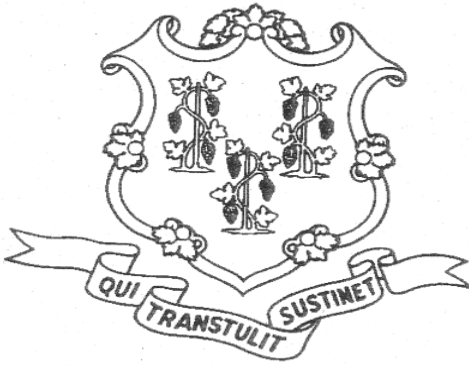


# State of Connecticut



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

Name of Facility (as licensed) The Suffield House	
Address (No. & Street, City, State, Zip Code) One Canal Road, Suffield CT 06078	
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 10/1/2015	Report for Year Ending 9/30/2016

License Numbers:	CCNH 2075-C	RHNS	(Specify)	Medicare Provider 07-5347
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Medicaid Provider Numbers:	CCNH 20751	RHNS	ICF-IID
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**For Department Use Only**

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

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### General Information

Name of Facility (as licensed) The Suffield House	License No. 2075-C	Report for Year Ended 9/30/2016	Page 1	of 37
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#### Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for The Suffield House [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) Carrie Riccio			Printed Name (Owner)		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility The Suffield House		Period Covered:	From 10/1/2015	To 9/30/2016
Address of Facility One Canal Road, Suffield CT 06078				
Report Prepared By		Phone Number	Date	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. <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 (860) 668-6111		Report for Year Ended 9/30/2016	Page 2	of 37
Name of Facility (as shown on license) The Suffield House		Address (No. & Street, City, State, Zip) One Canal Road, Suffield CT 06078		
License Numbers:	CCNH 2075-C	RHNS	(Specify)	Medicare Provider No. 07-5347
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 type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No      If "Yes," explain fully.				
<b>Administrator</b>				
Name of Administrator Carrie Riccio		Nursing Home Administrator's License No.:	1059	
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 The Suffield House	License No. 2075-C	Report for Year Ended 9/30/2016	Page 3A	of 37
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		
Suffield Manor Inc. dba The Suffield House	One Canal Road, Suffield CT 06078	CT		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Celia J. Moffie	One Canal Road, Suffield CT 06078	President	20	
Calvin Moffie	One Canal Road, Suffield CT 06078	Secretary	20	
Names of Stockholders Owning at Least 10% of Shares				
Carrie Riccio	One Canal Road, Suffield CT 06078		20	
Cathy Demio	One Canal Road, Suffield CT 06078		20	
Clinton Moffie	One Canal Road, Suffield CT 06078		20	





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

Name of Facility The Suffield House	License No. 2075-C	Report for Year Ended 9/30/2016	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?  Yes  No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Harold J Moffie	5 Schuyler Lane, Bloomfield CT 06002	<input type="radio"/>	<input checked="" type="radio"/>		Management Fee (Self Disallowed)	Page 16 Line 1m12	396,500	396,500
Eagle Point	One Canal Road, Suffield CT 06078	<input type="radio"/>	<input checked="" type="radio"/>		Advanced Funds and shares building	Page 32 Line D7	557,408	
Moffie Family Holding Company LLC	One Canal Road, Suffield CT 06078	<input type="radio"/>	<input checked="" type="radio"/>		Rent of Building	page 22 Line 9	703,811	
Moffie Family Holding Company LLC	One Canal Road, Suffield CT 06078	<input type="radio"/>	<input checked="" type="radio"/>		Advanced Funds	Page 34 Line B3	1,380,798	
Calvin Moffie of the Guilford House	109 Westlake Ave, Guilford CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		Advanced Funds	Page 32 Line D7	1,326	
Celia J Moffie of Suffield by the River, LLC	7 Canal Road, Suffield CT 06078	<input checked="" type="radio"/>	<input type="radio"/>	100%	Catering of Christmas Party	Page 16 Line 1L2	3,897	
Moffie Family Holding Company LLC	One Canal Road, Suffield CT 06078	<input type="radio"/>	<input checked="" type="radio"/>		Depreciation Leasehold Improvements	Page 22 Line 8C	17,278	
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					

\* Use additional sheets if necessary.

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

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility The Suffield House	License No. 2075-C	Report for Year Ended 9/30/2016	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.

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 The Suffield House		License No. 2075-C		Report for Year Ended 9/30/2016			Page 6	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
Pitney Bowes Global Financial Services, P. O. Box 371887, Pittsburgh PA 15250-7887	<input type="radio"/>	<input checked="" type="radio"/>	Postage Meter	09/04/13	63 months	1,825	1,820	
CBS, 50 Rockwell Rd, Newington CT 06111	<input type="radio"/>	<input checked="" type="radio"/>	HP40E Printer	06/30/14	39 months	434	434	
Wells Fargo Vendor Fin Serv/GE Capital, P.O. Box 70239, Philadelphia PA 19176-0239	<input type="radio"/>	<input checked="" type="radio"/>	Konica Minolta C754e / Konica Monolta 454e	07/30/15	60 months	8,906	8,906	
ACPL, 4999 Aircenter Circle, Ste 103, Reno NV 89502	<input type="radio"/>	<input checked="" type="radio"/>	Therapeutic Rehabilitation Equipment	09/22/15	12 months	12,256	12,256	
Derency Document Solutions, 130 Doty Circle, W. Springfield, MA 01089	<input type="radio"/>	<input checked="" type="radio"/>	Copier Maintenance Usage Cost	10/01/09	Monthly	3,485	3,485	
	<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 checked="" type="radio"/> No
<b>Total ***</b>							26,901	

\* 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 The Suffield House	License No. 2075-C	Report for Year Ended 9/30/2016	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:  
 Accrual     Cash     Modified Cash

Is the accounting basis for this period the same as for the previous period?     Yes     No    If "No," explain.

**Independent Accounting Firm**

Name of Accounting Firm 1 Cornerstone Accounting Group 2 Sheptoff, Rueber & Co. PC 3 4	Address (No. & Street, City, State, Zip Code) PO Box 7 Indian Valley, VA 24105 111 New London Tnpk, Glastonbury CT 06033
--	--

Services Provided by This Firm (*describe fully*)

1 Medicaid and Medicare Cost Reports	\$ 6,800
2 Tax Preparation/Preparation of Federal Form 8752/ Town Property Return	\$ 5,690
3	\$
4	\$
	Charge for Services Provided
	\$ 12,490

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

**Legal Services Information**

Name of Legal Firm or Independent Attorney 1 Letizia, Ambrose & Falls. P.C 2 Unemployment Tax Management 3 Murtha Cullina, LLP 4 Celtic Consulting, LLC 5 Federal Insurance Company, Chubb Group of Companies	Telephone Number (203) 787-7000 (781) 245-5353 (860) 240-6000 (860) 321-7413 (800) 472-5219
--	--

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

1 667-669 State Street, 2nd Floor, New Haven CT 06511
2 Lakeside Office Park, Wakefield MA 01880-5374
3 185 Asylum St., Hartford CT 06103
4 507 East Main St., Suite 308, Torrington CT 06790
5 82 Hopmeadow St., Simsbury CT 06070-7683

Services Provided by This Firm (*describe fully*)

1 Labor Law	\$ 1,276
2 Provide support for unemployment claims against the Facility	\$ 1,740
3 General Health Care Regulatory Rules	\$ 75
4 Medicare Consultants	\$ 42,540
5 Defense of Lawsuit against Suffield Manor Inc. dba The Suffield House	\$ 15,055
	Charge for Services Provided
	\$ 60,686

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

### Schedule of Resident Statistics

Name of Facility The Suffield House			License No. 2075-C		Report for Year Ended 9/30/2016				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	128	128			128	128			128	128		
B. On last day of THIS report period	128	128			128	128			128	128		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	125	125			125	125			126	126		
B. As of midnight of THIS report period	124	124			126	126			124	124		
3. Total Number of Days Care Provided During Period												
A. Medicare	7,950	7,950			5,876	5,876			2,074	2,074		
B. Medicaid (Conn.)	24,673	24,673			18,394	18,394			6,279	6,279		
C. Medicaid (other states)												
D. Private Pay	11,469	11,469			8,688	8,688			2,781	2,781		
E. State SSI for RCH												
F. Other (Specify) Managed Care	1,296	1,296			1,006	1,006			290	290		
G. Total Care Days During Period (3A thru F)	45,388	45,388			33,964	33,964			11,424	11,424		
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												
5. <b>Total Resident Days (3G + 4A + 4B)</b>	45,388	45,388			33,964	33,964			11,424	11,424		

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

Name of Facility The Suffield House			License No. 2075-C			Report for Year Ended 9/30/2016			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days								CCNH	RHNS	(Specify)			
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	22		70		32								
Per Diem Rate													
a. One bed rm.			228.00		440.00								
b. Two bed rms.			228.00		420.00								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								3,845	3,845				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								299	299				
2. Restorative Treatments													
C. Other								27,271	27,271				
D. <b>Total Physical Therapy Treatments</b>								31,415	31,415				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								45	45				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other								206	206				
D. <b>Total Speech Therapy Treatments</b>								251	251				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								2,350	2,350				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								167	167				
2. Restorative Treatments													
C. Other								22,748	22,748				
D. <b>Total Occupational Therapy Treatments</b>								25,265	25,265				

### Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
The Suffield House	2075-C	9/30/2016	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(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)	226,923	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	646,499	23,054				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	97,603	2,564				
c. Dietary Workers	650,633	36,394				
6. Housekeeping Service						
a. Head Housekeeper	86,320	2,120				
b. Other Housekeeping Workers	234,980	17,211				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	79,372	2,120				
b. Other Maintenance Workers	134,312	7,896				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	206,445	13,740				
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	111,670	2,080				
b. RN						
1. Direct Care	768,070	17,611				
2. Administrative**	749,793	25,665				
c. LPN						
1. Direct Care	936,193	32,983				
2. Administrative**						
d. Aides and Attendants	1,869,416	113,468				
e. Physical Therapists	611,545	16,674				
f. Speech Therapists	8,738	170				
g. Occupational Therapists	492,394	12,404				
h. Recreation Workers	297,969	7,954				
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	209,387	6,280				
n. Marketing						
o. Other (Specify)						
See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	8,418,262	342,468				

\* 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	
The Suffield House				2075-C	9/30/2016			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section I - Operators/Owners</b>										
Cathy Demio	124,849			Standard	Recreation	1,554	A12h			
Clinton Moffie	151,642			Standard	Dietary (Self Disallowed)	2,072	A5c			
<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>										
Aaron Riccio	1,262			None	Maintenance Worker	98	A7b			
Alexander Riccio	14,352			Standard	Administrative (Self Disallowed)	1,380	A4			
John Riccio	71,821			Standard	Director of Admissions	2,072	A12m			
Hannah Donnelly	1,823			None	Therapy Assistant	164	A12e			

\* 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	
The Suffield House				2075-C	9/30/2016			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section III - Administrators***</b>										
Carrie Riccio	226,923			Standard	Oversee operations of facility	2,080	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		
The Suffield House	2075-C	9/30/2016	13	37		
<b>Total Cost and Hours</b>						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian						
2. Dentist	4,800	71				
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	18,000	65				
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)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>22,800</b>	<b>136</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	License No.	Report for Year Ended	Page	of
The Suffield House	2075-C	9/30/2016	14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Gordon Holder D.D.S.	Dentist	<input type="radio"/>	<input checked="" type="radio"/>	
Leslie Lindenberg	Medical Director	<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"/>	
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		<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
The Suffield House	2075-C	9/30/2016		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 293,973	293,973			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 107,515	107,515			
4. Social Security (F.I.C.A.)	\$ 620,719	620,719			
5. Health Insurance	\$ 1,109,926	1,109,926			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 21,608	21,608			
8. Uniform Allowance	\$				
9. Other ( <i>Specify</i> ) See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 73,052	73,052			
d. Accounting and Auditing	\$ 12,490	12,490			
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 60,686	60,686			
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$				
g. Office Supplies	\$ 41,224	41,224			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 28,395	28,395			
2. Cellular Phones	\$ 1,702	1,702			
i. Appraisal ( <i>Specify purpose and         attach copy</i> )*	\$				
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$ 250	250			
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	\$ 759,705	759,705			
<b>Subtotal</b>	\$ 3,131,245	3,131,245			

\* 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**

The Suffield House  
9/30/2016

Attachment Page 15

**Schedule of Other Employee Benefits**

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

-----  
**Schedule of Other Taxes**

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

-----

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

Name of Facility	License No.	Report for Year Ended	Page	of	
The Suffield House	2075-C	9/30/2016	16	37	
Item		Total	CCNH	RHNS	(Specify)
<b>Subtotals Brought Forward:</b>		3,131,245	3,131,245		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	44,683	44,683		
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	1,448	1,448		
5. Education Expenses Related to Seminars and Conventions	\$	3,821	3,821		
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$	11,681	11,681		
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$	4,760	4,760		
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	11,290	11,290		
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	\$	6,866	6,866		
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	14,274	14,274		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	1,626	1,626		
10. Contributions*** See Attached Schedule	\$	375	375		
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$	113,198	113,198		
12. Administrative Management Services**	\$	396,500	396,500		
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	30,311	30,311		
<b>C-14 Total Administrative &amp; General Expenditures</b>		\$ 3,772,078	3,772,078		

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

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
BUSINESS PROMOTION	\$ 11,290		
<b>Total Other Advertising</b>	\$ 11,290	\$ -	\$ -

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
ALLSCRIPTS	\$ 4,444		
CAHCF	\$ 9,795		
INFECTION CONTROL NURSES OF CT, INC.	\$ 35		
<b>Total Dues</b>	\$ 14,274	\$ -	\$ -

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
DONATIONS	\$ 375		
<b>Total Contributions</b>	\$ 375	\$ -	\$ -

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
FEES AND REGISTRATION	\$ 1,160		
LICENSES AND PERMITS	\$ 3,431		
BANK CHARGES	\$ 66		
MISCELLANEOUS ADMIN EXPENSE	\$ 19,945		
SALES TAX	\$ 2,316		
LOSS ON DISPOSAL OF ASSETS	\$ 1,347		
CT BACKGROUND CHECK FEES	\$ 2,046		
<b>Total Other Administrative and General</b>	\$ 30,311	\$ -	\$ -



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

Name of Facility The Suffield House	License No. 2075-C	Report for Year Ended 9/30/2016	Page of 17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
H J Moffie 5 Shuler Lane, Bloomfield, CT 06002	396,500	Management Fees (self disallowed)	Page 16 Line 1m12

**\* 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	License No.	Report for Year Ended	Page	of
The Suffield House	2075-C	9/30/2016	18	37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 299,759	299,759		
2. Non-Food Supplies	\$ 35,793	35,793		
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) _____	\$ _____			
<b>2E. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 335,552</b>	<b>335,552</b>		
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*	370	370		
H. Is cost of employee meals included in 2E? <input checked="" type="radio"/> Yes <input type="radio"/> No				
I. Did you receive revenue from employees? <input checked="" type="radio"/> Yes <input type="radio"/> No                   If yes, specify amt.				
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)				P 30 L IV1
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input checked="" type="radio"/> Yes <input type="radio"/> No                   If yes, specify cost.				\$19,655
L. Is any revenue collected from these people? <input checked="" type="radio"/> Yes <input type="radio"/> No                   If yes, specify amt.				\$18,884
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)				P 30 L IV1
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 The Suffield House		License No. 2075-C	Report for Year Ended 9/30/2016	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. \$	18,206	18,206	
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. \$	21,752	21,752	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$			
c. Management Services**		\$			
d. Other (Specify)		\$			
<b>3E. Total Laundry Expenditures (3a + b + c + d)</b>		\$	<b>39,958</b>	<b>39,958</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	
The Suffield House	2075-C	9/30/2016	20	37	
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care					
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	48,697	48,697		
b. Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )	Sq. Ft. Serviced by Personnel				
	Amt. \$				
c. Management Services*	\$				
d. Other ( <i>Specify</i> )	\$				
<b>4E. Total Housekeeping Expenditures (4a + b + c + d)</b>	\$	48,697	48,697		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	408,291	408,291		
b. Medicine Cabinet Drugs	\$	34,478	34,478		
c. Medical and Therapeutic Supplies	\$	222,131	222,131		
d. Ambulance/Limousine***	\$	12,399	12,399		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	56,949	56,949		
f. X-rays and Related Radiological Procedures***	\$	28,598	28,598		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$	83,752	83,752		
i. Recreation	\$	15,753	15,753		
j. Other (Specify)**** See Attached Schedule	\$	67,703	67,703		
<b>5K. Total Resident Care Expenditures (5a - 5j)</b>	\$	930,054	930,054		

\* 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)
RESIDENT SPECIFIC SUPPLIES	\$ 67,703		
<b>Total Other Resident Care</b>	<b>\$ 67,703</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility The Suffield House			License No. 2075-C		Report for Year Ended 9/30/2016				Page of 21   37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Cox Communications		<input type="radio"/>	<input checked="" type="radio"/>		Cable Company	12,810			22	6f
Iron Mountain		<input type="radio"/>	<input checked="" type="radio"/>		Storage & Shredding	13,792			22	6f
Simplex Grinnell LP		<input type="radio"/>	<input checked="" type="radio"/>		Fire System Maintenance	14,702			22	6f
Somers Sanitation Service		<input type="radio"/>	<input checked="" type="radio"/>		Trash service	34,442			22	6f
Russo Lawn & LandScape		<input type="radio"/>	<input checked="" type="radio"/>		Lawn & Plantings	47,556			22	6f
Wescom Solutions, Inc.		<input type="radio"/>	<input checked="" type="radio"/>		Accounting & Billing Software	32,395			16	m11
Dart Chart Systems, LLC		<input type="radio"/>	<input checked="" type="radio"/>		Nursing Computer Charting System	14,000			16	m11
ADP, Inc.		<input type="radio"/>	<input checked="" type="radio"/>		Payroll Service	55,328			16	m11
Precision Mechanical, LLC		<input type="radio"/>	<input checked="" type="radio"/>		Heating Contractor	16,626			22	6a
Proline		<input type="radio"/>	<input checked="" type="radio"/>		Kitchen Appliance Repair	15,561			22	6a
Stericycle, Inc.		<input type="radio"/>	<input checked="" type="radio"/>		Hazardous Waste Removal	23,724			22	6f
		<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 The Suffield House	License No. 2075-C	Report for Year Ended 9/30/2016			Page 22	of 37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 121,539	121,539				
b. Heat	\$ 17,046	17,046				
c. Light & Power	\$ 133,165	133,165				
d. Water	\$ 53,099	53,099				
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 26,901	26,901				
f. Other ( <i>itemize</i> )	\$ 173,647	173,647				
See Attached Schedule						
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$ 525,397	525,397				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 104,970	104,970				
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$ 104,970	104,970				
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$ 6,788	6,788				
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 101,680	101,680				
d. Other ( <i>Specify</i> )	\$					
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$ 108,468	108,468				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 703,881	703,881				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 129,740	129,740				
c. Personal property taxes	\$ 15,928	15,928				
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$ 1,062,987	1,062,987				

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

**Schedule of Other Repairs and Maintenance**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
MAINTENANCE SERVICE CONTRACTS	\$ 101,561		
SEWER SYSTEM ASSESSMENT	\$ 26,566		
YARD MAINTENNACE	\$ 45,520		
<b>Total Other Repairs and Maintenance</b>	\$ 173,647	\$ -	\$ -

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The Suffield House  
9/30/2016

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

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

\*Ties to Page 23, Line A3

\*\*Ties to Page 23, Line A2

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

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

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

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

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

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2

## Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
10/7/2015	2 Dell Optiplex 3020 Minitower & Monitors	\$ 3,009	5	\$ 602
10/21/2015	Installation of New Washer & Dryers	\$ 3,722	5	\$ 682
10/22/2015	Maxi Twin PDPS Med W/Scale	\$ 4,993	5	\$ 915
10/22/2015	Maxi Twin PDPS Med W/Scale	\$ 4,993	5	\$ 915
10/21/2015	3 Unimac Washers & Dryers, 1 Unimac stk Dryer	\$ 106,495	5	\$ 19,524
10/21/2015	Electrical Connection of New Washer & Dryers	\$ 4,500	5	\$ 825
12/29/2015	1 Dell Optiplex 9030 AIO BTX	\$ 1,360	5	\$ 204
12/22/2015	Washers & Dryer Ethernet Gateway for Wireless Network	\$ 1,702	5	\$ 255
1/19/2016	4 Mattresses - Geo Ultra Max	\$ 2,141	5	\$ 285
3/10/2016	5 Televisions	\$ 787	7	\$ 66
3/22/2016	12 Ipad 2 Wi-Fi 16GB Space Gray	\$ 4,990	5	\$ 499
3/29/2016	1 Ipad 2 Wi-Fi 16GB Space Gray	\$ 832	5	\$ 83
4/14/2016	Meraki Wave 2 Access Point, Switches & Network Equipment	\$ 40,930	5	\$ 4,093
4/12/2016	Sweeper S9 Battery Powered Walk Behind	\$ 3,900	5	\$ 390
5/17/2016	Hp LJ M604DN Printer	\$ 957	5	\$ 64
6/9/2016	APC LCD 120V Smart-UPS	\$ 972	5	\$ 65
8/29/2016	In Sinkerator SS150-36 Disposal	\$ 2,890	5	\$ 48
10/6/2015	10 Power Lift Recliner	\$ 5,551	10	\$ 555
10/23/2015	7 Maxwell Thomas Kensington Dining Armchair	\$ 2,553	10	\$ 234
10/23/2015	8 Maxwell Thomas Kensington Dining Armchair	\$ 2,865	10	\$ 263
11/21/2015	2 4drw file Cabinets	\$ 496	7	\$ 59
10/17/2015	35 Beds 4-motor, Hi/Low, 34.5 W,Lock	\$ 45,992	7	\$ 6,023
10/17/2015	35 Bed Extender, Length, nylax 36x6x5	\$ 1,411	7	\$ 185
10/17/2015	35 Bed Rail, Side,Head Section, Hardware, Mounting Boards	\$ 4,397	7	\$ 576
1/16/2016	4 Bed Extension Kit Width 39" wide	\$ 264	7	\$ 28
1/12/2016	2 Elephant Lamps & 2 Colorful Flower Table Lamps	\$ 950	7	\$ 102
1/24/2016	Carmen Sofa TP 2	\$ 689	7	\$ 66
1/28/2016	4 Liliana Armchairs	\$ 1,548	10	\$ 103
2/24/2016	5 Z-Line Design 4-Drawer Vertical Files	\$ 1,070	7	\$ 89
2/4/2016	Parisian Coffee Table	\$ 400	7	\$ 38
6/15/2016	4 Chairs-Reupholstered	\$ 1,191	7	\$ 57
<b>Total additions for Movable Equipment</b>		\$ 258,549		\$ 37,893 *
<b>Deletions:</b>				
10/1/1995	Washer/Dryer	\$ (22,250)	7	\$ -
1/19/2007	Daniels Equipment	\$ (1,474)	5	\$ -
10/5/2004	Ro-Vic NE Link Floor Sweeper	\$ (2,776)	5	\$ -
10/1/1999	3 Patient lifts w/scale(2 Sarita)&(3	\$ (13,275)	5	\$ -
2/27/2009	1 Maximove & Maxitwin rec Therapy	\$ (4,349)	7	\$ 259
8/22/2000	4 Mattresses	\$ (959)	7	\$ -
5/31/1991	Furniture & Fixtures (35 Beds)	\$ (28,000)	7	\$ -
<b>Total deletions for Movable Equipment</b>		\$ (73,083)		\$ 259 **

\*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>				
2/12/2016	Wallpaper	\$ 8,992	7	\$ 856
2/12/2016	Interior Wall Covering	\$ 8,380	7	\$ 798
5/23/2016	3 Annunciators - Simplex 4002 Fire Alarm System	\$ 6,134	7	\$ 292
Various	Related Party Assets - Schedule Attached	\$ 1,053,054	Various	\$ 17,278
<b>Total additions for Leasehold Improvement</b>		\$ 1,076,560		\$ 19,225 *
<b>Deletions:</b>				
2/9/2001	Daniels Equipment	\$ (2,173)	7	\$ -

<b>Total deletions for Leasehold Improvement</b>	\$ (2,173)	\$ -
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\*\* Attachment Pages 23 24

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

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

**Amortization Schedule\***

Name of Facility The Suffield House			License No. 2075-C		Report for Year Ended 9/30/2016			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1. Bed Rights	4	98	180 months	561,752	70,114				
2. Deferred Fees	var	var	48 months	30,646	23,858			6,788	
3. Deferred Fees - Paid off Lease and e	var	var	48 months	(30,646)	(30,646)				
A-4. Subtotal									6,788
<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				2,558,298	550,949	Var		82,456	
2. Disposals (attach schedule)				(2,173)	(2,173)				
3. Acquired during this report period (attach schedule)				1,076,560				19,225	
C-4. Subtotal									101,680
<b>D. Total Amortization</b>									108,468

\* 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 The Suffield House	License No. 2075-C	Report for Year Ended 9/30/2016	Page 25	of 37	
<b>11. Property Questionnaire</b>					
<b>Part A</b>					
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description	Total				
1. Date Land Purchased					
2. Date Structure Completed	05/09/90				
3. If <b>NOT</b> Original Owner, Date of Purchase					
4. Date of Initial Licensure	05/09/90				
5. Total Licensed Bed Capacity	128				
6. Square Footage	59,478				
7. Acquisition Cost					
a. Land	363,400				
b. Building	9,437,089				
<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)	Var	Var			
b. Date Mortgage Obtained	06/30/91	03/18/09			
c. Interest Rate for the Cost Year	2.69%	2.65%			
d. Term of Mortgage (number of years)	20	20			
e. Amount of Principal Borrowed	10,500,000	1,170,000			
f. Principal balance outstanding as of 10/28/15					
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>					
g. Type of Financing (e.g., fixed, variable)	Fixed				
h. Date of Refinancing	10/28/15				
i. New Interest Rate	3.58%				
j. Term of Mortgage (number of years)	35				
k. Amount of Principal Borrowed	11,300,344				
l. Principal Outstanding on Note Paid-Off	7,632,397				
<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
The Suffield House		2075-C	9/30/2016		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$ 5,839	5,839		
Name of Lender		Rate				
People's United Bank		2.69%/2.65%				
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)			\$ 5,839	5,839		

*(Carry Subtotals forward to next page)*

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

Name of Facility The Suffield House		License No. 2075-C		Report for Year Ended 9/30/2016		Page 27	of 37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				5,839	5,839		
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$ 37,960	37,960		
A. Item		Rate	Amount				
Capital Leases		Various	37,960				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$ 37,960	37,960		
12. D. Other Interest Expense (Specify)				\$			
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)				\$ 43,799	43,799		
14. Insurance							
a. Insurance on Property (buildings only)				\$ 97,717	97,717		
b. Insurance on Automobiles				\$ 4,348	4,348		
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$			
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. <b>Total Insurance Expenditures</b> (14a + b + c)				\$ 102,065	102,065		
15. <b>Total All Expenditures</b> (A-13 thru C-14)				\$ 15,301,649	15,301,649		



### D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
The Suffield House				2075-C	9/30/2016	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.	10	a12g	Occupational Therapy	\$ 492,394	492,394		
4.			Other - See attached Schedule	\$ 165,994	165,994		
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 73,052	73,052		
10.	15	1e	Accounting & Legal	\$ 42,540	42,540		
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	1L2	Gifts, flowers and coffee shops	\$ 26,958	26,958		
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.	16	1L6	Automobile Expense (e.g. personal use)	\$ 11,549	11,549		
18.	16	1m2/3	Unallowable Advertising *	\$ 11,290	11,290		
19.	15	1j	Income Tax / Corporate Business Tax	\$ 250	250		
20.	16	1m4/	Fund Raising / Contributions	\$ 375	375		
21.	16	1m12	Unallowable Management Fees	\$ 396,500	396,500		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 62,606	62,606		
<b>Page 18 - Dietary Expenditures</b>							
24.	18	2a1	Meals to employees, guests and others who are not residents	\$ 19,655	19,655		
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 1,303,163	1,303,163		

\* 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)
10	A4	Alexander Riccio	\$ 14,352		
10	A5c	Clinton Moffie	\$ 151,642		
<b>Total Other Salaries Adjustment</b>			\$ 165,994	\$ -	\$ -

**Schedule of Fees Adjustments**

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

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	1m13	MISCELLANEOUS ADMIN EXPENSE	\$ 19,945		
15	1a1	WORKMEN'S COMP. - ALEXANDER RICCIO/CLINTON MOFFIE	\$ 5,810		
15	1a3	UNEMPLOYMENT INS - ALEXANDER RICCIO/CLINTON MOFFIE	\$ 2,158		
15	1a4	SOCIAL SECURITY - ALEXANDER RICCIO/CLINTON MOFFIE	\$12,284		
15	1a5	HEALTH INS - ALEXANDER RICCIO/CLINTON MOFFIE	\$21,911		
15	1a7	PENSIONS - ALEXANDER RICCIO/CLINTON MOFFIE	\$498		
<b>Total Other A&amp;G Adjustments</b>			\$ 62,606	\$ -	\$ -

Page/Line Acct

28/L17	50-4110	Automotive Expenses	3234
	50-4116	Passenger Van Expense	405
	50-4420	Auto Rental	7910
			<u>11549</u>

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

Name of Facility The Suffield House				License No. 2075-C	Report for Year Ended 9/30/2016	Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,303,163	1,303,163		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5a2	Prescription Drugs	\$ 408,291	408,291		
28.	20	5d	Ambulance/Limousine	\$ 12,399	12,399		
29.	20	5f	X-rays, etc	\$ 28,598	28,598		
30.	20	5h	Laboratory	\$ 83,752	83,752		
31.	20	5c	Medical Supplies	\$ 8,025	8,025		
32.	20	5e2	Oxygen (non emergency)	\$ 56,949	56,949		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 67,703	67,703		
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.	27	14b	Property Insurance	\$ 1,453	1,453		
<b>Other - Miscellaneous</b>							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$			
<b>Not For Profit Providers Only</b>							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51.	<b>Total Amount of Decrease (Items 1 - 50)</b>			\$ 1,970,333	1,970,333		

\*\*\* 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.

The Suffield House  
9/30/2016

**Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	RESIDENT SPECIFIC SUPPLIES	\$ 67,703		
<b>Total Other Ancillary Costs</b>			\$ 67,703	\$ -	\$ -

**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>			\$ -	\$ -	\$ -

Page/Line Acct

29/31	55-5354	Physical Therapy Expense A	6913
	55-5356	Physical Therapy Expense B	864
	55-5437	Medicare Non-Billable	248
			<u>8025</u>

29/41 All Auto related to Eagle Point Bus

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended		Page	of
The Suffield House	2075-C	9/30/2016		30	37
Item	Total	CCNH	RHNS	(Specify)	
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 10,191,351	10,191,351			
b. Medicaid Room and Board Contractual Allowance **	\$ (4,559,051)	(4,559,051)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 3,367,780	3,367,780			
b. Medicare Room and Board Contractual Allowance **	\$ 1,092,451	1,092,451			
4. a. Private-Pay Residents and Other	\$ 5,312,521	5,312,521			
b. Private-Pay Room and Board Contractual Allowance **	\$ (47,982)	(47,982)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 397,374	397,374			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (397,374)	(397,374)			
c. Prescription Drugs - Non-Medicare	\$ 60,766	60,766			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (60,489)	(60,489)			
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	\$ 1,810,315	1,810,315			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (1,704,818)	(1,704,818)			
c. Physical Therapy - Non-Medicare	\$ 267,625	267,625			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (257,978)	(257,978)			
4. a. Speech Therapy - Medicare	\$ 35,950	35,950			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (33,474)	(33,474)			
c. Speech Therapy - Non-Medicare	\$ 7,300	7,300			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (6,950)	(6,950)			
5. a. Occupational Therapy - Medicare	\$ 1,447,498	1,447,498			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (1,384,904)	(1,384,904)			
c. Occupational Therapy - Non-Medicare	\$ 198,269	198,269			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (188,905)	(188,905)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 15,547,275	15,547,275			
<b>IV. Other Revenue*</b>					
1. Meals sold to guests, employees & others	\$ 18,884	18,884			
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income ( <i>Specify</i> )	\$				
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$				
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 18,884	18,884			
<b>VI. Total All Revenue</b> (III +V)	\$ 15,566,159	15,566,159			

\* 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)
	LAB-MED A	\$ 36,788		
	RADIOLOGY - MED A	\$ 12,751		
	C/A MEDICARE A - ANCILLARIES	\$ (36,788)		
	C/A MEDICARE A - ANCILLARIES	\$ (12,751)		
<b>Total Other Resident Revenue - Medicare</b>		\$ -	\$ -	\$ -

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

**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
	LAB MEDICAID	\$ 45		
	LAB - OTHER	\$ 3,794		
	RADIOLOGY - OTHER	\$ 2,228		
	C/A MEDICAID - ANCILLARIES	\$ (45)		
	C/A MEDICAID - ANCILLARIES	\$ (3,794)		
	C/A MEDICAID - ANCILLARIES	\$ (2,228)		
<b>Total Other Resident Revenue</b>		\$ -	\$ -	\$ -

**Interest Income**

**Account**

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

**Schedule of Other Revenue**

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

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
The Suffield House	2075-C	9/30/2016	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	563,776
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	999,406
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	28,578
5. Prepaid Expenses			\$	113,286
a. S CORP TAX DEPOSIT	77,879			
b. PREPAID INSURANCE	9,565			
c. PREPAID OTHER	25,842			
d.				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	
_____				
_____				
_____				
<b>A-9. Total Current Assets (Lines A1 thru 8)</b>			\$	1,705,046
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 <u>3,632,684</u>		\$	2,982,227
	Accum. Depreciation <u>650,457</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>1,928,620</u>		\$	348,876
	Accum. Depreciation <u>1,579,744</u>	Net		
7. Motor Vehicles	*Historical Cost <u>40,763</u>		\$	
	Accum. Depreciation <u>40,763</u>	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
_____				
<b>B-10. Total Fixed Assets (Lines B1 thru 9)</b>			\$	3,331,103

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

(Carry Total forward to next page)



### G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
The Suffield House	2075-C	9/30/2016	32	37
<b>Account</b>			<b>Amount</b>	
Total Brought Forward:			\$	5,036,149
<b>C. Leasehold or like property recorded for Equity Purposes.</b>				
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			\$	
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$	
<b>D. Investment and Other Assets</b>				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	561,752		
	Accum. Depreciation	70,114	Net	\$ 491,638
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> )			\$	558,734
	DUE FROM GUILFORD HOUSE	1,326		
	DUE FROM EAGLE POINT	557,408		
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$	1,050,372
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$	6,086,521

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

### G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
The Suffield House	2075-C	9/30/2016	33	37
Account			Amount	
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable			\$	309,913
2. Notes Payable ( <i>itemize</i> )			\$	
_____				
_____				
_____				
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )			\$	
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )			\$	300,518
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )			\$	
6. Accrued Payroll Taxes Payable			\$	22,508
7. Medicare Final Settlement Payable			\$	
8. Medicare Current Financing Payable			\$	
9. Mortgage Payable ( <i>Current Portion</i> )			\$	
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )			\$	
11. Accrued Income Taxes*			\$	
12. Other Current Liabilities ( <i>itemize</i> )			\$	780,977
ACCRUED EXPENSES - OPERAT			466,597	
ACCRUED EXPENSES - INSURAN			116,563	
ACCRUED TAXES - PROPERTY			7,376	
ACCRUED NURSING HOME TAX			190,441	
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>			<b>\$</b>	<b>1,413,916</b>

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

(Carry Total forward to next page)

### G. Balance Sheet (cont'd)

Name of Facility The Suffield House	License No. 2075-C	Report for Year Ended 9/30/2016		Page 34	of 37
Account				Amount	
Total Brought Forward:				1,413,916	
<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> )				\$ 1,380,798	
Name and Address of Lender	Amount	Loan Date			
Moffie Family Holding Company LLC, 1 Canal Rd., Suffield CT 06078	1,380,798				
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$	
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 1,380,798	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 2,794,714	

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Suffield House	2075-C	9/30/2016	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> )			\$	1,035,776
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			\$	1,035,776
<b>B. Net Worth</b>				
1. Owner's Capital			\$	(488,765)
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	2,462,008
6. Gain or Loss for Period				
	10/1/2015	thru	9/30/2016	\$ 281,788
7. Total Net Worth			\$	2,256,031
<b>C. Total Reserves and Net Worth</b>			\$	3,291,807
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	6,086,521

### H. Changes in Total Net Worth

Name of Facility The Suffield House	License No. 2075-C	Report for Year Ended 9/30/2016	Page 36	of 37		
Account			Amount			
A. Balance at End of Prior Period as shown on Report of 09/30/2015			\$	2,463,008		
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$	15,566,159		
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$	15,284,371		
D. Net Income or Deficit			\$	281,788		
E. Balance			\$	2,744,796		
F. Additions						
1. Additional Capital Contributed ( <i>itemize</i> )						
Expenses Per Page 27	\$15,301,649					
(Less) F/S vs C/R Depreciation	(17,278)					
Total Expenses Per F/S	\$15,284,371					
2. Other ( <i>itemize</i> )						
F-3. Total Additions					\$	
G. Deductions						
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )					\$	488,765
Name and Address ( <i>No., City, State, Zip</i> )	Title	Amount				
		488,765				
2. Other Withdrawings ( <i>Specify</i> )			\$			
Purpose	Amount					
3. Total Deductions			\$	488,765		
H. <b>Balance at End of Period</b>			\$	2,256,031		
	09/30/16					

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

Name of Facility The Suffield House	License No. 2075-C	Report for Year Ended 9/30/2016	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (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		Date Signed
		Controller		
Printed Name of Preparer				
Mark Tomasello				
Address Address			Phone Number	
One Canal Road, Suffield CT 06078			(860) 658-2627	