State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2016

Name of Facility (as licensed) FILOSA FOR NURSING AND REHABILITATION		
Address (No. & Street, City, State, Zip Code) 13 HAKIM STREET, DANBURY, CT. 06810		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ ICF Mental Retardation		
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016	

License Numbers:	CCNH	RHNS	ICF Mental Retardation	Medicare Provider
	461-C			07-5074

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	4614		

For Department Use Only

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

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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 IMPRISIONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for FILOSA FOR NURSING AND REHABILITATION [facility name], for the cost report period beginning October 1, 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) Michael Malone			Printed Name (Owner) Barbara A. Malone	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility FILOSA FOR NURSING AND REHABILITATION	Period Covered:		From 10/1/2015	To 9/30/2016
Address of Facility 13 HAKIM STREET, DANBURY, CT. 06810				
Report Prepared By CLIFTONLARSONALLLEN LLP	Phone Number 617-984-8100		Date 3/14/2017	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

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

	CCNH	RHNS	ICF Mental Retardation	Medicare Provider No.
License Numbers:	461-C			07-5074

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ ICF Mental Retardation

Type of Ownership (Check appropriate box)

○ Proprietorship ○ LLC ○ Partnership ◉ Profit Corp. ○ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
Michael Malone		001685

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

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

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
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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 CONVALESCENT HOME, INC	13 HAKIM STREET, DANBURY, CT. 06810	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Frank D. Malone	105 Middle River Road, Danbury, CT 06811	Treasurer	128
Barbara A. Malone	105 Middle River Road, Danbury, CT 06811	Secretary	491
Michael D. Malone	197 Guinea Road, Monroe, CT 06468	President	129
Jennifer Malone-Seixas	592 Manville Road, Pleasantville, NY 10570	Vice-President	119
Names of Stockholders Owning at Least 10% of Shares			
Frank D. Malone	105 Middle River Road, Danbury, CT 06811	Treasurer	128
Barbara A. Malone	105 Middle River Road, Danbury, CT 06811	Secretary	491
Michael D. Malone	197 Guinea Road, Monroe, CT 06468	President	129
Jennifer Malone-Seixas	592 Manville Road, Pleasantville, NY 10570	Vice-President	119
John M. Malone	22 N. Dutcher St., Irvington, NY 10533	Director	119

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ⊙ Yes ○ No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Filosa Care Center DBA Hancock Hall	31 Staples St., Danbury, CT 06810	⊙	○		Shared Expenses	See attached	See Attached	See Attached
Barbara A Malone (Bamco, LLC)	105 Middle River Rd., Danbury, CT	○	⊙		Building Rental	Page 22 Line 9	684,000	684,000
Space Pants, LLC	197 Guinea Road, Monroe,CT 06468	○	⊙		Parking Lot Rental	Page 22 Line 9	5,650	5,650
Space Pants, LLC	197 Guinea Road, Monroe,CT 06468	○	⊙		Off Site Storage Rental	Page 22 Line 9	5,550	5,550
		○	○					
		○	○					
		○	○					
		✂	○					
		○	○					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

Cost allocated as required.

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 and Rehabilitation 64 Beds / 40%. Mainentance and housekeeping shared expenses allocated based on square feet. (Hancock Hall 59% and Filosa for Nursing and Rehabilitation 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.

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General Information and Questionnaire
Leases (Excluding Real Property)

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

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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
GE Capital/Ricoh USA, PO Box 41554, Philadelphia, PA 19101	○	◉	Copier Machine Lease	07/29/15	60 Months	4,873	4,873
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ○ No **Total ***** 4,873

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

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General Information and Questionnaire
Accounting Basis

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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	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 Returns	$ 22,370
2	Preparation of annual personal property tax returns	$ 900
3		$
4		$
	Charge for Services Provided	$ 23,270

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	
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.

No Legal Expense for FY2016

○ Yes ○ No

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Schedule of Resident Statistics

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	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	64	64			64	64			64	64		
B. On last day of THIS report period	64	64			64	64			64	64		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	61	61			61	61			60	60		
B. As of midnight of THIS report period	60	60			58	58			60	60		
3. Total Number of Days Care Provided During Period												
A. Medicare	795	795			633	633			162	162		
B. Medicaid (Conn.)	14,590	14,590			10,902	10,902			3,688	3,688		
C. Medicaid (other states)												
D. Private Pay	6,414	6,414			4,888	4,888			1,526	1,526		
E. State SSI for RCH												
F. Other (Specify) Commercial Insurance	63	63			55	55			8	8		
G. Total Care Days During Period (3A thru F)	21,862	21,862			16,478	16,478			5,384	5,384		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	10	10			10	10						
B. Other Bed Reserve Days	9	9			9	9						
5. ***Total Resident Days*** **(3G + 4A + 4B)**	21,881	21,881			16,497	16,497			5,384	5,384		

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Schedule of Resident Statistics (Cont'd)

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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	CCNH	RHNS	CCNH	RHNS	ICF Mental Retardation	R.C.H.	ICF-MR
No. of Residents		41		19				
Per Diem Rate								
a. One bed rm.				500.00				
b. Two bed rms.	627.46	247.65		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	1,362	1,362		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	1,770	1,770		
D. ***Total Physical Therapy Treatments***	3,132	3,132		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	236	236		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	127	127		
D. ***Total Speech Therapy Treatments***	363	363		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,516	1,516		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	1,887	1,887		
D. ***Total Occupational Therapy Treatments***	3,403	3,403		

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Report of Expenditures - Salaries & Wages

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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	ICF Mental Retardation	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)	236,734					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	78,466	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	99,403	5,226				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	21,272	832				
c. Dietary Workers	317,976	19,698				
6. Housekeeping Service						
a. Head Housekeeper	33,597	858				
b. Other Housekeeping Workers	141,109	11,546				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	43,668	858				
b. Other Maintenance Workers	90,507	3,294				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	94,066	6,434				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant	41,739	832				
b. Other Accountants	105,468	3,645				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	91,748	2,080				
b. RN						
1. Direct Care	677,629	19,741				
2. Administrative**	179,021	4,974				
c. LPN						
1. Direct Care	471,990	17,700				
2. Administrative**	29,099	854				
d. Aides and Attendants	1,030,648	62,842				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	110,414	4,819				
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	45,830	1,507				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	3,940,384	169,820				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		ICF Mental Retardation	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -		$ -	

Schedule of Other Fees (Page 13)

	CCNH		RHNS		ICF Mental Retardation	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Religious Services	$ 1,150	24				
Total	$ 1,150	24	$ -	-	$ -	-

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

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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	ICF Mental Retardation							
Section I - Operators/Owners										
Frank D. Malone	71,114				Treasurer/CFO			Hancock Hall, 31 Staples St, Danbury, CT 06810		
Jennifer Malone-Seixas	44,055				Vice President			Hancock Hall, 31 Staples St, Danbury, CT 06810	2,080	113,966
Michael Malone	121,565				President			Hancock Hall, 31 Staples St, Danbury, CT 06810		10,040
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	ICF Mental Retardation							
Section III - Administrators* **										
Michael Malone	78,466				Administrator	2,080	A. 2.			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

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	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	ICF Mental Retardation	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian	20,112	447				
2. Dentist						
3. Pharmacist	4,801	111				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	63,307	1,037				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	27,600	134				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)	175	1				
2. Pharmaceutical Committee (Quarterly meetings)	175	1				
3. Staff Development Committee (Once annually)	175	1				
e. Other (Specify)						
Psychiatric Evaluations	8,800	49				
9. Speech Therapist						
a. Resident Care	15,461	465				
b. Other						
10. Occupational Therapist						
a. Resident Care	66,865	1,072				
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-13 Total Fees Paid in Lieu of Salaries	208,621	3,342				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Grace Ahern, RD , 4 Westminster Rd, Danbury, CT 06811'	Dietary needs and reports	○	⊙	
Omnicare Pharmacy Services, 525 Knotter Dr., Cheshire, CT	General Supervision of Drug Regimen	○	⊙	
Alliance Rehab of CT., 1520 Kennsington Rd., Suite 105, Oakbrook, IL 60523	PT Evaluations & Treatments	○	⊙	
Serafima Glouzgal, 38 Grove St., Ridgefield, CT. 06877	Coordination of Medical Care for Residents	○	⊙	
Members of Organized Medical Staff-Robert Ruxin, MD, Frederick Kayal, MD, Jeanine	Infection Control Review	○	⊙	
Members of Organized Medical Staff-Robert Ruxin, MD, Frederick Kayal, MD, Jeanine	Pharmacy Review	○	⊙	
Members of Organized Medical Staff-Robert Ruxin, MD, Frederick Kayal, MD, Jeanine	Staff Development Review	○	⊙	
Orestes Arcuni,MD, 4 Bartrum Dr., West Redding, CT 06896	Psychiatric Evaluations	○	⊙	
Alliance Rehab of CT., 1520 Kennsington Rd., Suite 105, Oakbrook, IL 60523	ST Evaluations & Services	○	⊙	
Alliance Rehab of CT., 1520 Kennsington Rd., Suite 105, Oakbrook, IL 60523	OT Evaluations & Services	○	⊙	
St. Joseph Roman Catholic Chruch, 8 Robinson Ave., Danbury, CT 06877 Rev. David Franklin	Routine visits to Facility/Residents	○	⊙	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
,		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITAT	461-C	9/30/2016	15	37

Item		Total	CCNH	RHNS	ICF Mental Retardation
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	125,982	125,982		
2. Disability Insurance	$	21,301	21,301		
3. Unemployment Insurance	$	94,249	94,249		
4. Social Security (F.I.C.A.)	$	287,388	287,388		
5. Health Insurance	$	301,364	301,364		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	16,594	16,594		
(not-owners and not-operators)					
8. Uniform Allowance	$	5,998	5,998		
9. Other (*Specify*)	$	8,251	8,251		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	32,421	32,421		
d. Accounting and Auditing	$	23,270	23,270		
e. Legal (*Services should be fully described on Page 7)*	$				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	22,895	22,895		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	11,718	11,718		
2. Cellular Phones	$	2,710	2,710		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$	491	491		
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	441,835	441,835		
Subtotal	$	1,396,467	1,396,467		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	ICF Mental Retardation
Other Expense - Physicals	$ 8,251		
Total	$ 8,251	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	ICF Mental Retardation
Total	$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2016	16	37

Item		Total	CCNH	RHNS	ICF Mental Retardation
Subtotals Brought Forward:		1,396,467	1,396,467		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	6,181	6,181		
2. Holiday Parties for Staff	$	1,127	1,127		
3. Gifts to Staff and Residents	$	7,599	7,599		
4. Employee Travel	$	579	579		
5. Education Expenses Related to Seminars and Conventions	$	2,222	2,222		
6. Automobile Expense (*not purchase or depreciation*)	$	2,411	2,411		
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	3,955	3,955		
2. Advertising Telephone Directory (*all such expenses*)***	$	1,008	1,008		
3. Advertising Other (*Specify*)***	$	8,175	8,175		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$	2,545	2,545		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	11,908	11,908		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	9,381	9,381		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	510	510		
10. Contributions***	$	2,394	2,394		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	96,209	96,209		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	1,552,671	1,552,671		

* 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
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	ICF Mental Retardation
Promotions-Public Relations	$ 8,175		
Total Other Advertising	$ 8,175	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	ICF Mental Retardation
Dues - NH - Associations	$ 4,367		
Professional Dues / License / Fees	$ 5,014		
Total Dues	$ 9,381	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	ICF Mental Retardation
Contributions	$ 2,394		
Total Contributions	$ 2,394	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	ICF Mental Retardation
Discounts Earned	$ 480		
Adjustments	$ 1,787		
Small Renovations Projects Expens	$ 2,237		
Inservice-Staff Training / Inservice Books & Materials	$ 1,123		
Small Equipment Admin	$ 1,562		
Cable TV Expense	$ 11,646		
Contract Professional Services	$ 5,055		
Repairs/Service Office Equip	$ 38,505		
Payroll Services	$ 31,241		
Bank Service Charges	$ 1,723		
Resident Related Misc Exp / Late Charges	$ 850		
Total Other Administrative and General	$ 96,209	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABIL	461-C	9/30/2016	17 | 37

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2016	18 | 37

Item		Total	CCNH	RHNS	ICF Mental Retardation
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	178,112	178,112		
2. Non-Food Supplies	$	26,491	26,491		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	204,603	204,603		

		Total	CCNH	RHNS	ICF Mental Retardation
2F. Dietary Questionnaire					
G. Resident Meals:	Total no. of meals served per day:*	179	179		

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ 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.

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2016	19 | 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. $	9,619	9,619		
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. $	16,494	16,494		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*) Equipment Rental	$	8,295	8,295		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	34,408	34,408		

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITA	461-C	9/30/2016	20	37

Item			Total	CCNH	RHNS	ICF Mental Retardation
4. Housekeeping	Sq. Ft. Serviced by Personnel		39,605	39,605		
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	26,583	26,583		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	26,583	26,583		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Omnicare Pharmacy		$	37,712	37,712		
b. Medicine Cabinet Drugs		$	1,019	1,019		
c. Medical and Therapeutic Supplies		$	141,624	141,624		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	7,550	7,550		
f. X-rays and Related Radiological Procedures***		$	900	900		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	1,369	1,369		
i. Recreation		$	5,803	5,803		
j. Other (Specify)**** See Attached Schedule		$	2,301	2,301		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	198,278	198,278		

* 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	ICF Mental Retardation
Tech. Component Part A charges	$ 1,537		
Med/Surg Supply Part A	$ 764		
Total Other Resident Care	$ 2,301	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2016	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
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

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

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABILITA	461-C	9/30/2016	22 | 37

Item		Total	CCNH	RHNS	ICF Mental Retardation
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	57,327	57,327		
b. Heat	$	44,649	44,649		
c. Light & Power	$	64,696	64,696		
d. Water	$	29,076	29,076		
e. Equipment Lease (*Provide detail on page 6*)	$	4,873	4,873		
f. Other (*itemize*)	$	79,194	79,194		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	279,815	279,815		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	120,877	120,877		
c. Non-Movable Equipment	$				
d. Movable Equipment	$	60,004	60,004		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	180,881	180,881		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	67,723	67,723		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	67,723	67,723		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	574,323	574,323		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	56,497	56,497		
c. Personal property taxes	$	8,427	8,427		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	887,851	887,851		

* 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	$ 22,217		
Exterminating	$ 3,100		
Bed/Chair Alarms	$ 2,798		
Repairs/Maintenance Contracts	$ 25,140		
Interior Decor Maint/Supply	$ 9,181		
Repairs Maintenance Grounds	$ 16,758		
Total Other Repairs and Maintenance	$ 79,194	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2016	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	4,835,483		4,835,483	2,681,965	SL	40	120,877	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								120,877
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	378,928		378,928	378,928	SL	various		
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. 2006 Toyota Tacoma	X		10	2006	28,780		28,780	25,902	SL	10	2,878	
b. 2006 Toyota Tacoma - DISPOSAL					(28,780)			(28,780)				
c. 2015 Ford F250 Pickup	X		10	2015	48,934		48,934		SL	4	12,234	
d.												
2. Movable Equipment												
a. Acquired prior to this report period					530,978		530,978	325,938	SL	Various	38,129	
b. Disposals (attach schedule)					(20,325)		(20,325)	(16,640)			553	
c. Acquired during this report period (attach schedule)					51,159		51,159				6,210	
D-3. Subtotal												60,004
E. ***Total Depreciation***												180,881

FILOSA FOR NURSING AND REHABILITATION
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Schedule of Land Improvements Acquired during this report period

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

***Ties to Page 23, Line A3**
****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

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

***Ties to Page 23, Line B3**
****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Non-Movable Equipment		$ -		$ -	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

***Ties to Page 23, Line C3**
****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
	SEE ATTACHED	$ 51,159		$ 6,210	
Total additions for Movable Equipment		$ 51,159		$ 6,210	*
Deletions:					
	SEE ATTACHED	$ (20,325)		$ 553	
Total deletions for Movable Equipment		$ (20,325)		$ 553	**

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

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
	Per Attachment:				
4/25/2016	NEW PASSENGER ELEVATOR	$ 33,159	20	$ 829	
6/10/2016	AIR CONDITIONING SYSTEM	$ 9,593	10	$ 320	
Total additions for Leasehold Improvement		$ 42,752		$ 1,149	*
Deletions:					
	Per Attachment:				
9/1/2016	DOOR LOCK	$ (1,201)	10	$ 110	
9/1/2016	COMPRESSOR	$ (838)	7		
9/1/2016	COMPRESSOR	$ (3,443)	20	154	
9/1/2016	CARPET	$ (4,477)	5		
Total deletions for Leasehold Improvement		$ (9,959)		$ 264	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
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Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period			various	692,471	269,375	Actual Life	variou	66,310	
2. Disposals (attach schedule)				(9,959)	(8,797)			264	
3. Acquired during this report period									
(attach schedule)				42,752				1,149	
C-4. Subtotal									67,723
D. ***Total Amortization***									67,723

* Straight-line method must be used.

** Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.
B. Life of mortgage; OR
C. Remaining Life of Lease; OR
D. Actual Life if owned by Related Party.

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

Name of Facility	License No.	Report for Year Ended	Page	of
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11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	Various
2. Date Structure Completed	1995 Major Renov.
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	01/01/47
5. Total Licensed Bed Capacity	64
6. Square Footage	39,605
7. Acquisition Cost	
a. Land	398,123
b. Building	4,835,483

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed Mortgage			
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 9/30/2016	2,400,944			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility	License No.	Report for Year Ended			Page of
FILOSA FOR NURSING AND REH	461-C	9/30/2016			26 | 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 $				
Name of Lender / Rate				
Address of Lender				
3. Third Mortgage $				
Name of Lender / Rate				
Address of Lender				
4. Fourth Mortgage $				
Name of Lender / Rate				
Address of Lender				
B. CHEFA Loan Information				
1. Original Loan Amount $				
2. Loan Origination Date				
3. Interest Rate %				
4. Term				
5. CHEFA Interest Expense				
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $				

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND RE	461-C	9/30/2016	27 | 37

Item			Total	CCNH	RHNS	ICF Mental Retardation
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		$				
A. Item	Rate	Amount				
Maintenance Vehicle	5.89%	40,284				
Lender						
Ford Motor Credit						
Address of Lender						
2. Other (*Specify*)		$	3,042	3,042		
A. Item	Rate	Amount				
Equip - Hot Water System	4.00%					
Lender						
Union Savings Bank						
Address of Lender						
B. Item	Rate	Amount				
Improvements	4.00%					
Lender						
Union Savings Bank						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		$	3,042	3,042		
12. D. Other Interest Expense (*Specify*)		$	10,554	10,554		
Union Savings Bank - Line of Credit						
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)		$	13,596	13,596		
14. Insurance						
a. Insurance on Property (buildings only)		$	9,812	9,812		
b. Insurance on Automobiles		$	2,301	2,301		
c. Insurance other than Property (as specified above)						
1. Umbrella (*Blanket Coverage*)		$	7,020	7,020		
2. Fire and Extended Coverage		$	24,522	24,522		
3. Other (*Specify*)		$	6,024	6,024		
D&O INS $4,847 / 401K ERISA $989 / Pat Bond $368						
14d. ***Total Insurance Expenditures (14a + b + c)***		$	49,679	49,679		
15. ***Total All Expenditures (A-13 thru C-14)***		$	7,396,489	7,396,489		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2016	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	ICF Mental Retardation
Page 10 - Salaries and Wages							
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 $	236,734	236,734		
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $	4,441	4,441		
9.	15	1.c	Bad Debts $	32,421	32,421		
10.	15	1.e	Accounting & Legal $				
11.			Telephone $				
12.	15	1.h.2	Cellular Telephone $	1,355	1,355		
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.	16	l.3	Gifts, flowers and coffee shops $	7,599	7,599		
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	m.2 &	Unallowable Advertising * $	9,183	9,183		
19.	15	1.k.1	Income Tax / Corporate Business Tax $	491	491		
20.	16	m10	Fund Raising / Contributions $	2,394	2,394		
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	22,951	22,951		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $				
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	317,569	317,569		

* 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	$ 71,114		
10	A.1.	Michael Malone	$ 121,565		
10	A.1.	Jennifer Malone-Seixas	$ 44,055		
Total Other Salaries Adjustment			$ 236,734	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	ICF Mental Retardation
Total Other Fees Adjustments			$ -	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	ICF Mental Retardation
16	m.13.	Discounts Earned	$ 480		
16	m.13.	Adjustments	$ 1,787		
16	m.13.	Bank Service Charges	$ 1,723		
16	m.13.	Resident Misc Expense	$ 303		
16	m.13.	Non Allowable Interest Late Charges	$ 548		
15	a.4.	FICA on disallowed Owner/Officer salaries	$ 18,110		
Total Other A&G Adjustments			$ 22,951	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2016	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	ICF Mental Retardation
			Subtotals Brought Forward $	317,569	317,569		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $	37,712	37,712		
28.	20	5d	Ambulance/Limousine $				
29.	20	5f	X-rays, etc $	900	900		
30.	20	5h	Laboratory $	1,369	1,369		
31.	20	5c	Medical Supplies $	9,055	9,055		
32.	20	5e2	Oxygen (non emergency) $	7,550	7,550		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	2,301	2,301		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.	27	14.c.3	Property Insurance $	4,847	4,847		
Other - Miscellaneous							
42.			Research or Experimental Activities $				
43.	30	IV.4.	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 $				
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.	***Total Amount of Decrease (Items 1 - 50)*** $			381,303	381,303		

*** Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Attachment Page 29

FILOSA FOR NURSING AND REHABILITATION
9/30/2016

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	ICF Mental Retardation
20	5j	Tech. Component Part A charges	$ 1,537		
20	5j	Med/Surg Supply Part A	$ 764		
Total Other Ancillary Costs			$ 2,301	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	ICF Mental Retardation
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	ICF Mental Retardation
Total Other Property Adjustments			$ -	$ -	$ -

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	ICF Mental Retardation
Total Other Adjustments			$ -	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	ICF Mental Retardation
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABI	461-C	9/30/2016	30	37

Item		Total	CCNH	RHNS	ICF Mental Retardation
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	6,765,633	6,765,633		
b. Medicaid Room and Board Contractual Allowance **	$	(3,143,453)	(3,143,453)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	385,240	385,240		
b. Medicare Room and Board Contractual Allowance **	$	103,208	103,208		
4. a. Private-Pay Residents and Other	$	3,130,390	3,130,390		
b. Private-Pay Room and Board Contractual Allowance **	$	(100,371)	(100,371)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	50,325	50,325		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(50,325)	(50,325)		
c. Prescription Drugs - Non-Medicare	$	2,174	2,174		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(1,507)	(1,507)		
2. a. Medical Supplies - Medicare	$	10,863	10,863		
b. Medical Supplies - Medicare Contractual Allowance **	$	(6,536)	(6,536)		
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	121,975	121,975		
b. Physical Therapy - Medicare Contractual Allowance **	$	(87,326)	(87,326)		
c. Physical Therapy - Non-Medicare	$	5,433	5,433		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(5,433)	(5,433)		
4. a. Speech Therapy - Medicare	$	33,024	33,024		
b. Speech Therapy - Medicare Contractual Allowance **	$	(20,740)	(20,740)		
c. Speech Therapy - Non-Medicare	$	1,480	1,480		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(1,480)	(1,480)		
5. a. Occupational Therapy - Medicare	$	155,976	155,976		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(113,901)	(113,901)		
c. Occupational Therapy - Non-Medicare	$	7,953	7,953		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(7,953)	(7,953)		
6. a. Other *(Specify)* - Medicare	$	2,239	2,239		
b. Other *(Specify)* - Non-Medicare	$	24,319	24,319		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	7,261,207	7,261,207		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	114	114		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	18,353	18,353		
V. Total Other Revenue (1 thru 8)	$	18,467	18,467		
VI. Total All Revenue (III +V)	$	7,279,674	7,279,674		

* *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	$ 1,396		
30II6A-CCH	Lab	$ 1,451		
30II6A-CCH	Contr Adj X-Ray	$ (1,396)		
30II6A-CCH	Contr Adj Lab	$ (1,451)		
	Prior Year Adjustment	$ 2,239		
Total Other Resident Revenue - Medicare		$ 2,239	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	ICF Mental Retardation
30II6b-CCH	Non Emergency Facility Van Transport	$ 1,800		
30II6b-CCH	X-Ray	$ 75		
30II6b-CCH	Lab	$ 71		
30II6b-CCH	Ambulance	$ (75)		
	Prior Year Adjustment	$ 22,448		
Total Other Resident Revenue		$ 24,319	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	ICF Mental Retardation
30IV5-CCH	Interest Income		$ 114		
Total Interest Income			$ 114	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	ICF Mental Retardation
30IV8-CCH	Gain/Loss of Disposed Equipment	$ 3,153		
30IV8-CCH	Deferred Tax Benefit	$ 15,200		
Total Other Revenue		$ 18,353	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHAI	461-C	9/30/2016	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 48,738
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 431,267
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 11,454
4 Inventories				$
5. Prepaid Expenses				$ 25,501
a. Prepaid Insurance		17,667		
b. Prepaid Expenses		4,339		
c. Prepaid Income Tax		3,495		
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 21,100
Deferred Taxes		21,100		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 538,060
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	725,264		$ 396,963
	Accum. Depreciation	328,301	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	561,812		$ 207,622
	Accum. Depreciation	354,190	Net	
7. Motor Vehicles	*Historical Cost	48,934		$ 36,700
	Accum. Depreciation	12,234	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 641,285

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHAI	461-C	9/30/2016	32	37

Account				Amount
			Total Brought Forward:	$ 1,179,345
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$ 398,123
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost	4,835,483		
	Accum. Depreciation	2,802,842	Net	$ 2,032,641
4. Non-Movable Equipment	*Historical Cost	378,928		
	Accum. Depreciation	378,928	Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$ 2,430,764
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 48,001
Bed License		48,001		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 48,001
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 3,658,110

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILIT/	461-C	9/30/2016	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 111,494
	2. Notes Payable (*itemize*)				$ 302,707
	USB Line of Credit		257,569		
	USB Renovations (due 5/29/17, all current)		19,956		
	USB Elevator Rebuild (current is $14,905)		25,182		
	3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$ 24,120
	Name of Lender	Purpose	Amount	Date Due	
	Union Savings Bank	Hot Water System	14,049	04/05/17	
	Ford Motor Credit	Maintentance Vehicle	10,071	11/19/19	
	4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 184,448
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 14,656
	7. Medicare Final Settlement Payable				$
	8. Medicare Current Financing Payable				$
	9. Mortgage Payable (*Current Portion*)				$
	10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
	11. Accrued Income Taxes*				$
	12. Other Current Liabilities (*itemize*)				$ 137,780
	Accrued Expenses	16,470	Aetna Universal Life	50	
	Liability Resident Trust	130	In Acct Recreation	6,000	
	DSS Qtrly User Fee Liability	109,598	Medicare Settlement	144	
	Employee 401K	5,388			
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 775,205

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILI	461-C	9/30/2016	34	37

Account				Amount
			Total Brought Forward:	775,205
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$ 20,143
Name of Lender	Purpose	Amount	Date Due	
Ford Motor Credit	Maintentance Vehicle	20,143	11/19/19	
2. Mortgages Payable				$
3. Loans from Owners or Related Parties (*itemize*)				$ 43,193
Name and Address of Lender	Amount	Loan Date		
Hancock Hall	43,193			
4. Other Long-Term Liabilities (*itemize*)				$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 63,336
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 838,541

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHA	461-C	9/30/2016	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$ 398,123
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$ 2,032,641
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$ 2,430,764
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$ 90,310
	3. Paid-in Surplus	$ 183,510
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 231,800
	6. Gain or Loss for Period 10/1/2015 thru 9/30/2016	$ (116,815)
	7. Total Net Worth	$ 388,805
C.	***Total Reserves and Net Worth***	$ 2,819,569
D.	***Total Liabilities, Reserves, and Net Worth***	$ 3,658,110

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHAB	461-C	9/30/2016	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015			$ 505,620
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 7,279,674
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 7,396,489
D.	Net Income or Deficit			$ (116,815)
E.	Balance			$ 388,805
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period*** 09/30/16			$ 388,805

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND	461-C	9/30/2016	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ ICF Mental Retardation

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer

CLIFTONLARSONALLEN LLP

Addres Address	Phone Number
300 Crown Colony Dr., Ste 310, Quincy, MA 02368	617-984-8100

Error Check

Level	Item	Reported as		
	Page 22 - Movable Depreciation	60,004	is inconsistent with Page 23	60,004
	Page 23 - Accumulated Dep. of Movable Eq.	370,830	is inconsistent with Page 31	354,190