (Cont'd)

Name of Facility HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2016	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?       Yes       No

If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	ICF Mental Retardation	Lost			Gained			CCNH	RHNS	ICF Mental Retardation	
	(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	ICF Mental Retardation
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	ICF Mental Retardation	R.C.H.	ICF-MR
No. of Residents	7		57		30				
Per Diem Rate									
a. One bed rm.					500.00				
b. Two bed rms.	637.60		245.45		470.00				
c. Three or more bed rms.									

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	ICF Mental Retardation
A. Medicare - Part B	2,115	2,115		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	8,849	8,849		
<b>D. Total Physical Therapy Treatments</b>	<b>10,964</b>	<b>10,964</b>		

8. Total Number of Speech Therapy Treatments

	TOTAL	CCNH	RHNS	ICF Mental Retardation
A. Medicare - Part B	380	380		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	325	325		
<b>D. Total Speech Therapy Treatments</b>	<b>705</b>	<b>705</b>		

9. Total Number of Occupational Therapy Treatments

	TOTAL	CCNH	RHNS	ICF Mental Retardation
A. Medicare - Part B	1,316	1,316		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	8,468	8,468		
<b>D. Total Occupational Therapy Treatments</b>	<b>9,784</b>	<b>9,784</b>		

### Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
HANCOCK HALL	2185-C	9/30/2016	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	ICF Mental Retardation	Hours
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)	31,625					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	92,380	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	154,336	7,491				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	31,777	1,248				
c. Dietary Workers	397,771	27,023				
6. Housekeeping Service						
a. Head Housekeeper	48,376	1,223				
b. Other Housekeeping Workers	210,183	17,689				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	62,808	1,223				
b. Other Maintenance Workers	86,242	3,881				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	71,830	5,074				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant	62,601	1,248				
b. Other Accountants	129,194	4,027				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	200,506	4,160				
b. RN						
1. Direct Care	1,022,184	27,783				
2. Administrative**	107,380	3,502				
c. LPN						
1. Direct Care	801,103	28,023				
2. Administrative**	176,651	5,429				
d. Aides and Attendants	1,494,311	91,801				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	154,266	6,943				
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	92,947	2,874				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	5,428,471	242,722				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH		RHNS		ICF Mental Retardation	
	\$	Hours	\$	Hours	\$	Hours
<b>Total</b>	\$ -	-	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		ICF Mental Retardation	
	\$	Hours	\$	Hours	\$	Hours
Religious Expense	\$ 1,150	24				
<b>Total</b>	\$ 1,150	24	\$ -	-	\$ -	-



**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	
HANCOCK HALL				2185-C	9/30/2016			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	ICF Mental Retardation							
<b>Section I - Operators/Owners</b>										
Frank D. Malone					Treasurer/CFO			Filosa Conv. Home 13 Hakim St, Danbury, CT 06810		71,114
Jennifer Malone-Seixas	21,585				Vice President			Filosa Conv. Home 13 Hakim St, Danbury, CT 06810		44,055
Michael Malone	10,040				President			Filosa Conv. Home 13 Hakim St, Danbury, CT 06810	2,080	200,031
<b>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).</b>										

\* 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	
HANCOCK HALL				2185-C	9/30/2016			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	ICF Mental Retardation							
<b>Section III - Administrators***</b>										
Jennifer Malone-Seixas	92,380				Administrator	2,080	A. 2.			
<b>Section IV - Assistant Administrators</b>										

\*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		
HANCOCK HALL	2185-C	9/30/2016	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	ICF Mental Retardation	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary</b>						
(For all such services complete Schedule B1)						
1. Dietitian	47,779	1,062				
2. Dentist						
3. Pharmacist	7,104	154				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	207,630	3,662				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	40,200	281				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)	450	2				
2. Pharmaceutical Committee (Quarterly meetings)	450	2				
3. Staff Development Committee (Once annually)	225	1				
e. Other (Specify) Psychiatric evaluations and services	10,000	56				
9. Speech Therapist						
a. Resident Care	28,642	1,467				
b. Other						
10. Occupational Therapist						
a. Resident Care	177,913	3,256				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	1,150	24				
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>521,543</b>	<b>9,967</b>				

\* 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 HANCOCK HALL		License No. 2185-C	Report for Year Ended 9/30/2016	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Deborah Lyon, 7 North Branch Rd, Newtown, CT 06470	Dietician - dietary needs and reports	<input type="radio"/>	<input checked="" type="radio"/>		
Omnicare Pharmacy Services , 525 Knotter Drive, Cheshire, CT	General Supervision of Drug Administration	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
Alliance Rehab of CT , 1520 Kensington Rd, Suite105, Oakbrook, IL 60523///	PT evaluations and Treatment	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
Serafima Glouzgal/Daniel Wollman, 388 Grove St, Ridgefield, CT 06877/555 Bridgeport Ave,	Coordination of Medical care for Residents	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
Members of organized medical staff (Robert Ruxin, MD/ Jeanine Famiglietti, MD/Frederick	Infection Control Review	<input type="radio"/>	<input checked="" type="radio"/>		
Members of organized medical staff (Robert Ruxin, MD/ Jeanine Famiglietti, MD/Frederick	Pharmaceutical review	<input type="radio"/>	<input checked="" type="radio"/>		
Members of organized medical staff (Robert Ruxin, MD/ Jeanine Famiglietti, MD/Frederick	Staff Development Review	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
Orestes Arcuni, MD , 4 Bartram Drive, West Redding, CT 06896	Psychiatric evaluations and services	<input type="radio"/>	<input checked="" type="radio"/>		
Alliance Rehab of CT , 1520 Kensington Road, Suite 105, Oakbrook, IL 60523	Speech evaluations and treatments	<input type="radio"/>	<input checked="" type="radio"/>		
Alliance Rehab of CT , 1520 Kensington Road, Suite 105, Oakbrook, IL 60523	Occupational evaluations and treatments	<input type="radio"/>	<input checked="" type="radio"/>		
Rev. David Franklin, St. Joseph's Roman Catholic Church, 8 Robinson Ave, Danbury, CT 06810	Mass and clergy visits to facility residents	<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
HANCOCK HALL	2185-C	9/30/2016		15	37
Item	Total	CCNH	RHNS	ICF Mental Retardation	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 188,973	188,973			
2. Disability Insurance	\$ 38,231	38,231			
3. Unemployment Insurance	\$ 106,909	106,909			
4. Social Security (F.I.C.A.)	\$ 383,637	383,637			
5. Health Insurance	\$ 316,535	316,535			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 21,894	21,894			
8. Uniform Allowance	\$ 9,837	9,837			
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 13,273	13,273			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 52,692	52,692			
d. Accounting and Auditing	\$ 23,730	23,730			
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$				
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$				
g. Office Supplies	\$ 38,981	38,981			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 20,319	20,319			
2. Cellular Phones	\$ 4,328	4,328			
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*	\$				
2. Other ( <i>Specify</i> ) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 613,260	613,260			
<b>Subtotal</b>	\$ 1,832,599	1,832,599			

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

(Carry Subtotals forward to next page)

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

HANCOCK HALL  
9/30/2016

Attachment Page 15

**Schedule of Other Employee Benefits**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>ICF Mental Retardation</b>
Other Expense - Physicals	\$ 13,273		
<b>Total</b>	\$ 13,273	\$ -	\$ -

---

**Schedule of Other Taxes**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>ICF Mental Retardation</b>
<b>Total</b>	\$ -	\$ -	\$ -

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

Name of Facility HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2016	Page 16	of 37
Item	Total	CCNH	RHNS	ICF Mental Retardation
<b>Subtotals Brought Forward:</b>		1,832,599	1,832,599	
1. Travel and Entertainment				
1. Resident Travel and Entertainment	\$ 7,635	7,635		
2. Holiday Parties for Staff	\$ 1,602	1,602		
3. Gifts to Staff and Residents	\$ 11,551	11,551		
4. Employee Travel	\$ 947	947		
5. Education Expenses Related to Seminars and Conventions	\$ 7,348	7,348		
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$ 294	294		
7. Other ( <i>Specify</i> ) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$ 8,357	8,357		
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$			
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 15,423	15,423		
4. Fund-Raising***	\$			
5. Medical Records	\$ 3,817	3,817		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$			
7. Postage	\$ 19,770	19,770		
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 13,667	13,667		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$ 871	871		
10. Contributions*** See Attached Schedule	\$ 3,591	3,591		
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	\$ 130,280	130,280		
<b>C-14 Total Administrative &amp; General Expenditures</b>	<b>\$ 2,057,752</b>	<b>2,057,752</b>		

\* 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	ICF Mental Retardation
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

**Schedule of Other Advertising**

Description	CCNH	RHNS	ICF Mental Retardation
Promotion/Public Relations	\$ 15,423		
<b>Total Other Advertising</b>	\$ 15,423	\$ -	\$ -

**Schedule of Dues**

Description	CCNH	RHNS	ICF Mental Retardation
Dues - NH - Associations	\$ 6,551		
Professional Dues / License / Fees	\$ 6,096		
Facility License Fees	\$ 1,020		
<b>Total Dues</b>	\$ 13,667	\$ -	\$ -

**Schedule of Contributions**

Description	CCNH	RHNS	ICF Mental Retardation
Contributions	\$ 3,591		
<b>Total Contributions</b>	\$ 3,591	\$ -	\$ -

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	ICF Mental Retardation
Discounts earned	\$ 614		
Cable TV expense	\$ 18,950		
Contract professional services	\$ 7,584		
Repairs/service office equip	\$ 51,108		
Payroll service	\$ 40,895		
Miscellaneous expense	\$ 3,136		
Bank service charge and fees	\$ 6,688		
Resident related misc expense	\$ 1,305		
<b>Total Other Administrative and General</b>	\$ 130,280	\$ -	\$ -



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

Name of Facility HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2016	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 #

\* 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 HANCOCK HALL		License No. 2185-C	Report for Year Ended 9/30/2016	Page 18	of 37
Item		Total	CCNH	RHNS	ICF Mental Retardation
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 314,058	314,058		
2.	Non-Food Supplies	\$ 43,502	43,502		
3.	Other ( <i>Specify</i> ) _____ Dietary Small Equipment	\$ 664	664		
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)		\$			
c. Management Services**		\$			
d. Other ( <i>Specify</i> ) _____		\$			
<b>2E. Total Dietary Expenditures (2a + b + c + d)</b>		\$ 358,224	358,224		
2F. Dietary Questionnaire		Total	CCNH	RHNS	ICF Mental Retardation
G.	Resident Meals: Total no. of meals served per day:*	262	262		
H.	Is cost of employee meals included in 2E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		
I.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
L.	Is any revenue collected from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
O.	Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				

\* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.  
 \*\* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Name of Facility HANCOCK HALL		License No. 2185-C	Report for Year Ended 9/30/2016		Page 19	of 37
Item		Total	CCNH	RHNS	ICF Mental Retardation	
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. \$	12,258	12,258		
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. \$	19,903	19,903		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$				
c. Management Services**		\$				
d. Other (Specify) Laundry Equip Rental/Small Equip		\$	11,486	11,486		
3E. <b>Total Laundry Expenditures</b> (3a + b + c + d)		\$	43,647	43,647		
3F. Laundry Questionnaire						
G. Is cost of employee laundry included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H. Did you receive revenue from employees?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
I. Where is the revenue received reported in the Cost Report?		(Page/Line Item)				
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K. Did you receive revenue from these people?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
L. Where is the revenue received reported in the Cost Report?		(Page/Line Item)				

\* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3E.

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of	
HANCOCK HALL	2185-C	9/30/2016	20	37	
Item		Total	CCNH	RHNS	ICF Mental Retardation
4. Housekeeping	Sq. Ft. Serviced	56,300	56,300		
a. In-House Care	by Personnel				
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	35,479	35,479		
b. Purchased Services ( <i>by contract other than through Management Services</i> )	Sq. Ft. Serviced				
( <i>Complete Schedule C-2 att. Page 21</i> )	by Personnel				
	Amt. \$				
c. Management Services*	\$				
d. Other ( <i>Specify</i> )	\$				
<b>4E. Total Housekeeping Expenditures (4a + b + c + d)</b>	\$	35,479	35,479		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	147,240	147,240		
b. Medicine Cabinet Drugs	\$	1,327	1,327		
c. Medical and Therapeutic Supplies	\$	182,051	182,051		
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	21,750	21,750		
f. X-rays and Related Radiological Procedures***	\$	4,572	4,572		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$	5,916	5,916		
i. Recreation	\$	11,619	11,619		
j. Other (Specify)**** See Attached Schedule	\$	4,209	4,209		
<b>5K. Total Resident Care Expenditures (5a - 5j)</b>	\$	378,684	378,684		

\* 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 HANCOCK HALL			License No. 2185-C		Report for Year Ended 9/30/2016			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	ICF Mental Retardation	Pg	Line
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

\* 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 HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2016			Page 22	of 37
Item	Total	CCNH	RHNS	ICF Mental Retardation		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 106,151	106,151				
b. Heat	\$ 58,038	58,038				
c. Light & Power	\$ 79,623	79,623				
d. Water	\$ 48,131	48,131				
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 7,345	7,345				
f. Other ( <i>itemize</i> )	\$ 46,522	46,522				
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$ 345,810</b>	<b>345,810</b>				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$ 37,639	37,639				
b. Building & Building Improvements	\$ 165,252	165,252				
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 82,866	82,866				
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$ 285,757</b>	<b>285,757</b>				
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$ 1,582	1,582				
c. Leasehold Improvements	\$ 84,334	84,334				
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$ 85,916</b>	<b>85,916</b>				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 574,148	574,148				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 109,086	109,086				
c. Personal property taxes	\$ 16,503	16,503				
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$ 1,071,410</b>	<b>1,071,410</b>				

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

**Schedule of Other Repairs and Maintenance**

Description	CCNH	RHNS	ICF Mental Retardation
Refuse Removal	\$ 23,675		
Exterminating	\$ 3,382		
Bed/Chair Alarms	\$ 1,745		
Repairs/Maintenance Grounds	\$ 17,720		
<b>Total Other Repairs and Maintenance</b>	\$ 46,522	\$ -	\$ -

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HANCOCK HALL  
9/30/2016

Schedule of Land Improvements Acquired during this report period

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

\*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
<b>Additions:</b>				
<b>Total additions for Building Improvements</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
<b>Total additions for Non-Movable Equipment</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
	See attached fixed asset report accounts labeled 16250, 16350, 16450, 1655	\$ 33,526		\$ 2,072
<b>Total additions for Movable Equipment</b>		\$ 33,526		\$ 2,072 *
<b>Deletions:</b>				
	See attached fixed asset report accounts labeled 16250, 16350, 16450, 1655	\$ (36,225)		\$ -
<b>Total deletions for Movable Equipment</b>		\$ (36,225)		\$ - **

\*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
<b>Additions:</b>				
	See attached fixed asset report account labeled 16650	\$ 9,148		\$ 776
<b>Total additions for Leasehold Improvement</b>		\$ 9,148		\$ 776 *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Amortization Schedule\***

Name of Facility HANCOCK HALL			License No. 2185-C		Report for Year Ended 9/30/2016			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							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1. Loan related to parking lot improvem	5	2010	10 YRS	15,824	10,563	Life of loan		1,582	
2.									
3.									
B-4. Subtotal									1,582
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period	Various		Various	1,269,436	593,624	Actual Life		83,558	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	Various		10 YRS	9,148		Actual Life		776	
C-4. Subtotal									84,334
<b>D. Total Amortization</b>									85,916

\* 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 HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2016	Page 25	of 37
<b>11. Property Questionnaire</b>				
<b>Part A</b>				
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		02/23/84		
2. Date Structure Completed		03/09/84		
3. If <b>NOT</b> Original Owner, Date of Purchase				
4. Date of Initial Licensure		03/09/84		
5. Total Licensed Bed Capacity		96		
6. Square Footage		56,300		
7. Acquisition Cost				
a. Land		170,000		
b. Building		4,551,697		
<b>Part B - Owner and Related Parties</b>	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	02/18/05			
c. Interest Rate for the Cost Year	5.80%			
d. Term of Mortgage (number of years)	20			
e. Amount of Principal Borrowed	5,377,205			
f. Principal balance outstanding as of 9/30/2015	3,044,195			
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
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				
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility HANCOCK HALL		License No. 2185-C	Report for Year Ended 9/30/2016		Page 26	of 37
Item			Total	CCNH	RHNS	ICF Mental Retardation
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$ 7,795	7,795		
Name of Lender		Rate				
Union Savings Bank (parking lot loan)		4.35%				
Address of Lender						
225 Main Street Danbury, CT 06810						
3. Third Mortgage			\$ 2,455	2,455		
Name of Lender		Rate				
Union Savings Bank (renovation loan)		4.00%				
Address of Lender						
225 Main Street Danbury, CT 06810						
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. <b>Total Building Interest Expense</b> (A1 - A4 + B5)			\$ 10,250	10,250		

*(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
HANCOCK HALL		2185-C		9/30/2016			27	37
Item				Total	CCNH	RHNS	ICF Mental Retardation	
Subtotals Brought Forward:				10,250	10,250			
12. C. Movable Equipment								
1. Automotive Equipment				\$ 1,577	1,577			
A. Item		Rate	Amount					
Patient Van / Maint Vehicle		4.00% / 3	50000 / 23839					
Lender								
Union Savings Bank / Chase Auto Finance								
Address of Lender								
USB: 225 Main Street Danbury, CT 06810								
2. Other (Specify)				\$ 373	373			
A. Item		Rate	Amount					
Fire Pump		4.00%	25,000					
Lender								
Union Savings Bank								
Address of Lender								
225 Main Street Danbury, CT 06810								
B. Item		Rate	Amount					
Lender								
Address of Lender								
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$ 1,950	1,950			
12. D. Other Interest Expense (Specify)				\$ 16,586	16,586			
Line of Credit								
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)				\$ 28,786	28,786			
14. Insurance								
a. Insurance on Property (buildings only)				\$ 14,846	14,846			
b. Insurance on Automobiles				\$ 3,482	3,482			
c. Insurance other than Property (as specified above)								
1. Umbrella (Blanket Coverage)				\$ 10,529	10,529			
2. Fire and Extended Coverage				\$ 36,433	36,433			
3. Other (Specify)				\$ 10,425	10,425			
D&O \$7901/Fidelity \$1774/Patient Bond \$750								
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$ 75,715	75,715			
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$ 10,345,521	10,345,521			

### D. Adjustments to Statement of Expenditures

Name of Facility HANCOCK HALL				License No. 2185-C	Report for Year Ended 9/30/2016	Page 28	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	ICF Mental Retardation
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.	10	12.n.	Salaries not related to Resident Care	\$			
3.	10	12.g.	Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 31,625	31,625		
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1.c	Bad Debts	\$ 52,692	52,692		
10.			Accounting & Legal	\$			
11.			Telephone	\$			
12.	15	h.2	Cellular Telephone	\$ 2,164	2,164		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	15	1.3	Gifts, flowers and coffee shops	\$ 11,551	11,551		
15.	16	1.5	Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$ 3,412	3,412		
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 *	\$ 15,423	15,423		
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m10	Fund Raising / Contributions	\$ 3,591	3,591		
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 14,161	14,161		
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 134,619	134,619		

\* 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	ICF Mental Retardation
10	A.1	Frank Malone	\$ 21,585		
10	A.1	Jennifer Malone-Seixas	\$ 10,040		
<b>Total Other Salaries Adjustment</b>			\$ 31,625	\$ -	\$ -

**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	ICF Mental Retardation
<b>Total Other Fees Adjustments</b>			\$ -	\$ -	\$ -

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	ICF Mental Retardation
16	m.13	Discounts Earned	\$ 614		
16	m.13	Miscellaneous Expense	\$ 3,136		
16	m.13	Banke Service Charges and Fees	\$ 6,688		
16	m.13	Resident Related Misc Expense	\$ 1,304		
15	l.a.4	FICA on Owner/Operator salaries	\$ 2,419		
<b>Total Other A&amp;G Adjustments</b>			\$ 14,161	\$ -	\$ -

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

Name of Facility HANCOCK HALL			License No. 2185-C	Report for Year Ended 9/30/2016	Page 29	of 37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	ICF Mental Retardation
Subtotals Brought Forward				\$ 134,619	134,619		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5a2	Prescription Drugs	\$ 147,240	147,240		
28.	20	5d	Ambulance/Limousine	\$			
29.	20	5f	X-rays, etc	\$ 4,572	4,572		
30.	20	5h	Laboratory	\$ 5,916	5,916		
31.	20	5c	Medical Supplies	\$ 12,982	12,982		
32.	20	5e2	Oxygen (non emergency)	\$ 21,750	21,750		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 4,209	4,209		
<b>Page 22 - Maintenance and Property</b>							
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	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.	27	14.c.3	Property Insurance	\$ 7,901	7,901		
<b>Other - Miscellaneous</b>							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$			
<b>Not For Profit Providers Only</b>							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51.	<b>Total Amount of Decrease (Items 1 - 50)</b>			\$ 339,189	339,189		

\*\*\* 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.

HANCOCK HALL  
9/30/2016

**Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	ICF Mental Retardation
20	5.j	Tech Component Part A	\$ 2,500		
20	5.j	Med/Surg Supply Part A	\$ 1,409		
20	5.j	DME Rental Supply Part A	\$ 300		
<b>Total Other Ancillary Costs</b>			\$ 4,209	\$ -	\$ -

**Schedule of Excess Movable Equipment Depreciation**

Page Ref	Line Ref	Description	CCNH	RHNS	ICF Mental Retardation
<b>Total Excess Movable Equipment Depreciation</b>			\$ -	\$ -	\$ -

**Schedule of Other Property Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	ICF Mental Retardation
<b>Total Other Property Adjustments</b>			\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	ICF Mental Retardation
<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	ICF Mental Retardation
<b>Total Unallowable Building Interest</b>			\$ -	\$ -	\$ -

### F. Statement of Revenue

Name of Facility HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2016			Page 30	of 37
Item	Total	CCNH	RHNS	ICF Mental Retardation		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 10,604,771	10,604,771				
b. Medicaid Room and Board Contractual Allowance **	\$ (4,984,558)	(4,984,558)				
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 1,409,700	1,409,700				
b. Medicare Room and Board Contractual Allowance **	\$ 432,667	432,667				
4. a. Private-Pay Residents and Other	\$ 2,965,292	2,965,292				
b. Private-Pay Room and Board Contractual Allowance **	\$ (160,916)	(160,916)				
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 191,352	191,352				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (191,352)	(191,352)				
c. Prescription Drugs - Non-Medicare	\$ 23,454	23,454				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (23,144)	(23,144)				
2. a. Medical Supplies - Medicare	\$ 6,407	6,407				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (2,975)	(2,975)				
c. Medical Supplies - Non-Medicare	\$ 562	562				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (556)	(556)				
3. a. Physical Therapy - Medicare	\$ 401,608	401,608				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (346,624)	(346,624)				
c. Physical Therapy - Non-Medicare	\$ 52,959	52,959				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (52,258)	(52,258)				
4. a. Speech Therapy - Medicare	\$ 67,052	67,052				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (44,759)	(44,759)				
c. Speech Therapy - Non-Medicare	\$ 6,057	6,057				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (5,312)	(5,312)				
5. a. Occupational Therapy - Medicare	\$ 429,320	429,320				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (394,400)	(394,400)				
c. Occupational Therapy - Non-Medicare	\$ 62,100	62,100				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (61,279)	(61,279)				
6. a. Other ( <i>Specify</i> ) - Medicare	\$ (858)	(858)				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ (3,786)	(3,786)				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 10,380,524	10,380,524				
<b>IV. Other Revenue*</b>						
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> )	\$ 147	147				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$ (3,506)	(3,506)				
<b>V. Total Other Revenue</b> (1 thru 8)	\$ (3,359)	(3,359)				
<b>VI. Total All Revenue</b> (III +V)	\$ 10,377,165	10,377,165				

\* 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	ICF Mental Retardation
30II6A-CCH	X-Ray	\$ 5,925		
30II6A-CCH	Contractual Adj - X-Ray Med A	\$ (5,925)		
30II6A-CCH	Lab	\$ 7,393		
30II6A-CCH	Contractual Adj - Lab Med A	\$ (7,393)		
30IIA-CCH	Prior Year Adjustment	\$ (858)		
<b>Total Other Resident Revenue - Medicare</b>		\$ (858)	\$ -	\$ -

**Schedule of Other Non-Medicare Resident Revenue**

**Related Exp**

Page Ref	Description	CCNH	RHNS	ICF Mental Retardation
30II6b-CCH	Non Emergency Facility Van Transport	\$ 5,925		
30II6b-CCH	Prior Year Adjustment	\$ (9,723)		
30II6b-CCH	X-Ray	\$ 150		
30II6b-CCH	Contractual Adj X-Ray Managed Care	\$ (148)		
30II6b-CCH	Lab	\$ 794		
30II6b-CCH	Contractual Adj Lab Managed Care	\$ (784)		
<b>Total Other Resident Revenue</b>		\$ (3,786)	\$ -	\$ -

**Interest Income**

**Account**

Page Ref	Account	Balance	CCNH	RHNS	ICF Mental Retardation
30IV5-CCH	Interest Income (detail below):		\$ 147		
<b>Total Interest Income</b>			\$ 147	\$ -	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	ICF Mental Retardation
30IV8-CCH	Gain/Loss of Disposed Equipment	\$ (3,506)		
<b>Total Other Revenue</b>		\$ (3,506)	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
HANCOCK HALL	2185-C	9/30/2016	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	42,872
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	740,312
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	20,712
4. Inventories			\$	
5. Prepaid Expenses			\$	36,440
a. 401k Forfeiture One Account	856			
b. Prepaid Insurance	25,327			
c. Prepaid Expenses	8,397			
d. Prepaid Corporate Income Tax	1,860			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	
_____				
_____				
_____				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	840,336
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	512,490	\$	257,301
	Accum. Depreciation	255,189		Net
3. Buildings	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		Net
4. Leasehold Improvements	*Historical Cost	1,278,584	\$	600,626
	Accum. Depreciation	677,958		Net
5. Non-Movable Equipment	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		Net
6. Movable Equipment	*Historical Cost	940,188	\$	253,621
	Accum. Depreciation	686,567		Net
7. Motor Vehicles	*Historical Cost	89,239	\$	60,391
	Accum. Depreciation	28,848		Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
_____				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	1,171,939

\* 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
HANCOCK HALL	2185-C	9/30/2016	32	37
Account			Amount	
Total Brought Forward:			\$	2,012,275
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	170,000
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	5,118,999		
	Accum. Depreciation	5,044,945	Net	\$ 74,054
4. Non-Movable Equipment				
	*Historical Cost	138,445		
	Accum. Depreciation	138,445	Net	\$
5. Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
6. Motor Vehicles				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
7. Minor Equipment-Not Depreciable			\$	
C-8 <b>Total Leasehold or Like Properties</b> (C1 thru 7)			\$	244,054
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> )			\$	43,193
Name and Address		Amount	Loan Date	
Filosa Convalescent Home DBA Filosa For Nursing and Rehabilitation		43,193		
7. Other Assets ( <i>itemize</i> )			\$	91,419
Bed license (net of amortization)		88,000		
Financing Costs (net of amortization)		3,419		
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	134,612
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$	2,390,941

\* 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
HANCOCK HALL		2185-C	9/30/2016	33	37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	402,580
2. Notes Payable ( <i>itemize</i> )				\$	580,084
USB for Renovation (due 5/29/17; all current)				33,765	
USB for Parking Lot (due 4/28/20; current is \$415)				157,517	
USB Line of Credit				388,802	
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$	20,475
Name of Lender		Purpose	Amount	Date Due	
Union Savings Bank		Patient Van	12,529	03/01/19	
Chase Auto Finance		Maintenance Vehicle	7,946	04/20/19	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$	242,428
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	13,787
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable ( <i>Current Portion</i> )				\$	
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities ( <i>itemize</i> )				\$	53,366
In Acct Recreation				16,000	
Accrued Expenses				37,366	
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>				\$	<b>1,312,720</b>

\* 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 HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2016	Page 34	of 37
Account				Amount
Total Brought Forward:				1,312,720
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )				
				\$ 32,313
Name of Lender	Purpose	Amount	Date Due	
Union Savings Bank	Patient Van	19,731	3/1/19	
Chase Auto Finance	Maintenance Vehicle	12,582	4/20/19	
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> )				\$
_____				
_____				
_____				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 32,313
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 1,345,033

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

Name of Facility	License No.	Report for Year Ended	Page	of	
HANCOCK HALL	2185-C	9/30/2016	35	37	
Account			Amount		
<b>A. Reserves</b>					
1. Reserve for value of leased land			\$	170,000	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	74,054	
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			\$	244,054	
<b>B. Net Worth</b>					
1. Owner's Capital			\$		
2. Capital Stock			\$	1,000	
3. Paid-in Surplus			\$	257,500	
4. Treasury Stock			\$		
5. Cumulated Earnings			\$	511,710	
6. Gain or Loss for Period	10/1/2015	thru	9/30/2016	\$	31,644
7. Total Net Worth			\$	801,854	
<b>C. Total Reserves and Net Worth</b>			\$	1,045,908	
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	2,390,941	

### H. Changes in Total Net Worth

Name of Facility HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2016	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2015			\$	770,210
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$	10,377,165
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$	10,345,521
D. Net Income or Deficit			\$	31,644
E. Balance			\$	801,854
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. <b>Balance at End of Period</b>			\$	801,854
				09/30/16

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

Name of Facility HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2016	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> ICF Mental Retardation		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
CLIFTONLARSONALLEN LLP				
Address Address			Phone Number	
300 Crown Colony Dr., Ste 310, Quincy, MA 02368			617-984-8100	

Error Check

Level	Item	Reported as	
	Page 23 - Accumulated Dep. of Movable Eq.	722792 is inconsistent with Page 31	686567