

State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2016

Name of Facility (as licensed) GREYSTONE REST HOME INC	
Address (No. & Street, City, State, Zip Code) 44 HIGH STREET-PO BOX 499 PORTLAND,CT 06480	
Type of Facility <input type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> Residential Care Home	
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016

License Numbers:	CCNH	RHNS	Residential Care Home 1275	Medicare Provider
------------------	------	------	-------------------------------	-------------------

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
----------------------------	------	------	---------

For Department Use Only

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

Table of Contents

General Information - Administrator's/Owner's Certification	1
General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
General Information and Questionnaire - Type of Facility - Organization Structure	2
General Information and Questionnaire - Partners/Members	3
General Information and Questionnaire - Corporate Owners	3A
General Information and Questionnaire - Individual Proprietorship	3B
General Information and Questionnaire - Related Parties	4
General Information and Questionnaire - Basis for Allocation of Costs	5
General Information and Questionnaire - Leases	6
General Information and Questionnaire - Accounting Basis	7
Schedule of Resident Statistics	8
Schedule of Resident Statistics (Cont'd)	9
A. Report of Expenditures - Salaries & Wages	10
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B. Report of Expenditures - Professional Fees	13
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C. Expenditures Other than Salaries - Administrative and General	15
C. Expenditures Other than Salaries (Cont'd) - Administrative and General	16
Schedule C-1 - Management Services	17
C. Expenditures Other than Salaries (Cont'd) - Dietary	18
C. Expenditures Other than Salaries (Cont'd) - Laundry	19
C. Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
Depreciation Schedule	23
Amortization Schedule	24
C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C. Expenditures Other than Salaries (Cont'd) - Interest	26
C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D. Adjustments to Statement of Expenditures	28
D. Adjustments to Statement of Expenditures (Cont'd)	29
F. Statement of Revenue	30
G. Balance Sheet	31
G. Balance Sheet (Cont'd)	32
G. Balance Sheet (Cont'd)	33
G. Balance Sheet (Cont'd)	34
G. Balance Sheet (Cont'd) - Reserves and Net Worth	35
H. Changes in Total Net Worth	36
I. Preparer's/Reviewer's Certification	37

General Information

Name of Facility (as licensed) GREYSTONE REST HOME INC	License No. 1275	Report for Year Ended 9/30/2016	Page 1	of 37
---	---------------------	------------------------------------	-----------	----------

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for GREYSTONE REST HOME INC [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) LUEL SWANSON			Printed Name (Owner) LUCILLE SWANSON		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility GREYSTONE REST HOME INC		Period Covered:	From 10/1/2015	To 9/30/2016
Address of Facility 44 HIGH STREET-PO BOX 499 PORTLAND,CT 06480				
Report Prepared By THOMAS J. DEMCHAK,CPA		Phone Number 203-605-7255	Date 2/11/2017	
Item	Total	CCNH	RHNS	Residential Care Home
1. Dietary wages paid	\$ 104,535			104,535
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$ 69,158			69,158
4. Nursing wages paid	\$			
5. All other wages paid	\$ 455,418			455,418
6. Total Wages Paid	\$ 629,111			629,111
7. Total salaries paid	\$ 96,284			96,284
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$ 725,395			725,395

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-342-2509		Report for Year Ended 9/30/2016	Page 2	of 37
Name of Facility (as shown on license) GREYSTONE REST HOME INC		Address (No. & Street, City, State, Zip) 44 HIGH STREET-PO BOX 499 PORTLAND,CT 06480		
License Numbers:	CCNH	RHNS	Residential Care Home 1275	Medicare Provider No.
Type of Facility (Check appropriate box(es))				
<input type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> Residential Care Home				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?				
<input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator LUEL SWANSON		Nursing Home Administrator's License No.:		
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name N/A		License No.:		

General Information and Questionnaire Corporate Owners

Name of Facility GREYSTONE REST HOME INC	License No. 1275	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	
GREYSTONE REST HOME INC	44 HIGH STREET-PORTLAND,CT 06480		CT	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
LUCILLE SWANSON	44 HIGH STREET-PORTLAND,CT 06480	PRESIDENT	40	
LUCEL SWANSON	44 HIGH STREET-PORTLAND,CT 06480	VICE PRESIDENT		
BERGETTE SWANSON	44 HIGH STREET-PORTLAND,CT 06480	SECRETARY		
SARAH SWANSON	44 HIGH STREET-PORTLAND,CT 06480	TREASURER		
Names of Stockholders Owning at Least 10% of Shares				
LUCILLE SWANSON	44 HIGH STREET-PORTLAND,CT 06480	PRESIDENT	40	

General Information and Questionnaire
Individual Proprietorship

Name of Facility GREYSTONE REST HOME INC	License No. 1275	Report for Year Ended 9/30/2016	Page 3B	of 37
---	---------------------	------------------------------------	------------	----------

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

N/A

Annual Report of Long-Term Care Facility

**General Information and Questionnaire
Related Parties***

Name of Facility GREYSTONE REST HOME INC	License No. 1275	Report for Year Ended 9/30/2016	Page 4	of 37
---	---------------------	------------------------------------	-----------	----------

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	%**				
LUCILLE SWANSON	22 SPRING STREET- PORTLAND,CT 06480	<input type="radio"/>	<input checked="" type="radio"/>		RENTAL-MTG PAYMENT-INTEREST	PG26 12 A1	27,650	27,650
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					

* Use additional sheets if necessary.

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

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility GREYSTONE REST HOME INC	License No. 1275	Report for Year Ended 9/30/2016	Page 5	of 37
---	---------------------	------------------------------------	-----------	----------

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

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

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

1. In the preparation of this Report, were all costs allocated as required? 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.

N/A

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.

N/A

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 GREYSTONE REST HOME INC			License No. 1275	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						
N/A	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ? <input checked="" type="radio"/> Yes <input type="radio"/> No Total ***								

* 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 GREYSTONE REST HOME INC	License No. 1275	Report for Year Ended 9/30/2016	Page 7	of 37
---	---------------------	------------------------------------	-----------	----------

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 MICHAEL A. OLENSKI,CPA 2 THOMAS J. DEMCHAK, CPA 3 4	Address (No. & Street, City, State, Zip Code) 9 RESEARCH DR.-MILFORD,CT 13 RIVERWALK-BRANFORD,CT
---	--

Services Provided by This Firm (*describe fully*)

1 REVIEW FINANCIAL STATEMENTS AND TAX RETURNS	\$ 7,350
2 PREPARATION OF COST REPORT,COST REP. AUDITS , REIMBURSEMENT ISSUES	\$ 6,133
3	\$
4	\$
	Charge for Services Provided
	\$ 13,483

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

- Yes No PG. 15. 1. D.

Legal Services Information

Name of Legal Firm or Independent Attorney 1 ZELDES,NEEDLE &COOPER 2 3 BROWN,PAINDIRIS & SCOTT,LLP 4 5	Telephone Number 203-333-9441 860-659-0700
---	--

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

1 1000 LAFAYETTE BLVD
2 BRIDGEPORT, CT 06601
3 2252 MAIN STREET
4 GLASTONBURY,CT 06033
5

Services Provided by This Firm (*describe fully*)

1 GENERAL EMPLOYMENT ADVICE ISSUES	\$ 680
2 ADVICE REGARDING VACATON PAY	\$ 90
3	\$
4	\$
5	\$
	Charge for Services Provided
	\$ 770

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

- Yes No PG 15 I. E

Schedule of Resident Statistics

Name of Facility GREYSTONE REST HOME INC			License No. 1275		Report for Year Ended 9/30/2016				Page 8	of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total Residential Care Home	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Residential Care Home	Total	CCNH	RHNS	Residential Care Home
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period									58			58
B. On last day of THIS report period	58			58					58			58
2. Number of Residents												
A. As of midnight of PREVIOUS report period									54			54
B. As of midnight of THIS report period	53			53					53			53
3. Total Number of Days Care Provided During Period												
A. Medicare												
B. Medicaid (Conn.)	17,120			17,120	12,797			12,797	4,323			4,323
C. Medicaid (other states)												
D. Private Pay	2,233			2,233	1,792			1,792	441			441
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	19,353			19,353	14,589			14,589	4,764			4,764
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. Total Resident Days (3G + 4A + 4B)	19,353			19,353	14,589			14,589	4,764			4,764

Annual Report of Long-Term Care Facility

Schedule of Resident Statistics (Cont'd)

Name of Facility GREYSTONE REST HOME INC	License No. 1275	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? 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	Residential Care Home	Lost			Gained			CCNH	RHNS	Residential Care Home	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Residential Care Home	
N/A													

5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number RESIDENT DAYS for 90 days following the change.

Change in Resident Days	CCNH	RHNS	Residential Care Home
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	Residential Care Home	R.C.H.	ICF-MR
No. of Residents						6	47	
Per Diem Rate								
a. One bed rm.						\$138-\$164		
b. Two bed rms.						\$94-\$130	\$75.85-\$76.80	
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	Residential Care Home
A. Medicare - Part B	N/A			N/A
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. Total Physical Therapy Treatments				
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. Total Speech Therapy Treatments				
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. Total Occupational Therapy Treatments				

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
GREYSTONE REST HOME INC	1275	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	Residential Care Home	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)					96,284	2,080
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)					96,044	3,704
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor					22,701	1,004
c. Dietary Workers					81,834	7,543
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers					69,158	4,873
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers					71,458	4,134
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses						
b. RN						
1. Direct Care						
2. Administrative**						
c. LPN						
1. Direct Care						
2. Administrative**						
d. Aides and Attendants					271,042	17,481
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers					16,784	1,112
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						
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>					725,305	41,931

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

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

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

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH		RHNS		Residential Care Home	
	\$	Hours	\$	Hours	\$	Hours
Total	\$ -	-	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		Residential Care Home	
	\$	Hours	\$	Hours	\$	Hours
Total	\$ -	-	\$ -	-	\$ -	-

**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		
GREYSTONE REST HOME INC			1275	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	Residential Care Home							
Section I - Operators/Owners										
LUCILLE SWANSON			10,141			840	PG 10. 12D			
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).										
LUEL SWANSON			24,320			2,128	PG10. 12D			

* 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	
GREYSTONE REST HOME INC				1275	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	Residential Care Home							
Section III - Administrators***										
LUEL SWANSON			96,284	COMP-UNEMPLOYMENT INS	OVERSEES OPERATIONS	2,080	PG10 A2			
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.

Annual Report of Long-Term Care Facility

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
GREYSTONE REST HOME INC	1275	9/30/2016	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	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						
2. Dentist						
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)						
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-13 Total Fees Paid in Lieu of Salaries						

* 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 GREYSTONE REST HOME INC		License No. 1275		Report for Year Ended 9/30/2016		Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship			
		Yes	No				
N/A		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<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
GREYSTONE REST HOME INC	1275	9/30/2016	15	37
Item	Total	CCNH	RHNS	Residential Care Home
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 12,458			12,458
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 10,514			10,514
4. Social Security (F.I.C.A.)	\$ 61,915			61,915
5. Health Insurance	\$ 7,297			7,297
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$			
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$			
d. Accounting and Auditing	\$ 13,483			13,483
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 770			770
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 2,691			2,691
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 3,157			3,157
2. Cellular Phones	\$ 1,065			1,065
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$			
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$ 218			218
2. Other (<i>Specify</i>) See Attached Schedule	\$ 319			319
3. Resident Day User Fee	\$			
Subtotal	\$ 113,887			113,887

* 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**

GREYSTONE REST HOME INC
9/30/2016

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Residential Care Home
Total	\$ -	\$ -	\$ -

Schedule of Other Taxes

Description	CCNH	RHNS	Residential Care Home
SALES TAX			\$ 319
Total	\$ -	\$ -	\$ 319

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

Name of Facility	License No.	Report for Year Ended	Page	of
GREYSTONE REST HOME INC	1275	9/30/2016	16	37
				Residential
Item	Total	CCNH	RHNS	Care Home
<i>Subtotals Brought Forward:</i>	113,887			113,887
1. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$			
3. Gifts to Staff and Residents	\$			
4. Employee Travel	\$			
5. Education Expenses Related to Seminars and Conventions	\$ 495			495
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 1,314			1,314
7. Other (<i>Specify</i>)	\$			
See Attached Schedule				
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 56			56
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$ 5,881			5,881
3. Advertising Other (<i>Specify</i>)***	\$			
See Attached Schedule				
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	\$ 948			948
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>)	\$ 1,481			1,481
See Attached Schedule				
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 285			285
9. Subscriptions	\$			
10. Contributions***	\$			
See Attached Schedule				
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$			
12. Administrative Management Services**	\$			
13. Other (<i>Specify</i>)	\$ 12,124			12,124
See Attached Schedule				
<i>C-14 Total Administrative & General Expenditures</i>	\$ 136,471			136,471

* 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	Residential Care Home
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	Residential Care Home
Total Other Advertising	\$ -	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
CT ASSOC OF RESIDENTIAL CARE			\$ 650
CBLA			\$ 250
HARTFORD COURANT			\$ 457
AAA			\$ 124
Total Dues	\$ -	\$ -	\$ 1,481

Schedule of Contributions

Description	CCNH	RHNS	Residential Care Home
Total Contributions	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
PAYROLL PROCESSING			\$ 10,790
LICENSES AND PERMITS			\$ 1,334
Total Other Administrative and General	\$ -	\$ -	\$ 12,124

Schedule C-1 - Management Services*

Name of Facility GREYSTONE REST HOME INC	License No. 1275	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 #
N/A			

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
GREYSTONE REST HOME INC		1275	9/30/2016		18	37
Item		Total	CCNH	RHNS	Residential Care Home	
2. Dietary						
a. In-House Preparation & Service						
1.	Raw Food	\$ 132,222				132,222
2.	Non-Food Supplies	\$ 270				270
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)		\$ 132,492				132,492
2F. Dietary Questionnaire		Total	CCNH	RHNS	Residential Care Home	
G. Resident Meals: Total no. of meals served per day:*						
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No						
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.						
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.						
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.						
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.						
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.						
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)						

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

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

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

Name of Facility GREYSTONE REST HOME INC		License No. 1275	Report for Year Ended 9/30/2016		Page 19	of 37
Item		Total	CCNH	RHNS	Residential Care Home	
3. Laundry						
a. In-House Processing*		Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***		Lbs.				
		Amt. \$				
3. Personal clothing of residents washed, ironed, and/or processed.***		Lbs.				
		Amt. \$				
4. Repair and/or purchase of linens.***		Lbs.				
		Amt. \$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	6,114			6,114
c. Management Services**		\$				
d. Other (Specify)		\$				
3E. Total Laundry Expenditures (3a + b + c + d)		\$	6,114			6,114
3F. Laundry Questionnaire						
G. Is cost of employee laundry included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H. Did you receive revenue from employees?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
I. Where is the revenue received reported in the Cost Report?		(Page/Line Item)				
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K. Did you receive revenue from these people?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
L. Where is the revenue received reported in the Cost Report?		(Page/Line Item)				

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
 All allocations should add to total recorded in 3E.

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of	
GREYSTONE REST HOME INC	1275	9/30/2016	20	37	
Item		Total	CCNH	RHNS	Residential Care Home
4. Housekeeping	Sq. Ft. Served by Personnel				
a. In-House Care					
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.)</i>)	Amt. \$	24,840			24,840
b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Served by Personnel				
	Amt. \$				
c. Management Services*	\$				
d. Other (<i>Specify</i>)	\$				
4E. Total Housekeeping Expenditures (4a + b + c + d)	\$	24,840			24,840
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$				
b. Medicine Cabinet Drugs	\$				
c. Medical and Therapeutic Supplies	\$				
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$				
f. X-rays and Related Radiological Procedures***	\$				
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory****	\$				
i. Recreation	\$	2,800			2,800
j. Other (Specify)**** See Attached Schedule	\$	6,440			6,440
5K. Total Resident Care Expenditures (5a - 5j)	\$	9,240			9,240

* 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	Residential Care Home
MINOR MEDICAL SUPPLIES			\$ 6,440
Total Other Resident Care	\$ -	\$ -	\$ 6,440

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

Name of Facility GREYSTONE REST HOME INC				License No. 1275	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	Residential Care Home	Pg	Line
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
GREYSTONE REST HOME INC	1275	9/30/2016			22	37
Item	Total	CCNH	RHNS	Residential Care Home		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 54,382				54,382	
b. Heat	\$ 22,319				22,319	
c. Light & Power	\$ 38,053				38,053	
d. Water	\$ 14,361				14,361	
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$					
f. Other (<i>itemize</i>)	\$ 4,407				4,407	
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 133,522				133,522	
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$ 32,188				32,188	
c. Non-Movable Equipment	\$ 617				617	
d. Movable Equipment	\$ 2,834				2,834	
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 35,639				35,639	
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$					
10. Property Taxes						
a. Real estate taxes paid by owner	\$ 47,369				47,369	
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$ 1,413				1,413	
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 84,421				84,421	

* 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	Residential Care Home
PROPANE			\$ 4,407
Total Other Repairs and Maintenance	\$ -	\$ -	\$ 4,407

Depreciation Schedule

Name of Facility GREYSTONE REST HOME INC			License No. 1275			Report for Year Ended 9/30/2016			Page 23	of 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			28,069		28,069	28,069	SL	VARIOUS					
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			1,814,697		1,814,697	1,219,061	SL	VARIOUS	32,188				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal										32,188			
C. Non-Movable Equipment													
1. Acquired prior to this report period			51,400		51,400	48,313	SL	VARIOUS	617				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal										617			
		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. 2010 FORD VAN		X		9	2010	36,161		36,161	36,161	SL	5YRS		
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period						154,621		154,621	148,986	SL	VARIOUS	1,764	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)						5,350		5,350		SL	5 YRS	1,070	
D-3. Subtotal													2,834
E. Total Depreciation													35,639

GREYSTONE REST HOME INC
9/30/2016

Schedule of Land Improvements Acquired during this report period

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

*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 Improvement		\$ -		\$ - *
Deletions:				
Total deletions for Building Improvement		\$ -		\$ - **

*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:				
10/6/2015	FREEZERS	\$ 1,380	5	\$ 276
10/12/2015	REFRIGERATOR	\$ 509	5	\$ 102
10/23/2015	CHESTS AND HEADBOARDS	1175	5	235
7/7/2016	COMPUTERS AND PRINTERS	2286	5	457
Total additions for Movable Equipmen		\$ 5,350		\$ 1,070 *
Deletions:				
Total deletions for Movable Equipmen		\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

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

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

Amortization Schedule*

Name of Facility GREYSTONE REST HOME INC			License No. 1275		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							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility GREYSTONE REST HOME INC	License No. 1275	Report for Year Ended 9/30/2016	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description		Total		
1. Date Land Purchased		10/04/87		
2. Date Structure Completed		VARIOUS		
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity		58		
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building				
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage
1. Financing		4th Mortgage		
a. Type of Financing (e.g., fixed, variable)		FIXED		
b. Date Mortgage Obtained		03/04/04		
c. Interest Rate for the Cost Year		675.00%		
d. Term of Mortgage (number of years)		15		
e. Amount of Principal Borrowed		1,100,000		
f. Principal balance outstanding as of <u>09/30/2016</u>		353,790		
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.

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

Name of Facility GREYSTONE REST HOME INC		License No. 1275	Report for Year Ended 9/30/2016		Page 26	of 37
Item			Total	CCNH	RHNS	Residential Care Home
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$ 27,650			27,650
Name of Lender WELLS FARGO		Rate 6.75%				
Address of Lender 1060 MAIN ST-STAMFORD,CT						
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)			\$ 27,650			27,650

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended			Page	of
GREYSTONE REST HOME INC		1275		9/30/2016			27	37
Item				Total	CCNH	RHNS	Residential Care Home	
Subtotals Brought Forward:				27,650			27,650	
12. C. Movable Equipment								
1. Automotive Equipment				\$				
A. Item		Rate	Amount					
Lender								
Address of Lender								
2. Other (Specify)				\$				
A. Item		Rate	Amount					
Lender								
Address of Lender								
B. Item		Rate	Amount					
Lender								
Address of Lender								
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$				
12. D. Other Interest Expense (Specify) WELLS FARGO-WORKING CAPITAL L/C				\$ 394			394	
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$ 28,044			28,044	
14. Insurance								
a. Insurance on Property (buildings only)				\$ 30,131			30,131	
b. Insurance on Automobiles				\$ 1,619			1,619	
c. Insurance other than Property (as specified above)								
1. Umbrella (Blanket Coverage)				\$				
2. Fire and Extended Coverage				\$				
3. Other (Specify)				\$				
14d. Total Insurance Expenditures (14a + b + c)				\$ 31,750			31,750	
15. Total All Expenditures (A-13 thru C-14)				\$ 1,312,199			1,312,199	

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
GREYSTONE REST HOME INC				1275	9/30/2016	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 285			285
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.			Accounting & Legal	\$			
11.	15	H.1	Telephone	\$ 595			595
12.	15	H.2	Cellular Telephone	\$ 435			435
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	15	M.2	Unallowable Advertising *	\$ 5,881			5,881
19.	15	J	Income Tax / Corporate Business Tax	\$ 218			218
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$			
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)				\$ 7,414			7,414

* 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	Residential Care Home
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
16	M.8A	CHAMBER OF COMMERCE DUES			\$ 285
Total Other Fees Adjustments			\$ -	\$ -	\$ 285

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Other A&G Adjustments			\$ -	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
GREYSTONE REST HOME INC				1275	9/30/2016	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward				\$ 7,414			7,414
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$			
28.			Ambulance/Limousine	\$			
29.			X-rays, etc	\$			
30.			Laboratory	\$			
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 6,440			6,440
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			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	\$			
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)			\$ 13,854			13,854

*** 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.

GREYSTONE REST HOME INC
9/30/2016

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
20	5.J	MINOR MEDICAL SUPPLIES			\$ 6,440
Total Other Ancillary Costs			\$ -	\$ -	\$ 6,440

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Excess Movable Equipment Depreciation			\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Property Adjustments			\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Adjustments			\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Unallowable Building Interest			\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
GREYSTONE REST HOME INC	1275	9/30/2016			30	37
Item	Total	CCNH	RHNS	Residential Care Home		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 1,303,706			1,303,706		
b. Medicaid Room and Board Contractual Allowance **	\$					
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents(<i>all inclusive</i>)	\$					
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$ 261,880			261,880		
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$					
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$					
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$					
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$					
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$					
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$					
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$					
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$					
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 1,565,586			1,565,586		
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ 23			23		
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$					
V. Total Other Revenue (1 thru 8)	\$ 23			23		
VI. Total All Revenue (III + V)	\$ 1,565,609			1,565,609		

* 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	Residential Care Home
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Resident Revenue		\$ -	\$ -	\$ -

Interest Income

		Account			
Page Ref	Account	Balance	CCNH	RHNS	Residential Care Home
30 IV.5	MONEY MARKET FUNDS				\$ 23
Total Interest Income			\$ -	\$ -	\$ 23

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Revenue		\$ -	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
GREYSTONE REST HOME INC	1275	9/30/2016	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	132,324
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	66,212
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	754
a. MISCELLANEOUS PREPAID EXPENSES	754			
b. _____				
c. _____				
d. _____				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	8,912
UNDEPOSITED FUNDS	8,912			
A-9. Total Current Assets (Lines A1 thru 8)			\$	208,202
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	28,069	\$	
	Accum. Depreciation	28,069		Net
3. Buildings	*Historical Cost	1,814,697	\$	563,448
	Accum. Depreciation	1,251,249		Net
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation			Net
5. Non-Movable Equipment	*Historical Cost	51,400	\$	2,470
	Accum. Depreciation	48,930		Net
6. Movable Equipment	*Historical Cost	159,971	\$	8,151
	Accum. Depreciation	151,820		Net
7. Motor Vehicles	*Historical Cost	36,161	\$	
	Accum. Depreciation	36,161		Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	574,069

* 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
GREYSTONE REST HOME INC	1275	9/30/2016	32	37
Account			Amount	
Total Brought Forward:			\$ 782,271	
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements			\$	
*Historical Cost _____		Net		
Accum. Depreciation _____			\$	
3. Buildings			\$	
*Historical Cost _____		Net		
Accum. Depreciation _____			\$	
4. Non-Movable Equipment			\$	
*Historical Cost _____		Net		
Accum. Depreciation _____			\$	
5. Movable Equipment			\$	
*Historical Cost _____		Net		
Accum. Depreciation _____			\$	
6. Motor Vehicles			\$	
*Historical Cost _____		Net		
Accum. Depreciation _____			\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense			\$	
*Historical Cost _____		Net		
Accum. Depreciation _____			\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$ 9,478	
Name and Address		Amount	Loan Date	
L. SWANSON-22 SPRING ST- PORTLAND,CT		9,478	VARIOUS	
7. Other Assets (<i>itemize</i>)			\$	

D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ 9,478	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 791,749	

* 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
GREYSTONE REST HOME INC	1275	9/30/2016	33	37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable			\$	25,230
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>)			\$	12,036
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$	
6. Accrued Payroll Taxes Payable			\$	1,067
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>)			\$	31,091
ACCRUED PROFESSIONAL FEE		10,000		
ACCRUED VACATION		1,323		
DEFERRED REVENUE		19,630		
OTHER ACCRUED EXPENSES		138		
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	69,424

* 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 GREYSTONE REST HOME INC	License No. 1275	Report for Year Ended 9/30/2016	Page 34	of 37
Account			Amount	
Total Brought Forward:			69,424	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				
\$				
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$
DUE TO THE STATE OF CT		18,518	18,518	
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 18,518
C. Total All Liabilities (Lines A-13 + B-5)				\$ 87,942

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

Name of Facility	License No.	Report for Year Ended	Page	of
GREYSTONE REST HOME INC	1275	9/30/2016	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	7,140
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	134,244
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	141,384
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	4,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	477,001
6. Gain or Loss for Period	10/1/2015	thru	9/30/2016	\$ 81,422
7. Total Net Worth			\$	562,423
C. Total Reserves and Net Worth			\$	703,807
D. Total Liabilities, Reserves, and Net Worth			\$	791,749

H. Changes in Total Net Worth

Name of Facility GREYSTONE REST HOME INC	License No. 1275	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			\$	395,579
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	1,565,609
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	1,312,199
D. Net Income or Deficit			\$	253,410
E. Balance			\$	648,989
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
LESS: RENT PAID TO RELATED PARTY			(216,500)	
LESS-NON REIMBURSEABLE EXPENSES			(6,363)	
ADD: DEPRECIATION-LESSOR			23,225	
ADD:MTG INT PAID BY OWNER			27,650	
F-3. Total Additions			\$	(171,988)
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <i>Balance at End of Period</i>		09/30/16	\$	477,001

I. Preparer's/Reviewer's Certification

Name of Facility GREYSTONE REST HOME INC	License No. 1275	Report for Year Ended 9/30/2016	Page 37	of 37
<i>Check appropriate category</i>				
<input type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> Residential Care Home		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
THOMAS J. DEMCHAK, CPA				
Address Address		Phone Number		
13 RIVERWALK BRANFORD, CT 06405		203-605-7255		