

Mr. Chris LaVigne  
CON & Reimbursement  
Department of Social Services  
55 Farmington Avenue  
Hartford, CT 06105

Mr. LaVigne:

This enclosed 2015 Medicaid Cost Report intentionally omits the following disallowances:

- a. Administrator and Related Party salaries
- b. Dues and Membership Fees to Professional Associations
- c. Physical or Speech Therapy salaries or fees
- d. Depreciation and/or interest expense related to capitalized items previously deemed unallowable by the Department



225 Pitkin Street  
East Hartford  
Connecticut 06108

860.610.9009 (t)  
860.610.9030 (f)

[cjl.com](http://cjl.com)

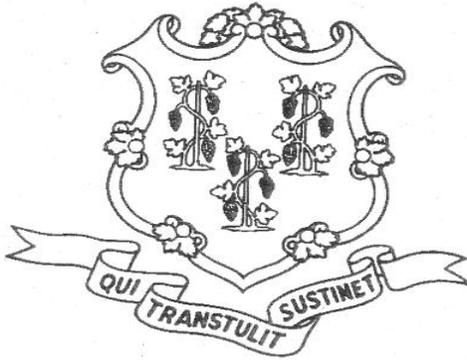
It is our understanding that the software utilized by the Department in the rate setting process computes the necessary disallowances for these areas and our intention is to eliminate the potential for a duplicate disallowance.

If you have any questions, please contact me at 860-610-9009.

Respectfully,

Craig J. Lubitski, CPA  
Partner

# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2015

Name of Facility (as licensed) Brook Hollow HCC dba Village Green of Wallingford	
Address (No. & Street, City, State, Zip Code) 55 Kondracki Lane, Wallingford CT 06492	
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"/> (Specify)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH 2223-C	RHNS	(Specify)	Medicare Provider 07-5234
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Medicaid Provider Numbers:	CCNH 20149	RHNS	SLTC
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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)	License No.	Report for Year Ended	Page	of
Brook Hollow HCC dba Village Green of Wallingford	2223-C	9/30/2015	1	37

**Administrator's/Owner's Certification**

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR 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 Brook Hollow HCC dba Village Green of Wallingford [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)		Date
			<i>Carole Scillia</i>		8/24/2016
Printed Name (Administrator)			Printed Name (Owner)		
C. Fitzgerald			Carole Scillia for Revera Health Systems Management		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)		Comm. Expires
			<i>Davy Delaney</i>		2/28/2017
Address of Notary Public					
129 Birchwood Drive, Middletown CT 06457					

(Notary Seal)

State of Connecticut  
**Department of Social Services**  
 25 Sigourney Street, Hartford, Connecticut 06106

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Brook Hollow HCC dba Village Green of Wallingford		Period Covered:	From 10/1/2014	To 9/30/2015
Address of Facility 55 Kondracki Lane, Wallingford CT 06492				
Report Prepared By Craig J. Lubitski Consulting LLC		Phone Number 860-610-9009	Date 2/15/2016	
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. <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) 265-6771	Report for Year Ended 9/30/2015	Page 2	of 37
Name of Facility (as shown on license) Brook Hollow HCC dba Village Green of Wallingford			Address (No. & Street, City, State, Zip) 55 Kondracki Lane, Wallingford CT 06492		
License Numbers:	CCNH 2223-C	RHNS	(Specify)	Medicare Provider No. 07-5234	
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"/> (Specify)	
Type of Ownership (Check appropriate box)					
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input 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 N/A	Date Closed N/A	
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.	
<b>Administrator</b>					
Name of Administrator C. Fitzgerald			Nursing Home Administrator's License No.:	877	
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 Brook Hollow HCC dba Village Green of W	License No. 2223-C	Report for Year Ended 9/30/2015	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	

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each

Names of Stockholders Owning at Least 10% of Shares	Business Address	Title	No. Shares Held by Each

Connecticut Subacute LLC	538 Preston Avenue, Suite 270, Meriden, CT 06450		
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**General Information and Questionnaire  
 Related Parties\***

Name of Facility Brook Hollow HCC dba Village Green of Wallingford	License No. 2223-C	Report for Year Ended 9/30/2015	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	%**				
Revera Health Systems, LLC	538 Preston Avenue, Suite 270, Meriden, CT 06450	<input type="radio"/>	<input checked="" type="radio"/>		Administrative Management Services	Pg 16/m12	548,550	548,550
Revera Health Systems, LLC	538 Preston Avenue, Suite 270, Meriden, CT 06450	<input type="radio"/>	<input checked="" type="radio"/>		Pension	Pg 15/1a7	15,612	15,612
Cap Pharmacy, LLC	80 Clark Drive #B, East Berlin, CT 06023	<input type="radio"/>	<input checked="" type="radio"/>		Pharmacy	Pg 20/5a1	483,101	483,101
Premier Therapy	201 South Main St., Building A, Loft, Lambertville, NJ 08530	<input checked="" type="radio"/>	<input type="radio"/>	10%	PT/ST/OT	Pg 13/B5, B9, B10	676,368	676,368
Revera Health Systems, LLC	538 Preston Avenue, Suite 270, Meriden, CT 06450	<input type="radio"/>	<input checked="" type="radio"/>		Shared Health Insurance	Pg 15/1a5	556,234	556,234
Revera Health Systems, LLC	538 Preston Avenue, Suite 270, Meriden, CT 06450	<input type="radio"/>	<input checked="" type="radio"/>		Shared Dental Insurance	Pg 15/1a5	28,782	28,782
Revera Health Systems, LLC	538 Preston Avenue, Suite 270, Meriden, CT 06450	<input type="radio"/>	<input checked="" type="radio"/>		Shared Workers Comp.	Pg 15/1a1	356,893	356,893
Revera Health Systems, LLC	538 Preston Avenue, Suite 270, Meriden, CT 06450	<input type="radio"/>	<input checked="" type="radio"/>		Shared Life Insurance	Pg 15/1a6	7,312	7,312
Revera Health Systems, LLC	538 Preston Avenue, Suite 270, Meriden, CT 06450	<input type="radio"/>	<input checked="" type="radio"/>		Loaned Funds	34/B3	21,006,481	N/A

\* 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 Brook Hollow HCC dba Village Green of Wall	License No. 2223-C	Report for Year Ended 9/30/2015	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.

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			License No.	Report for Year Ended			Page	of	
Brook Hollow HCC dba Village Green of Wallingford			2223-C	9/30/2015			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							
Pitney Bowes, 2225 American Drive, Neenah, WI 54956	<input type="radio"/>	<input checked="" type="radio"/>	Mailing System	N/A	Ongoing	3,076	3,076		
	<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"/>							
<b>Is a Mileage Log Book Maintained for All Leased Vehicles ?</b>							<input type="radio"/> Yes <input type="radio"/> No	<b>Total ***</b>	3,076

\* 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 Brook Hollow HCC dba Village Gr	License No. 2223-C	Report for Year Ended 9/30/2015	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 Deloitte & Touche LLP 2 3 4	Address (No. & Street, City, State, Zip Code) 220 W. Main St. Louisville, KY 40202
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Services Provided by This Firm (*describe fully*)

1 Year-End Audit	\$ 4,820
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 4,820

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

- Yes     No    Pg 15, line 1d

**Legal Services Information**

Name of Legal Firm or Independent Attorney 1 See Attached 2 3 4 5	Telephone Number
--	------------------

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

1	
2	
3	
4	
5	

Services Provided by This Firm (*describe fully*)

1 See Attached	\$ 30,470
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided
	\$ 30,470

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

- Yes     No    Pg 15, line 1e

**Schedule of Resident Statistics**

Name of Facility Brook Hollow HCC dba Village Green of Wallingford			License No. 2223-C			Report for Year Ended 9/30/2015				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	180	180			180	180			180	180		
B. On last day of THIS report period	180	180			180	180			180	180		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	130	130			130	130			113	113		
B. As of midnight of THIS report period	106	106			113	113			106	106		
3. Total Number of Days Care Provided During Period												
A. Medicare	6,303	6,303			5,302	5,302			1,001	1,001		
B. Medicaid (Conn.)	32,357	32,357			24,749	24,749			7,608	7,608		
C. Medicaid (other states)	1,095	1,095			819	819			276	276		
D. Private Pay	2,540	2,540			2,104	2,104			436	436		
E. State SSI for RCH												
F. Other (Specify) Insurances/VA/Hospice	1,578	1,578			1,122	1,122			456	456		
G. Total Care Days During Period (3A thru F)	43,873	43,873			34,096	34,096			9,777	9,777		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days	11	11			11	11						
5. <b>Total Resident Days (3G + 4A + 4B)</b>	43,884	43,884			34,107	34,107			9,777	9,777		

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

Name of Facility Brook Hollow HCC dba Village Green of Wa			License No. 2223-C			Report for Year Ended 9/30/2015			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-IID				
No. of Residents	9		79		18								
Per Diem Rate													
a. One bed rm.	Various RUGS		199.00		414.00								
b. Two bed rms.	Various RUGS		199.00		391.00								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								1,029	1,029				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								1,012	1,012				
C. Other								3,859	3,859				
D. <b>Total Physical Therapy Treatments</b>								5,900	5,900				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								397	397				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								185	185				
C. Other								977	977				
D. <b>Total Speech Therapy Treatments</b>								1,559	1,559				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								2,398	2,398				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								1,157	1,157				
C. Other								4,204	4,204				
D. <b>Total Occupational Therapy Treatments</b>								7,759	7,759				

### Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Brook Hollow HCC dba Village Green of Wallingford	2223-C	9/30/2015	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	(Specify)	Hours
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	114,251	2,346				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	256,877	10,950				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	412,038	30,284				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	70,679	2,293				
b. Other Maintenance Workers	32,933	2,069				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
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	166,913	3,599				
b. RN						
1. Direct Care	668,515	16,847				
2. Administrative**	215,343	6,014				
c. LPN						
1. Direct Care	1,448,326	49,678				
2. Administrative**						
d. Aides and Attendants	1,707,726	116,255				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	117,284	6,363				
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	257,577	8,226				
n. Marketing						
o. Other (Specify) See Attached Schedule	31,682	1,569				
<i>A-13. Total Salary Expenditures</i>	5,500,144	256,493				

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

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

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



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

Name of Facility				License No.	Report for Year Ended				Page	of
Brook Hollow HCC dba Village Green of Wallingford				2223-C	9/30/2015				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)							
<b>Section I - Operators/Owners</b>										
<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	
Brook Hollow HCC dba Village Green of Wallingford				2223-C	9/30/2015			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)							
<b>Section III - Administrators***</b>										
Kimberly Coleman 10/1/14-3/17/15	55,034			Standard Benefits	Full responsibility for facility operations	1,133	A2			
C. Fitzgerald 3/18/15-9/30/15	59,217			Standard Benefits	Full responsibility for facility operations	1,213	A2			
<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		
Brook Hollow HCC dba Village Green of Wallingfo	2223-C	9/30/2015	13	37		
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	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						
2. Dentist						
3. Pharmacist						
4. Podiatrist	397	4				
5. Physical Therapy						
a. Resident Care	241,363	3,792				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	36,000	180				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify) Other Physician / Phychiatrist	4,311	Disallowed				
9. Speech Therapist						
a. Resident Care	72,823	1,255				
b. Other						
10. Occupational Therapist						
a. Resident Care	362,182	6,092				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	51,856	777				
2. Administrative***	94,842	607				
b. LPN						
1. Direct Care	2,378	57				
2. Administrative***						
c. Aides	23,254	954				
d. Other						
12. Other (Specify) See Attached Schedule						
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>889,405</b>	<b>13,718</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 Brook Hollow HCC dba Village Green of Wallingford		License No. 2223-C		Report for Year Ended 9/30/2015	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Premier Therapy, 201 South Main St., Building A, Loft, Lambertville, NJ 08530	PT/ST/OT	<input checked="" type="radio"/>	<input type="radio"/>	Revera owns 100%		
Cap Pharmacy: 80 Clark Drive #B, East Berlin, CT 06023	Pharmacists	<input checked="" type="radio"/>	<input type="radio"/>	Parent Co. owns 51% of Pharmacy		
Anuruddha Walaliyadda M.D: 11 New England Drive, Wallingford, CT 06492	Medical Director (Old)	<input type="radio"/>	<input checked="" type="radio"/>			
Paul Monaco: 2690 Whitney Ave. Hamden, CT 06518	Physician / Associate Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
Giosa & Brown Pulmonary Associates: 455 Lewis Ave. Suite 200, Meriden CT 06451	Pulmonologist	<input type="radio"/>	<input checked="" type="radio"/>			
Robert Badrigian: 5 South Main St. Suite 515, Branford CT 06405	Dentist	<input type="radio"/>	<input checked="" type="radio"/>			
Swallowing Diagnostics: PO Box 484 Avon, CT 06001	Speech Language Pathologist	<input type="radio"/>	<input checked="" type="radio"/>			
Benjamin Yeboah M.D: 15 Roxbury Court, Cheshire, CT 06410	Medical Director (New March 2014)	<input type="radio"/>	<input checked="" type="radio"/>			
Clinical Resources LLC, 3338 Peachtree Road, Atlanta, GA 30326	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Leader Stat, 8149 E Evans Road, Scottsdale, AZ 85260	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Maxim Healthcare, 1344 Silas Deane Hwy, Rocky Hill, CT 06067	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>			
The Nurse Network, 653 Main Street, Plantsville, CT 06479	Nursing Pool	<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"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input 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
Brook Hollow HCC dba Village Green of Wallin	2223-C	9/30/2015		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 356,893	356,893			
2. Disability Insurance	\$ 277	277			
3. Unemployment Insurance	\$ 135,271	135,271			
4. Social Security (F.I.C.A.)	\$ 408,105	408,105			
5. Health Insurance	\$ 408,175	408,175			
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 7,312	7,312			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 15,612	15,612			
8. Uniform Allowance	\$ (80)	(80)			
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 21,132	21,132			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 260,623	260,623			
d. Accounting and Auditing	\$ 4,820	4,820			
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 30,470	30,470			
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$				
g. Office Supplies	\$ 51,173	51,173			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 12,899	12,899			
2. Cellular Phones	\$ 3,194	3,194			
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	\$ 791,863	791,863			
<b>Subtotal</b>	\$ 2,507,739	2,507,739			

\* 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
Brook Hollow HCC dba Village Green of Wallingford	2223-C	9/30/2015		16	37
Item	Total	CCNH	RHNS	(Specify)	
<b>Subtotals Brought Forward:</b>		2,507,739	2,507,739		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$ 600	600			
2. Holiday Parties for Staff	\$ 6,026	6,026			
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 30,442	30,442			
5. Education Expenses Related to Seminars and Conventions	\$ 18,735	18,735			
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> )	\$ 2,639	2,639			
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 23,772	23,772			
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	\$				
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 14,205	14,205			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
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**	\$ 548,550	548,550			
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 1,301,659	1,301,659			
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 4,454,369	4,454,369			

\* 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)
Meals & Entertainment			
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
Marketing	\$ 23,772		
<b>Total Other Advertising</b>	\$ 23,772	\$ -	\$ -

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 12,159		
The Joint Commission	\$ 2,046		
<b>Total Dues</b>	\$ 14,205	\$ -	\$ -

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
<b>Total Contributions</b>	\$ -	\$ -	\$ -

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
Administrative Purchased Services	\$ 7,338		
Bank Charges	\$ 1,289		
Penalties	\$ 33,281		
Software Fees	\$ 40,625		
IT Supplies & Fees	\$ 5,985		
Licenses	\$ 9,156		
Gain/Loss on Disposal of Assets	\$ 10,264		
Write Down of Carrying Value	\$ 1,193,722		
<b>Total Other Administrative and General</b>	\$ 1,301,659	\$ -	\$ -

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

Name of Facility Brook Hollow HCC dba Village Green of	License No. 2223-C	Report for Year Ended 9/30/2015	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 #
Revera Health Systems, LLC, 538 Preston Ave., Suite 270, Meriden, CT 06450	548,550	Management Oversight	Pg 16/m12

**\* 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 Brook Hollow HCC dba Village Green of Wallingford	License No. 2223-C	Report for Year Ended 9/30/2015	Page 18	of 37
<b>Item</b>	<b>Total</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 215,787	215,787		
2. Non-Food Supplies	\$ 45,693	45,693		
3. Other (Specify) _____	\$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 221,986	221,986		
c. Management Services**	\$			
d. Other (Specify) _____	\$			
<b>2E. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 483,467</b>	<b>483,467</b>		
<b>2F. Dietary Questionnaire</b>	<b>Total</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
G. Resident Meals: Total no. of meals served per day:*				
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 Brook Hollow HCC dba Village Green of Wallingford		License No. 2223-C	Report for Year Ended 9/30/2015	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. \$			
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)		\$	194,580	194,580	
c. Management Services**		\$			
d. Other (Specify)		\$			
<b>3E. Total Laundry Expenditures (3a + b + c + d)</b>		<b>\$</b>	<b>194,580</b>	<b>194,580</b>	
<b>3F. Laundry Questionnaire</b>					
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
Brook Hollow HCC dba Village Green of Walli		2223-C	9/30/2015		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced	42,521	34,769		7,752
	a. In-House Care	by Personnel				
	1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	28,248	28,248		
	b. Purchased Services ( <i>by contract other than through Management Services</i> )	Sq. Ft. Serviced	42,521	34,769		7,752
	( <i>Complete Schedule C-2 att. Page 21</i> )	by Personnel				
		Amt. \$	310,475	310,475		
	c. Management Services*	\$				
	d. Other ( <i>Specify</i> )	\$				
4E.	<b>Total Housekeeping Expenditures</b> (4a + b + c + d)	\$	338,723	338,723		
5.	Resident Care (Supplies)**					
	a. Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from	\$	483,101	483,101		
	b. Medicine Cabinet Drugs	\$				
	c. Medical and Therapeutic Supplies	\$	235,893	235,893		
	d. Ambulance/Limousine***	\$	49,345	49,345		
	e. Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	12,141	12,141		
	f. X-rays and Related Radiological Procedures***	\$	21,820	21,820		
	g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$	7,195	7,195		
	h. Laboratory***	\$	31,702	31,702		
	i. Recreation	\$	29,620	29,620		
	j. Other (Specify)**** See Attached Schedule	\$	111,627	111,627		
5K.	<b>Total Resident Care Expenditures</b> (5a - 5j)	\$	982,445	982,445		

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

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

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

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

**Schedule of Other Resident Care**

Description	CCNH	RHNS	(Specify)
IV Therapy	\$ 26,558		
Professional Fees	\$ 6,480		
OT Supplies	\$ 4,032		
Catheter & Ostomy Supplies	\$ 2,667		
Equipment	\$ 21,883		
Tube Feed Supplies	\$ 470		
RT Supplies & Equipment	\$ 42,895		
Professiona Fee for Rehab/Ancillary	\$ 6,642		
<b>Total Other Resident Care</b>	\$ 111,627	\$ -	\$ -

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

Name of Facility Brook Hollow HCC dba Village Green of Wallingford			License No. 2223-C		Report for Year Ended 9/30/2015				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
		<input type="radio"/>	<input checked="" type="radio"/>							
Morrison Management Specialist	PO Box 102289, Atlanta, GA 30368	<input type="radio"/>	<input checked="" type="radio"/>		Contracted Dietary Services			221,986	18	2b
Healthcare Services Group, Inc.	Suite 300, 3220 Tilmann, Dr. Bansalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Contracted Housekeeping Services			310,475	20	4b
Healthcare Services Group, Inc.	Suite 300, 3220 Tilmann, Dr. Bansalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Contracted Laundry Services			194,580	19	3b
		<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"/>							

\* 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
Brook Hollow HCC dba Village Green of Wa	2223-C	9/30/2015	22	37
Item	Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant				
a. Repairs & Maintenance	\$ 150,761	150,761		
b. Heat	\$ 35,736	35,736		
c. Light & Power	\$ 132,883	132,883		
d. Water	\$ 61,368	61,368		
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 3,076	3,076		
f. Other ( <i>itemize</i> )	\$ 128,928	128,928		
See Attached Schedule				
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$ 512,753	512,753		
7. Depreciation ( <i>complete schedule page 23*</i> )				
a. Land Improvements	\$ 21,728	21,728		
b. Building & Building Improvements	\$ 146,340	146,340		
c. Non-Movable Equipment	\$ 142,885	142,885		
d. Movable Equipment	\$ 160,640	160,640		
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$ 471,594	471,594		
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )				
a. Organization Expense	\$			
b. Mortgage Expense	\$			
c. Leasehold Improvements	\$			
d. Other ( <i>Specify</i> )	\$			
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$			
10. Property Taxes				
a. Real estate taxes paid by owner	\$ 160,423	160,423		
b. Real estate taxes paid by lessor	\$			
c. Personal property taxes	\$ 550	550		
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$ 632,566	632,566		

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

**Schedule of Other Repairs and Maintenance**

Description	CCNH	RHNS	(Specify)
Equipmenet Rental/Storage Fees	\$ 95,843		
Elevator Contracts	\$ 8,168		
Alarm Contract	\$ 8,074		
Grounds Contract	\$ 11,495		
HVAC Contract	\$ 5,348		
<b>Total Other Repairs and Maintenance</b>	\$ 128,928	\$ -	\$ -

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Brook Hollow HCC dba Village Green of Wallingford  
9/30/2015

**Schedule of Land Improvements Acquired during this report period**

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
Various	Various - See Attached	\$ 19,837	15	\$ 1,213
<b>Total additions for Land Improvements</b>		\$ 19,837		\$ 1,213
<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>				
Various	Various - See Attached	\$ 116,067	Var	\$ 3,965
<b>Total additions for Building Improvements</b>		\$ 116,067		\$ 3,965
<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>				
Various	Various - See Attached	\$ 53,366	Var	\$ 2,666
<b>Total additions for Non-Movable Equipment</b>		\$ 53,366		\$ 2,666
<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>				
Various	Various - See Attached	\$ 48,370	Var	\$ 5,663
<b>Total additions for Movable Equipment</b>		\$ 48,370		\$ 5,663 *
<b>Deletions:</b>				
<b>Total deletions for Movable Equipment</b>		\$ -		\$ - **

\*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>				
<b>Total additions for Leasehold Improvement</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

Village Green of Wallingford Assets Schedule

9/30/2015

Asset #	Start Depr. Date	Description	Total Addition	Useful Life	Depr. Expense
<b>Land</b>					
2071161	10/17/2014	upgrades to sidewalk	19,837.00	15	1,212.86
		Margaret Mikolinski DBA Conn			
		<b>Total Land</b>	<u>19,837.00</u>		<u>1,212.86</u>
<b>Building</b>					
2104209	10/31/2014	Roof upgrades	106,037.33	25	3,889.98
2199041	3/26/2015	resident room window	✓ 1,937.50	40	24.33
2132031	6/25/2015	replace sewer pump	✓ 8,092.54	40	50.99
		<b>Total Building</b>	<u>116,067.37</u>		<u>3,965.30</u>
<b>Non-Movable</b>					
2145465	7/28/2015	retile kitchen/dishroom	✓ 9,840.13	10	164.99
2146020	3/1/2015	heating unit motor upgrades	1,457.47	25	29.28
2154732	4/10/2015	lease buyout of copier	✓ 4,466.77	3	624.63
2009560	10/17/2014	make up air unit for kitchen	19,244.03	25	705.97
2042423	10/7/2014	boiler exhaust fan	2,958.00	25	108.51
1945751	10/1/2014	Annunciator panel	1,494.22	15	289.09
1995513	10/1/2014	HVAC upgrade	1,105.29	25	59.08
1995521	10/1/2014	HVAC upgrade	1,105.29	25	59.08
2077087	10/1/2014	compressor/walk-in fridge	✓ 3,555.48	10	356.28
2077440	10/1/2014	Project Manager Wages	✓ 752.74	40	17.25
2077749	10/1/2014	Project Manager Wages	✓ 53.08	40	1.22
2087904	11/1/2014	Project Manager Wages	✓ 93.66	3	26.06
2088165	11/1/2014	Project Manager Wages	✓ 875.60	40	7.84
2088472	11/1/2014	Project Manager Wages	✓ 426.32	40	8.89
2100451	12/1/2014	Project Manager Wages	✓ 93.66	3	23.41
2100697	12/1/2014	Project Manager Wages	✓ 748.85	40	14.04
2101032	12/1/2014	Project Manager Wages	✓ 52.14	40	0.98
2077204	10/1/2014	Project Manager Wages	✓ 93.36	3	28.54
2113156	1/1/2015	Project Manager Wages	✓ 93.50	3	20.74
2113391	1/1/2015	Project Manager Wages	✓ 230.90	40	3.84
2113682	1/1/2015	Project Manager Wages	✓ 397.44	40	6.61
2123741	2/1/2015	Project Manager Wages	✓ 93.50	3	18.29
2123987	2/1/2015	Project Manager Wages	✓ 506.14	40	7.43
2124285	2/1/2015	Project Manager Wages	✓ 103.23	40	1.51
2136702	3/1/2015	Project Manager Wages	✓ 93.50	3	15.65
2136921	3/1/2015	Project Manager Wages	✓ 282.29	40	3.54
2137220	3/1/2015	Project Manager Wages	✓ 192.06	40	2.41
2166936	4/1/2015	Project Manager Wages	✓ 28.78	40	0.30
2167218	4/1/2015	Project Manager Wages	✓ 92.11	3	12.88
2167437	4/1/2015	Project Manager Wages	✓ 451.32	40	4.73
2179171	5/1/2015	Project Manager Wages	✓ 92.11	3	10.29
2179391	5/1/2015	Project Manager Wages	✓ 282.42	40	2.37

✓ = 3yr  
 $\Sigma \checkmark = \$5812.47$   
 ✓ = 10yr  
 $\Sigma \checkmark = \$15,699$   
 ✓ = 40yr  
 $\Sigma \checkmark = \$15,120.-$

2179761	6/1/2015	Project Manager Wages	Monthly	206.32	40	1.73
2195294	6/1/2015	Project Manager Wages	Monthly	542.46	10	13.67
2195593	6/1/2015	Project Manager Wages	Monthly	29.39	10	0.74
2205368	7/1/2015	Project Manager Wages	Monthly	573.80	10	9.62
2221827	8/1/2015	Project Manager Wages	Monthly	563.11	10	4.71
2231064	9/1/2015	Project Manager Wages	Monthly	595.05	10	-
<b>Total Non-Movable</b>				<u>53,365.52</u>		<u>2,666.20</u>

**Movable**

1997017	10/1/2014	FF&E rm. 102	BSD Care	538.77	10	283.25
1997025	10/1/2014	FF&E rm. 103	BSD Care	538.77	10	283.25
1997033	10/1/2014	FF&E rm. 211	BSD Care	538.77	10	283.25
1997041	10/1/2014	FF&E rm. 212	BSD Care	538.77	10	283.25
1997050	10/1/2014	FF&E rm. 213	BSD Care	538.77	10	283.25
1997068	10/1/2014	FF&E rm. 214	BSD Care	538.77	10	283.25
1997076	10/1/2014	FF&E rm. 215	BSD Care	538.77	10	283.25
1997084	10/1/2014	FF&E rm. 216	BSD Care	538.77	10	283.26
1997092	10/1/2014	FF&E rm. 217	BSD Care	538.77	10	283.25
1997105	10/1/2014	FF&E rm. 218	BSD Care	538.76	10	283.26
2084578	12/9/2014	resident lifts	Direct Supply Equipment	5,124.72	10	384.35
2084586	12/9/2014	resident lifts	Direct Supply Equipment	5,124.72	10	384.35
2084594	12/9/2014	resident lifts	Direct Supply Equipment	5,124.72	10	384.35
2084607	12/9/2014	resident lifts	Direct Supply Equipment	5,124.70	10	384.35
2102406	12/10/2014	resident lifts	Direct Supply Equipment	5,803.03	10	435.23
2102414	12/10/2014	resident lifts	Direct Supply Equipment	5,803.03	10	435.23
2126862	12/31/2014	rack shelves		650.00	3	162.50
2138610	3/26/2015	ptac unit rm. 201	Direct Supply Equipment	702.54	25	14.11
2138628	3/26/2015	ptac unit rm. 202	Direct Supply Equipment	702.54	25	14.11
2138636	3/26/2015	ptac unit rm. 203	Direct Supply Equipment	702.55	25	14.12
2138644	3/26/2015	ptac unit rm. 204	Direct Supply Equipment	702.55	25	14.12
2138652	3/26/2015	ptac unit rm. 205	Direct Supply Equipment	702.55	25	14.12
2138661	3/26/2015	ptac unit rm. 206	Direct Supply Equipment	702.55	25	14.12
2138679	3/26/2015	ptac unit rm. 207	Direct Supply Equipment	702.55	25	14.12
2138687	3/26/2015	ptac unit rm. 208	Direct Supply Equipment	702.55	25	14.12
2138695	3/26/2015	ptac unit rm. 209	Direct Supply Equipment	702.55	25	14.12
2138708	3/26/2015	ptac unit rm. 210	Direct Supply Equipment	702.55	25	14.12
2138716	3/26/2015	ptac unit rm. 211	Direct Supply Equipment	702.55	25	14.12
2140550	4/2/2015	air mattress room 123	Direct Supply Equipment	1,249.60	10	52.42
2140568	4/2/2015	air mattress room 232	Direct Supply Equipment	1,249.60	10	52.42
2063478	10/1/2014	van, wrap, registration	National Van Builders Inc.	66,665.81	3.33	20,040.84
<b>Total Movable</b>				<u>48,369.84</u>		<u>5,663.02</u>

**Total on Cost Report**

304,305.54

33,548.22

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

**Amortization Schedule\***

Name of Facility Brook Hollow HCC dba Village Green of Wallingford			License No. 2223-C		Report for Year Ended 9/30/2015			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.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
<b>D. Total Amortization</b>									

\* 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 Brook Hollow HCC dba Village Green	License No. 2223-C	Report for Year Ended 9/30/2015	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					
2. Date Structure Completed					
3. If <b>NOT</b> Original Owner, Date of Purchase	04/01/99				
4. Date of Initial Licensure	04/01/99				
5. Total Licensed Bed Capacity	180				
6. Square Footage	70,922				
7. Acquisition Cost					
a. Land					
b. Building					
<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)	N/A				
b. Date Mortgage Obtained	N/A				
c. Interest Rate for the Cost Year	N/A				
d. Term of Mortgage (number of years)	N/A				
e. Amount of Principal Borrowed	N/A				
f. Principal balance outstanding as of _____	N/A				
<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		License No.	Report for Year Ended		Page	of
Brook Hollow HCC dba Village Gree		2223-C	9/30/2015		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. <b>Total Building Interest Expense</b> (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
Brook Hollow HCC dba Village Gr		2223-C		9/30/2015		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)				\$			
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)				\$			
14. Insurance							
a. Insurance on Property (buildings only)				\$ 38,350	38,350		
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$			
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$ 64,377	64,377		
Crime, Bonds, Excess & General Liability							
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$ 102,727	102,727		
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$ 14,091,179	14,091,179		

### D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Brook Hollow HCC dba Village Green of Wallingford			2223-C	9/30/2015	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.	13	B10b	Occupational Therapy	\$ 362,182	362,182		
7.			Other - See attached Schedule	\$ 4,311	4,311		
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 260,623	260,623		
10.	15	1e	Accounting & Legal	\$ 25,215	25,215		
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 1,754	1,754		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	12	Gifts, flowers and coffee shops	\$ 5,231	5,231		
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 *	\$ 23,772	23,772		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 1,238,532	1,238,532		
<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	\$			
<b>Subtotal (Items 1 - 26)</b>				\$ 1,921,620	1,921,620		

\* 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)
<b>Total Other Salaries Adjustment</b>			\$ -	\$ -	\$ -

**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B8e	Other Physician Fees	\$ 4,311		
<b>Total Other Fees Adjustments</b>			\$ 4,311	\$ -	\$ -

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Gain/Loss on Disposal	\$ 10,264		
16	m13	Write Down of Carrying Value	\$ 1,193,722		
16	m13	Penalties	\$ 33,281		
30	IV8	Medical Transcript Revenue	\$ 1,266		
<b>Total Other A&amp;G Adjustments</b>			\$ 1,238,532	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Brook Hollow HCC dba Village Green of Wallingford			2223-C	9/30/2015	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,921,620	1,921,620		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5a2	Prescription Drugs	\$ 483,101	483,101		
28.	20	5d	Ambulance/Limousine	\$ 49,345	49,345		
29.	20	5f	X-rays, etc	\$ 21,820	21,820		
30.	20	5h	Laboratory	\$ 31,702	31,702		
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 12,141	12,141		
33.	20	5j	Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 72,590	72,590		
<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.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Research or Experimental Activities	\$			
43.	30	IV4	Radio and Television Revenue	\$ 349	349		
44.			Vending Machine Revenue	\$			
45.	30	IV8	Purchase Discounts and Allowances	\$ 451	451		
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>			\$ 2,593,121	2,593,121		

\*\*\* 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.

Brook Hollow HCC dba Village Green of Wallingford  
 9/30/2015

**Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV Therapy	\$ 26,558		
20	5j	Catheter / Ostomy	\$ 2,667		
20	5j	Tube Feed Supplies	\$ 470		
20	5j	Respiratory Therapy	\$ 42,895		
<b>Total Other Ancillary Costs</b>			\$ 72,590	\$ -	\$ -

**Schedule of Excess Movable Equipment Depreciation**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Excess Movable Equipment Depreciation</b>			\$ -	\$ -	\$ -

**Schedule of Other Property Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Property Adjustments</b>			\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Unallowable Building Interest</b>			\$ -	\$ -	\$ -

### F. Statement of Revenue

Name of Facility Brook Hollow HCC dba Village Green of 2223-C	License No.	Report for Year Ended 9/30/2015	Page 30	of 37
Item	Total	CCNH	RHNS	(Specify)
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>				
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 12,746,440	12,746,440		
b. Medicaid Room and Board Contractual Allowance **	\$ (6,213,699)	(6,213,699)		
2. a. Medicaid ( <i>All other states</i> )	\$ 425,856	425,856		
b. Other States Room and Board Contractual Allowance **	\$ (201,710)	(201,710)		
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 1,757,645	1,757,645		
b. Medicare Room and Board Contractual Allowance **	\$ 494,831	494,831		
4. a. Private-Pay Residents and Other	\$ 2,190,915	2,190,915		
b. Private-Pay Room and Board Contractual Allowance **	\$ (312,366)	(312,366)		
<b>II. Other Resident Revenue</b>				
1. a. Prescription Drugs - Medicare	\$ 310,139	310,139		
b. Prescription Drugs - Medicare Contractual Allowance **	\$			
c. Prescription Drugs - Non-Medicare	\$ 102,002	102,002		
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	\$ 494,993	494,993		
b. Physical Therapy - Medicare Contractual Allowance **	\$			
c. Physical Therapy - Non-Medicare	\$ 232,048	232,048		
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$			
4. a. Speech Therapy - Medicare	\$ 161,406	161,406		
b. Speech Therapy - Medicare Contractual Allowance **	\$			
c. Speech Therapy - Non-Medicare	\$ 53,018	53,018		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$			
5. a. Occupational Therapy - Medicare	\$ 825,141	825,141		
b. Occupational Therapy - Medicare Contractual Allowance **	\$			
c. Occupational Therapy - Non-Medicare	\$ 270,906	270,906		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$			
6. a. Other ( <i>Specify</i> ) - Medicare	\$ (1,525,006)	(1,525,006)		
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ (834,912)	(834,912)		
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 10,977,646	10,977,646		
<b>IV. Other Revenue*</b>				
1. Meals sold to guests, employees & others	\$ (7,206)	(7,206)		
2. Rental of rooms to non-residents	\$			
3. Telephone	\$			
4. Rental of Television and Cable Services	\$ 349	349		
5. Interest Income ( <i>Specify</i> )	\$ 7	7		
6. Private Duty Nurses' Fees	\$			
7. Barber, Coffee, Beauty and Gift shops	\$			
8. Other ( <i>Specify</i> )	\$ 1,717	1,717		
<b>V. Total Other Revenue</b> (1 thru 8)	\$ (5,132)	(5,132)		
<b>VI. Total All Revenue</b> (III +V)	\$ 10,972,514	10,972,514		

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

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

**Schedule of Other Resident Revenue - Medicare**

**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
30 - II6a	Respiratory Therapy	\$ 4,665		
30 - II6a	Laboratory	\$ 14,444		
30 - II6a	X-Ray	\$ 12,126		
30 - II6a	IV Therapy	\$ 5,180		
30 - II6a	Contractual Allowances	\$ (1,561,420)		
<b>Total Other Resident Revenue - Medicare</b>		\$ (1,525,006)	\$ -	\$ -

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

**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
30 - II6b	Respiratory Therapy	\$ 2,562		
30 - II6b	Laboratory	\$ 5,958		
30 - II6b	X-Ray	\$ 5,364		
30 - II6b	IV Therapy	\$ 3,610		
30 - II6b	Contractual Allowances	\$ (676,984)		
30 - II6b	PY Adjustment	\$ (175,422)		
<b>Total Other Resident Revenue</b>		\$ (834,912)	\$ -	\$ -

**Interest Income**

**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Misc. Interest Income		\$ 7		
<b>Total Interest Income</b>			\$ 7	\$ -	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
30 - IV8	Medical Records	\$ 1,266		
30 - IV8	Rebates	\$ 451		
<b>Total Other Revenue</b>		\$ 1,717	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Brook Hollow HCC dba Village Green	2223-C	9/30/2015	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	57,931
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,194,584
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	87,893
a. Prepaid Insurance	60,158			
b. Prepaid W/C Insurance	20,619			
c. Prepaid Expenses	7,115			
d.				
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)			\$	1,340,408
B. Fixed Assets				
1. Land			\$	1,640,000
2. Land Improvements	*Historical Cost	150,165	\$	69,318
	Accum. Depreciation	80,847		Net
3. Buildings	*Historical Cost	9,692,806	\$	5,242,488
	Accum. Depreciation	4,450,318		Net
4. Leasehold Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		Net
5. Non-Movable Equipment	*Historical Cost	2,550,865	\$	631,549
	Accum. Depreciation	1,919,316		Net
6. Movable Equipment	*Historical Cost	1,400,714	\$	630,766
	Accum. Depreciation	769,948		Net
7. Motor Vehicles	*Historical Cost	100,360	\$	46,626
	Accum. Depreciation	53,734		Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	(1,367,848)
Book vs. Cost Report		(1,367,848)		
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	6,892,899

\* 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 Brook Hollow HCC dba Village Green	License No. 2223-C	Report for Year Ended 9/30/2015	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	8,233,306
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 <b>Total Leasehold or Like Properties</b> (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> )			\$	
Name and Address	Amount	Loan Date		
7. Other Assets ( <i>itemize</i> )			\$	
_____				
_____				
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$ 8,233,306	

\* 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 Brook Hollow HCC dba Village Green of V	License No. 2223-C	Report for Year Ended 9/30/2015		Page 34	of 37
Account				Amount	
Total Brought Forward:				1,537,739	
<b>Liabilities (cont'd)</b>					
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> )				\$ 21,006,481	
Name and Address of Lender	Amount	Loan Date			
Revera Health Systems, LLC	21,006,481				
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$	
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 21,006,481	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 22,544,220	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Brook Hollow HCC dba Village Green	2223-C	9/30/2015	35	37
Account			Amount	
<b>A. Reserves</b>				
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>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	4,225,000
3. Paid-in Surplus			\$	(1,108,119)
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(14,309,131)
6. Gain or Loss for Period			\$	(3,118,664)
	10/1/2014	thru	9/30/2015	
7. Total Net Worth			\$	(14,310,914)
<b>C. Total Reserves and Net Worth</b>			\$	(14,310,914)
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	8,233,306

### H. Changes in Total Net Worth

Name of Facility Brook Hollow HCC dba Village Green o	License No. 2223-C	Report for Year Ended 9/30/2015	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2014			\$	(11,192,250)
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$	10,972,514
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$	14,091,179
D. Net Income or Deficit			\$	(3,118,664)
E. Balance			\$	(14,310,914)
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>			\$	(14,310,914)
				09/30/15

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

Name of Facility Brook Hollow HCC dba Village Green of	License No. 2223-C	Report for Year Ended 9/30/2015	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"/> (Specify)		
<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 Partner	Date Signed 2-24-16		
Printed Name of Preparer Craig J. Lubitski Consulting LLC				
Address 225 Pitkin Street, East Hartford, CT 06108		Phone Number 806-610-9009		