NOTE:
If amended pages are necessary, please submit the amended pages with changes highlighted in yellow, along with a signed and notarized Page 1. As a reminder, if any expense pages have changed, which result in a net increase or decrease to total expenses, please submit the necessary amended Pages 27, 35 and 36. If any depreciation and/or amortization expenses have changed, please submit the corresponding Page 23 or 24 along

General Information

Cover

Name of Facility	Address	Phone Number
GILMORE MANOR, INC.	1381 MAIN STREET, GLASTONBURY, CT 06033	860-633-4411

Type of Facility and License Number(s)

☐ CCNH ☐ RHNS Residential Care Home

License Number			1777
Medicaid Provider Number			

Report for Year Beginning	Report for Year Ending
10/1/2016	9/30/2017

Page 1

Medicare Provider Number

Printed Name (Administrator)	Printed Name (Owner)
THEODORE L. FARACI	THEODORE L. FARACI

Page 1A

Report Prepared By	Phone Number	Date
CATHERINE J. FOLEY	860-633-4411	1/17/2018

Type of Ownership (Check appropriate box)

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

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

Has there been any change in ownership or operation during this report year? If "Yes," explain fully.

○ Yes ◉ No

Page 2

Name of Administrator
THEODORE L. FARACI

Nursing Home Administrator's License No.	

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

Name	License #

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Page 3

Name of Partners/Members	Business Address	Title	% Owned

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
GILMORE MANOR, INC.	1381 MAIN STREET, GLASTONBURY, CT 06033	CT

Page 3A

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
THEODORE L. FARACI	1381 MAIN STREET, GLASTONBURY, CT 06033	PRESIDENT	500
CATHERINE J. FOLEY	1381 MAIN STREET, GLASTONBURY, CT 06033	TREASURER	500
Names of Stockholders Owning at Least 10% of Shares			
THEODORE L. FARACI	1381 MAIN STREET, GLASTONBURY, CT 06033	PRESIDENT	500
CATHERINE J. FOLEY	1381 MAIN STREET, GLASTONBURY, CT 06033	TREASURER	500

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

Page 3B

Owner(s) of Facility

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.

Page 4

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
THEODORE L. FARACI	1381 MAIN STREET, GLASTONBURY, CT 06033	○ Yes ◉ No	ADMINISTRATOR	PAGE 10, LINE A2		71,955
Percentage Non-Related		0.00%				
CATHERINE J. FOLEY	1381 MAIN STREET, GLASTONBURY, CT 06033	○ Yes ◉ No	CLERICAL	PAGE 10. LINE A4		59,793
Percentage Non-Related		0.00%				
THEODORE L. FARACI	1381 MAIN STREET, GLASTONBURY, CT 06033	○ Yes ◉ No	LOANING OF FUNDS	PAGE 33, LINE A12		3,234
Percentage Non-Related		0.00%				
		○ Yes ○ No				
Percentage Non-Related		0.00%				
		○ Yes ○ No				
Percentage Non-Related		0.00%				
		○ Yes ○ No				
Percentage Non-Related		0.00%				
		○ Yes ○ No				
Percentage Non-Related		0.00%				
		○ Yes ○ No				
Percentage Non-Related		0.00%				
		○ Yes ○ No				
Percentage Non-Related		0.00%				

Page 5

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

◉ Yes ○ No

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

◉ Yes ○ No

Page 6

A **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 and Address of Lessor	Description of Items Leased	Date of Lease	Term of Lease	Annual Amount of Lease	Amount Claimed	Related to Owners
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
			Total		0	
			Is a Mileage Log Book Maintained for All Leased Vehicles ?			○ Yes ○ No

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? If "No," explain.

◉ Yes ○ No

	Name of Accounting Firm	Address of Accounting Firm
1	CRAIG J LUBITSKI CONSULTING	225 PITKIN STREET, EAST HARTFORD, CT 06108
2		
3		
4		

Page 7

	Services Provided by This Firm (describe fully)	Charge for Service Provided
1	ASSISTED WITH COST REPORT, CORPORATE TAX RETURNS, DEPRECIATION SCHEI	2,520
2		
3		
4		

Are these charges reflected in the expenditure portion of this report? If Yes, specify expense classification and line number.

◉ Yes ○ No

PAGE 15, LINE 1D

	Name of Legal Firm or Independent Attorney	Address	Telephone Number
1			
2			
3			
4			
5			

	Services Provided by This Firm	Charge for Service Provided
1		
2		
3		
4		
5		

Are these charges reflected in the expenditure portion of this report? If Yes, specify expense classification and line number.

○ Yes ○ No

○ Yes ○ No

Page 10

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

Name & Address of Individual	Full Explanation of Services	Explanation of Relationship	Related to Owners, Operators, Officers
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No

Page 14

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

Page 17

2H	**Is the cost of employee meals included in 2E?**	○ Yes ◉ No		
2I	**Did you receive revenue from employees?**	○ Yes ◉ No	**If yes, specify amt.**	
2J	**Where is the revenue received reported in the Cost Report?**		**(Page/Line Item)**	

Page 18

2K	**Is the cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?**	○ Yes ◉ No	**If yes, specify cost.**	
2L	**Is any revenue collected from these people?**	○ Yes ◉ No	**If yes, specify amt.**	
2M	**Where is the revenue received reported in the Cost Report?**		**(Page/Line Item)**	

2N	**Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?**	○ Yes ◉ No	**If yes, specify cost.**	
2O	**Is any revenue collected from employees?**	○ Yes ◉ No	**If yes, specify amt.**	
2P	**Where is the revenue received reported in the Cost Report?**		**(Page/Line Item)**	

Page 19

3G	**Is cost of employee laundry included in 3E?**	○ Yes ◉ No	**If yes, specify cost.**	
3H	**Did you receive revenue from employees?**	○ Yes ◉ No	**If yes, specify amt.**	
3I	**Where is the revenue received reported in the Cost Report?**		**(Page/Line Item)**	

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

Is the property either owned by the Facility or leased from a Related Party?	◉ Yes ○ No	**If "Yes" complete Part B.**	
		If "No" complete Part C.	

	Description	Total
11A1	**Date Land Purchased**	9/15/1983
11A2	**Date Structure Completed**	
11A3	**If NOT Original Owner, Date of Purchase**	9/15/1983
11A4	**Date of Initial Licensure**	9/15/1983
11A5	**Total Licensed Bed Capacity**	22
11A6	**Square Footage**	
11A7a	**Original Cost - Land**	19,260
11A7b	**Original Cost - Building**	141,240

Page 25

	Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
11B1a	**Type of Financing (e.g., fixed, variable)**				
11B1b	**Date Mortgage Obtained**				
11B1c	**Interest Rate for the Cost Year**				
11B1d	**Term of Mortgage (number of years)**				
11B1e	**Amount of Principal Borrowed**				
11B1f	**Principal balance outstanding as of _____**				
	Complete if Mortgage was Refinanced During Current Cost Year				
11B1g	**Type of Financing (e.g., fixed, variable)**				
11B1h	**Date of Refinancing**				
11B1i	**New Interest Rate**				
11B1j	**Term of Mortgage (number of years)**				
11B1k	**Amount of Principal Borrowed**				
11B1l	**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
C	**Arms-length leases**					
	Arms-length leases					
	Arms-length leases					
	Arms-length leases					
	Arms-length leases					

Page 37

Printed Name of Preparer
CATHERINE J FOLEY

Address of Preparer
1381 MAIN STREET, GLASTONBURY, CT 06033

Phone Number of Preparer
860-633-4411

	A	B	C	D	E	F	G	H	I
355		27	Prescription Drugs	0					
356		28	Ambulance/Limousine	0					
357		29	X-rays, etc.	0					
358		30	Laboratory	0					
359		31	Medical Supplies	0					
360		32	Oxygen (not emergency)	0					
361		33	Occupational Therapy	0					
362		34	Other Ancillary Costs (Page 29 Schedule)	0	-	-	-		
363			***Page 22 - Maintenance and Property***						
364		35	Excess Movable Equipment Depreciation (Page 29 Schedule)	0	-	-	-		
365		36	Depreciation on Unallowable Motor Vehicles	0					
366		37	Unallowable Property and Real Estate Taxes	0					
367	Page 29	38	Rental of Building Space or Rooms	0					
368		39	Other Property Costs (Page 29 Schedule)	0	-	-	-		
369			***Page 27 - Insurance***						
370		40	Mortgage Insurance	0					
371		41	Property Insurance	0					
372			***Other - Miscellaneous***						
373		42	Research or Experimental Activities	0					
374		43	Radio and Television Revenue	0					
375		44	Vending Machine Revenue	0					
376		45	Purchase Discounts and Allowances	0					
377		46	Duplication of functions or services	0					
378		47	Expenditures for protection, promotion of provider interest	0					
379		48	Interest Income on Account Rec.	0					
380		49	Other Adjustments to Expense (Page 29 Schedule)	(2)	-	-	(2)		
381			***Not For Profit Providers Only***						
382		50	Building/Non Movable Eq. Depreciation Unallowable Build Int (Page 29 Schedule)	0	-	-	-		
383									
384		51	***Total Amount of Decrease***	565	0	0	565		
385									

	A	Line #	Description	Total	CCNH	RHNS	Residential Care Home
386							
387			*Resident Room, Board & Routine Care Revenue*				
388		I1a	Medicaid Residents (*CT Only*)	595,846			595,846
389		I1b	Medicaid Room and Board Contractual Allowance	0			
390		I2a	Medicaid (*All Other States*)	0			
391		I2b	Other States Room and Board Contractual Allowance	0			
392		I3a	Medicare Residents *(all inclusive)*	0			
393		I3b	Medicare Room and Board Contractual Allowance	0			
394		I4a	Private-Pay Residents and Other	31,920			31,920
395		I4b	Private-Pay Room and Board Contractual Allowance	0			
396			*Other Resident Revenue*				
397		II1a	Prescription Drugs - Medicare	0			
398		II1b	Prescription Drugs - Medicare Contractual Allowance	0			
399		II1c	Prescription Drugs - Non-Medicare	0			
400		II1d	Prescription Drugs - Non-Medicare Contractual Allowance	0			
401		II2a	Medical Supplies - Medicare	0			
402		II2b	Medical Supplies - Medicare Contractual Allowance	0			
403		II2c	Medical Supplies - Non-Medicare	0			
404		II2d	Medical Supplies - Non-Medicare Contractual Allowance	0			
405		II3a	Physical Therapy - Medicare	0			
406	Page 30	II3b	Physical Therapy - Medicare Contractual Allowance	0			
407		II3c	Physical Therapy - Non-Medicare	0			
408		II3d	Physical Therapy - Non-Medicare Contractual Allowance	0			
409		II4a	Speech Therapy - Medicare	0			
410		II4b	Speech Therapy - Medicare Contractual Allowance	0			
411		II4c	Speech Therapy - Non-Medicare	0			
412		II4d	Speech Therapy - Non-Medicare Contractual Allowance	0			
413		II5a	Occupational Therapy - Medicare	0			
414		II5b	Occupational Therapy - Medicare Contractual Allowance	0			
415		II5c	Occupational Therapy - Non-Medicare	0			
416		II5d	Occupational Therapy - Non-Medicare Contractual Allowance	0			
417		II6a	Other (Specify) - Medicare (Other Resident Rev)	0	-	-	-
418		II6b	Other (Specify) - Non-Medicare	0	-	-	-
419		III	***Total Resident Revenue***	627,766	0	0	627,766
420			*Other Revenue*				
421		IV1	Meals sold to guests, employees & others	350			350
422		IV2	Rental of rooms to non-residents	0			
423		IV3	Telephone and Telegraph	0			
424		IV4	Rental of Televisions and Cable Services	0			
425		IV5	Interest Income (Specify) (Interest Income)	0	-	-	-
426		IV6	Private Duty Nurses' Fees	0			
427		IV7	Barber, Coffee, Beauty & Gift shops	0			
428		IV8	Other (Specify) (Other Revenue)	350	-	-	350
429			**See Attached Schedule**				
430		V	***Total Other Revenue***	701	0	0	701
431	30	VI	***Total All Revenue***	628,467	0	0	628,467

	B	C	D	E	F	G
46	7A	**Physical Therapy - Medicare Part B**	**0**			
47	7B1	**Maintenance Treatments**	**0**			
48	7B2	**Restorative Treatments**	**0**			
49	7C	**Physical Therapy - Other**	**0**			
50	7D	***Total Physical Therapy Treatments***	**0**	**0**	**0**	**0**
51	8A	**Speech Therapy - Medicare Part B**	**0**			
52	8B1	**Maintenance Treatments**	**0**			
53	8B2	**Restorative Treatments**	**0**			
54	8C	**Speech Therapy - Other**	**0**			
55	8D	***Total Speech Therapy Treatments***	**0**	**0**	**0**	**0**
56	9A	**Occupational Therapy - Medicare Part B**	**0**			
57	9B1	**Maintenance Treatments**	**0**			
58	9B2	**Restorative Treatments**	**0**			
59	9C	**Occupational Therapy - Other**	**0**			
60	9D	***Total Occupational Therapy Treatments***	**0**	**0**	**0**	**0**
61						

Line #

Page 11 & 12

Please fill out the following information for all Operators/Owners, Administrators, Assistant Administrators and other relatives of Owners employed in and paid by facility.

	Name	CCNH	RHNS	Residential Care Home	Total Hours Worked	Line Where Claimed on Page 10	Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
Section I-Operators/Owners	CATHERINE J. FOLEY, 1657 MAIN ST, GLASTONBURY, CT 06033			59,793	2,080	A4	HEALTH INSURANCE,	OFFICE MANAGER, RESPONSIBLE FOR			
	CATHERINE J. FOLEY, 1657 MAIN ST, GLASTONBURY, CT 06033			59,793	2,080	A4	HEALTH INSURANCE,	OFFICE MANAGER, RESPONSIBLE FOR			
Section II-Other Related Parties											
Section III-Administrators	THEODORE L. FARACI, 1657 MAIN ST, GLASTONBURY, CT 06033			71,955	2,080	A2	HEALTH INSURANCE,	ADMINISTRATOR, RESPONSIBLE FOR			
Section IV-Assistant Administrators											

List all contracted services - not just those you consider pertain to resident care.

Page 21

Name of Individual/Company	Address	Related to Owner: Operators, Officers	Explanation of Relationship	Full Explanation of Services Provided	Total Cost/Page Ref.: CCNH	RHNS	Residential Care Home	Page	Line
		○ Yes ○ No							
		○ Yes ○ No							
		○ Yes ○ No							
		○ Yes ○ No							
		○ Yes ○ No							
		○ Yes ○ No							
		○ Yes ○ No							
		○ Yes ○ No							
		○ Yes ○ No							
		○ Yes ○ No							
		○ Yes ○ No							
		○ Yes ○ No							
		○ Yes ○ No							
		○ Yes ○ No							

Line #

Please fill in the Depreciation Schedule as follows:

Page 23

Asset Addition Schedule

		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
A1	**Land Improvements - Acquired prior to report period**							
A2	**Land Improvements - Disposals**	-						-
A3	**Land Improvements - Acquired during this report period (attach schedule)**							-
B1	**Building Improvements - Acquired prior to this report period**							
B2	**Building Improvements - Disposals**	-						-
B3	**Building Improvements - Acquired during this report period (attach schedule)**							-
C1	**Non-Movable Equipment - Acquired prior to this report period**							
C2	**Non-Movable Equipment -Disposals**	-						-
C3	**Non-Movable Equipment - Acquired during this report period (attach schedule)**							-

	Movable Equipment - Motor vehicles (specify name, model and year of each vehicle)	Is a mileage logbook maintained? Yes	No	Date of Acquisition Month	Year	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
D1a	2014 Dodge Caravan	x		3	2,014	17,751		17,751	11,095	SL	4	4,438
D1b												
D1c												
D1d												
D2a	**Movable Equipment - Acquired prior to this report period**			VAR	VAR	56,961		56,961	56,961	SL		-
D2b	**Disposals**					-						-
D2c	**Movable Equipment - Acquired during this report period (attach schedule)**					-						-

Please fill in the Amortization Schedule as follows:

Page 24

	Organization Expense	Date of Acquisition Month	Year	Length of Amortization	Cost to be Amortized	Accumulated Amortization to Beginning of Year's Operations	Basis for Computing Amortization	Rate %	Amortization for This Year
A1									
A2									
A3									
	Mortgage Expense								
B1									
B2									
B3									
C1	**Leasehold Improvements and Other - Acquired prior to this report period**	VAR	VAR	VAR	233,216	222,394	SL	VAR	3,334
C2	**Leasehold Improvements and Other - Disposals**				-				-
C3	**Leasehold Improvements and Other - Acquired during this report period (attach schedule)**	VAR	VAR	5	10,387				1,280

	A	B	C	D	E
1		**Line #**	**Description**	**Subtotal**	**Total**
2			*Current Assets*		
3		A1	Cash (*on hand and in banks*)		**160,940**
4		A2	Resident Accounts Receivable		**35,038**
5		A3	Other Accounts Receivable		
6		A4	Inventories		
7		A5	Prepaid Expenses (*itemize*)		**20,681**
8		a	**Prepaid insurance**	**20,681**	
9		b			
10		c			
11		d			
12		A6	Interest Receivable		
13		A7	Medicare Final Settlement Receivable		
14		A8	Other Current Assets (*itemize*)		**0**
15					
16					
17					
18					
19		A9	***Total Current Assets*** (Lines A1 thru 8)		**216,659**
20					
21			*Fixed Assets*		
22		B1	Land		
23	**Page 31**	B2	Land Improvements		**0**
24			Historical Cost		
25			Accumulated Depreciation		
26		B3	Buildings		**0**
27			Historical Cost		
28			Accumulated Depreciation		
29		B4	Leasehold Improvements		**16,595**
30			Historical Cost	**243,603**	
31			Accumulated Depreciation	**227,008**	
32		B5	Non-Movable Equipment		**0**
33			Historical Cost		
34			Accumulated Depreciation		
35		B6	Movable Equipment		**0**
36			Historical Cost	**56,961**	
37			Accumulated Depreciation	**56,961**	
38		B7	Motor Vehicles		**2,219**
39			Historical Cost	**17,751**	
40			Accumulated Depreciation	**15,532**	
41		B8	Minor Equipment-Not Depreciable		
42		B9	Other Fixed Assets (*itemize*)		**(1)**
43			**Rounding**	**(1)**	
44					
45		B10	***Total Fixed Assets*** (Lines B1 thru 9)		**18,813**
46				**Total Brought Forward**	**235,472**
47			*Leasehold or like property recorded for Equity Purposes*		
48		C1	Land		
49		C2	Land Improvements		**0**
50			Historical Cost		
51			Accumulated Depreciation		
52		C3	Buildings		**0**
53			Historical Cost		
54			Accumulated Depreciation		
55		C4	Non-Movable Equipment		**0**
56			Historical Cost		
57			Accumulated Depreciation		
58		C5	Movable Equipment		**0**
59			Historical Cost		
60			Accumulated Depreciation		
61		C6	Motor Vehicles		**0**
62			Historical Cost		
63			Accumulated Depreciation		
64		C7	Minor Equipment -Not Depreciable		
65		C8	***Total Leasehold or Like Properties*** (C1 thru 7)		**0**
66					
67	**Page 32**		*Investment and Other Assets*		
68		D1	Deferred Deposits		
69		D2	Escrow Deposits		

	A	B	C	D	E
70		D3	Organization Expense		**0**
71			Historical Cost		
72			Accumulated Depreciation		
73		D4	Goodwill		
74		D5	Investments Related to Resident Care		**0**
75					
76					
77		D6	Loans to Owners or Related Parties		**0**
78			Name and Address		
79			Amount		
80			Loan Date		
81					
82		D7	Other Assets		**0**
83					
84					
85					
86		D8	***Total Investments and Other Assets*** (Lines D1 thru 7)		**0**
87		D9	***Total All Assets*** (Lines A9 + B10 + C8 + D8)		**235,472**
88					
89		*Current Liabilities*			
90		A1	Trade Accounts Payable		**53,820**
91		A2	Notes Payable (itemize)		**0**
92					
93					
94					
95					
96		A3	Loans Payable for Equipment		**0**
97			Name of Lender		
98			Purpose		
99			Amount		
100			Date Due		
101					
102			Name of Lender		
103			Purpose		
104			Amount		
105			Date Due		
106					
107		A4	Accrued Payroll (*Exclusive of Owners & Stockholders*)		**56,172**
108		A5	Accrued Payroll (*Owners & Stockholders only*)		
109		A6	Accrued Payroll Taxes Payable		**3,380**
110		A7	Medicare Final Settlement Payable		
111		A8	Medicare Current Financing Payable		
112		A9	Mortgage Payable		
113		A10	Interest Payable		
114		A11	Accrued Income Taxes		
115		A12	Other Current Liabilities (itemize)		**(3,014)**
116			Due to owner	**(3,234)**	
117			Payroll CCSPC	**220**	
118					
119					
120					
121					
122					
123					
124		A13	***Total Current Liabilities*** Lines A1 thru 12)		**110,359**
125				**Total Brought Forward**	**110,359**
126		*Long-Term Liabilities*			
127		B1	Loans Payable-Equipment		**2,044**
128			Name of Lender	**TD Auto**	
129			Purpose	**Company van**	
130			Amount	**2,044**	
131			Date Due	**48 month term**	
132					
133			Name of Lender		
134			Purpose		
135			Amount		
136			Date Due		
137					
138		B2	Mortgages Payable		

	A	B	C	D	E
139	Page 34	B3	Loans from Owners or Related Parties		**0**
140			Name and Address of Lender		
141			Amount		
142			Loan Date		
143					
144			Name and Address of Lender		
145			Amount		
146			Loan Date		
147					
148		B4	Other Long-Term Liabilities (itemize)		**0**
149					
150					
151					
152					
153		B5	***Total Long-Term Liabilities*** (Lines B1 thru 4)		**2,044**
154		C	***Total All Liabilities*** (Lines A13 + B5)		**112,403**
155					
156		*Reserves*			
157		A1	Reserve for value of leased land		
158		A2	Reserve for depreciation value of leased buildings and appurtenances to be amortized		
159		A3	Reserve for depreciation value of leased personal property (Equity)		
160		A4	Reserve for leasehold real properties on which fair rental value is based		
161		A5	Reserve for funds set aside as donor restricted		
162	Page 35	A6	***Total Reserves***		**0**
163		*Net Worth*			
164		B1	Owner's Capital		
165		B2	Capital Stock		
166		B3	Paid-in Surplus		
167		B4	Treasury Stock		**1,000**
168		B5	Cumulated Earnings		**110,829**
169		B6	Gain or Loss for Period 10/1/2016 thru 09/30/2017		**11,240**
170		B7	***Total Net Worth***		**123,069**
171		C	***Total Reserves and Net Worth***		**123,069**
172		D	***Total Liabilities, Reserves, and Net Worth***		**235,472**
173					
174		A	Balance at End of Prior Period		**111,829**
175		B	Total Revenue		**628,116**
176		C	Total Expenditures		**616,878**
177		D	Net Income or Deficit		**11,238**
178		E	Balance		**123,067**
179		F1	Additional Capital Contributed (itemize)		
180			Rounding	**2**	
181					
182					
183					
184		F2	Other (itemize)		
185					
186					
187					
188					
189	Page 36	F3	***Total Additions***		**2**
190		G1	Drawings of Owners/Operators/Partners		
191			Name and Address		
192			Title		
193			Amount		
194					
195			Name and Address		
196			Title		
197			Amount		
198		G2	Other Withdrawings		
199			Purpose		
200			Amount		
201					
202			Purpose		
203			Amount		
204		G3	Total Deductions		

	A	B	C	D	E
205		H	***Balance at End of Period***		**123,069**

State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2017

Name of Facility (as licensed) GILMORE MANOR, INC.		
Address (No. & Street, City, State, Zip Code) 1381 MAIN STREET, GLASTONBURY, CT 06033		
Type of Facility ☐ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☑ Residential Care Home		
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017	

License Numbers:	CCNH	RHNS	Residential Care Home	Medicare Provider
			1777	

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for GILMORE MANOR, INC. [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, 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) THEODORE L. FARACI			Printed Name (Owner) THEODORE L. FARACI	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1A Rev. 6/95

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 GILMORE MANOR, INC.	Period Covered:		From 10/1/2016	To 9/30/2017
Address of Facility 1381 MAIN STREET, GLASTONBURY, CT 06033				
Report Prepared By CATHERINE J. FOLEY	Phone Number 860-633-4411		Date 1/17/2018	

Item		Total	CCNH	RHNS	Residential Care Home
1. Dietary wages paid	$	27,426			27,426
2. Laundry wages paid	$	17,544			17,544
3. Housekeeping wages paid	$	17,544			17,544
4. Nursing wages paid	$				
5. All other wages paid	$	270,893			270,893
6. ***Total Wages Paid***	$	333,407			333,407
7. Total salaries paid	$				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$	333,407			333,407

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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-2 Rev. 10/2005

General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-633-4411	9/30/2017	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
GILMORE MANOR, INC.	1381 MAIN STREET, GLASTONBURY, CT 06033

License Numbers:	CCNH	RHNS	Residential Care Home	Medicare Provider No.
			1777	

Type of Facility (Check appropriate box(es))

☐ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☑ Residential Care Home

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
THEODORE L. FARACI	

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

Name	License No.:

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3 Rev. 10/2005

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3A Rev. 10/2005

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	3A	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
GILMORE MANOR, INC.	1381 MAIN STREET, GLASTONBURY, CT 06033	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
THEODORE L. FARACI	1381 MAIN STREET, GLASTONBURY, CT 06033	PRESIDENT	500
CATHERINE J. FOLEY	1381 MAIN STREET, GLASTONBURY, CT 06033	TREASURER	500
Names of Stockholders Owning at Least 10% of Shares			
THEODORE L. FARACI	1381 MAIN STREET, GLASTONBURY, CT 06033	PRESIDENT	500
CATHERINE J. FOLEY	1381 MAIN STREET, GLASTONBURY, CT 06033	TREASURER	500

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	3B	37

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

Owner(s) of Facility

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-4 Rev. 10/2005

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	4	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	%**				
THEODORE L. FARACI	1381 MAIN STREET, GLASTONBURY, CT 06033	○	⊙		ADMINISTRATOR	PAGE 10, LINE A2		71,955
CATHERINE J. FOLEY	1381 MAIN STREET, GLASTONBURY, CT 06033	○	⊙		CLERICAL	PAGE 10. LINE A4		59,793
THEODORE L. FARACI	1381 MAIN STREET, GLASTONBURY, CT 06033	○	⊙		LOANING OF FUNDS	PAGE 33, LINE A12		3,234
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					

* Use additional sheets if necessary.

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-5 Rev. 9/2002

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	5	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 (*See listing page 13*)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

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

1. In the preparation of this Report, were all costs allocated as required? ⊙ Yes ○ No

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

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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-6 Rev. 9/2002

General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
						Total ***	

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ○ No

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 6/95

General Information and Questionnaire

Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	7	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	Address (No. & Street, City, State, Zip Code)
1 CRAIG J LUBITSKI CONSULTING	225 PITKIN STREET, EAST HARTFORD, CT 06108
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1 ASSISTED WITH COST REPORT, CORPORATE TAX RETURNS, DEPRECIATION SCHEDULES, ETC..	$ 2,520
2	$
3	$
4	$
	Charge for Services Provided $ 2,520

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	Telephone Number
1	
2	
3	
4	
5	

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

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

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

○ Yes ○ No

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 9/2002

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	8	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	22			22	22			22	22			22
B. On last day of THIS report period	22			22	22			22	22			22
2. Number of Residents												
A. As of midnight of PREVIOUS report period	22			22	22			22	22			22
B. As of midnight of THIS report period	22			22	22			22	22			22
3. Total Number of Days Care Provided During Period												
A. Medicare												
B. Medicaid (Conn.)												
C. Medicaid (other states)												
D. Private Pay	365			365	273			273	92			92
E. State SSI for RCH	7,654			7,654	5,722			5,722	1,932			1,932
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	8,019			8,019	5,995			5,995	2,024			2,024
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)**	8,019			8,019	5,995			5,995	2,024			2,024

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	9	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 (1)	RHNS (2)	Residential Care Home (3)	Lost (1)	Lost (2)	Lost (3)	Gained (1)	Gained (2)	Gained (3)	CCNH	RHNS	Residential Care Home	

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	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								
Per Diem Rate								
a. One bed rm.						87.45	76.16	
b. Two bed rms.						85.00	76.16	
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	Residential Care Home
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B				
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***				

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ 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)					71,955	2,080
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)					66,448	2,498
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers					27,426	1,723
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers					17,544	1,102
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers						
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers					17,544	1,102
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					132,489	8,322
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers						
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						
A-13. Total Salary Expenditures					333,407	16,827

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

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-11 Rev. 10/2005

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
GILMORE MANOR, INC.	1777	9/30/2017	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										
#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
CATHERINE J. FOLEY, 1657 MAIN ST, GLASTONBURY, CT 06033			59,793	HEALTH INSURANCE, PENSION	OFFICE MANAGER, RESPONSIBLE FOR ACCOUNTING,	2,080	A4			
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).										
#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-12 Rev. 10/2005

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
GILMORE MANOR, INC.	1777	9/30/2017	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* **										
THEODORE L. FARACI, 1657 MAIN ST, GLASTONBURY, CT 06033			71,955	HEALTH INSURANCE, PENSION	ADMINISTRATOR, RESPONSIBLE FOR OVERSEEING	2,080	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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
GILMORE MANOR, INC.	1777	9/30/2017	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	15	37

Item		Total	CCNH	RHNS	Residential Care Home
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	7,979			7,979
2. Disability Insurance	$				
3. Unemployment Insurance	$	4,304			4,304
4. Social Security (F.I.C.A.)	$	25,548			25,548
5. Health Insurance	$	36,345			36,345
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	48,181			48,181
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	2,520			2,520
e. Legal (*Services should be fully described on Page 7)*	$				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	3,758			3,758
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	5,087			5,087
2. Cellular Phones	$				
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$	367			367
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$				
Subtotal	$	134,090			134,090

* 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**

GILMORE MANOR, INC. Attachment Page 15
9/30/2017

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	16	37

Item		Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:		134,090			134,090
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	3,942			3,942
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$				
5. Education Expenses Related to Seminars and Conventions	$				
6. Automobile Expense (*not purchase or depreciation*)	$	2,081			2,081
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	687			687
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$				
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	$	430			430
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	550			550
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	106			106
10. Contributions***	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	2,254			2,254
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	144,140			144,140

* 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
CARCH membership paid 2/6/2017			$ 550
Total Dues	$ -	$ -	$ 550

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
3/16/2017 Secretary of State certificate of good standing			$ 50
3/27/2017 Treasurer, State of CT for RCH license renewal			$ 664
6/15/2017 Town of Glastonbury food license			$ 300
Monthly payroll charges, Intuit/Bank of America			$ 400
Employee background checks			$ 280
Secretary of State annual filing fee			$ 560
Total Other Administrative and General	$ -	$ -	$ 2,254

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
GILMORE MANOR, INC.	1777	9/30/2017	17 | 37

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-18 Rev. 9/2002

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
GILMORE MANOR, INC.	1777	9/30/2017	18 | 37

Item		Total	CCNH	RHNS	Residential Care Home
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	43,745			43,745
2. Non-Food Supplies	$				
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)	$	43,745			43,745

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?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-19 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page of
GILMORE MANOR, INC.	1777	9/30/2017	19 | 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. $	1,336			1,336
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)*	$				
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	1,336			1,336

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

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

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-20 Rev. 9/2002

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
GILMORE MANOR, INC.	1777	9/30/2017	20	37

Item			Total	CCNH	RHNS	Residential Care Home
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	4,102			4,102
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	4,102			4,102
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$				
b. Medicine Cabinet Drugs		$	352			352
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 (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$				
i. Recreation		$				
j. Other (Specify)**** See Attached Schedule		$				
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	352			352

* 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
Total Other Resident Care	$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 10/2001

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

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	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
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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).

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
GILMORE MANOR, INC.	1777	9/30/2017	22 | 37

Item		Total	CCNH	RHNS	Residential Care Home
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	25,427			25,427
b. Heat	$	8,509			8,509
c. Light & Power	$	11,745			11,745
d. Water	$	3,958			3,958
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	781			781
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	50,420			50,420
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$				
d. Movable Equipment	$	4,438			4,438
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	4,438			4,438
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	4,614			4,614
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	4,614			4,614
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	$				
b. Real estate taxes paid by lessor	$	17,137			17,137
c. Personal property taxes	$	339			339
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	26,528			26,528

* 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
Minor equipment			$ 781
Total Other Repairs and Maintenance	$ -	$ -	$ 781

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-23 Rev. 10/2006

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	23	37

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

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. 2014 Dodge Caravan	x		3	2014	17,751		17,751	11,095	SL	4	4,438	
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			VAR	VAR	56,961		56,961	56,961	SL			
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)												
D-3. Subtotal												4,438
E. ***Total Depreciation***												4,438

GILMORE MANOR, INC.
9/30/2017

Schedule of Land Improvements Acquired during this report period

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

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

Schedule of Building Improvements Acquired during this report period

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

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

Schedule of Non-Movable Equipment Acquired during this report period

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

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

Schedule of Movable Equipment Acquired during this report period

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

***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:					
11/14/2016	Painting	$ 2,000	5	$ 367	
2/16/2017	Electrical Work	2,240	5	298	
3/29/2017	Electrical Work	1,891	5	189	
6/30/2017	Dishwasher & Installation	4,256	5	426	
Total additions for Leasehold Improvement		$ 10,387		$ 1,280	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	VAR	VAR	VAR	233,216	222,394	SL	VAR	3,334	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	VAR	VAR	5	10,387				1,280	
C-4. Subtotal									4,614
D. ***Total Amortization***									4,614

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-25 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	09/15/83
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	09/15/83
4. Date of Initial Licensure	09/15/83
5. Total Licensed Bed Capacity	22
6. Square Footage	
7. Acquisition Cost	
a. Land	19,260
b. Building	141,240

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				
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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-26 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
GILMORE MANOR, INC.	1777	9/30/2017	26 | 37

Item	Total	CCNH	RHNS	Residential Care Home
12. Interest				
A. Building, Land Improvement & Non-Movable Equipment				
1. First Mortgage $				
Name of Lender / Rate				
Address of Lender				
2. Second Mortgage $				
Name of Lender / Rate				
Address of Lender				
3. Third Mortgage $				
Name of Lender / Rate				
Address of Lender				
4. Fourth Mortgage $				
Name of Lender / Rate				
Address of Lender				
B. CHEFA Loan Information				
1. Original Loan Amount $				
2. Loan Origination Date				
3. Interest Rate %				
4. Term				
5. CHEFA Interest Expense				
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $				

(*Carry Subtotals forward to next page*)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-27 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
GILMORE MANOR, INC.	1777	9/30/2017	27 | 37

Item	Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:				
12. C. Movable Equipment				
1. Automotive Equipment $	103			103
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) $	103			103
12. D. Other Interest Expense (*Specify*) $				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	103			103
14. Insurance				
a. Insurance on Property (buildings only) $	10,546			10,546
b. Insurance on Automobiles $	2,199			2,199
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)*** $	12,745			12,745
15. ***Total All Expenditures (A-13 thru C-14)*** $	616,878			616,878

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-28 Rev. 9/2002

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
GILMORE MANOR, INC.	1777	9/30/2017	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 $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $				
10.	15	1d	Accounting & Legal $	100			100
11.			Telephone $				
12.			Cellular Telephone $				
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.			Unallowable Advertising * $				
19.	15	1j	Income Tax / Corporate Business Tax $	117			117
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $				
Page 18 - Dietary Expenditures							
24.	30	IV1	Meals to employees, guests and others who are not residents $	350			350
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) $	567			567

* 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
Total Other Fees Adjustments			$ -	$ -	$ -

Schedule of Other A&G Adjustments

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-29 Rev. 10/2006

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

Name of Facility	License No.	Report for Year Ended	Page of
GILMORE MANOR, INC.	1777	9/30/2017	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
			Subtotals Brought Forward $	567			567
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 $				
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 $	(2)			(2)
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)*** $	565			565

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

Attachment Page 29

GILMORE MANOR, INC.
9/30/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Ancillary Costs			$ -	$ -	$ -

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			$ -	$ -	$ -

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
page 28	line 23	Reconciliation discrepancy			$ (2)
Total Other Adjustments			$ -	$ -	$ (2)

Schedule of Unallowable Building Interest

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
GILMORE MANOR, INC.	1777	9/30/2017	30 | 37

Item		Total	CCNH	RHNS	Residential Care Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	595,846			595,846
b. Medicaid Room and Board Contractual Allowance **	$				
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$				
b. Medicare Room and Board Contractual Allowance **	$				
4. a. Private-Pay Residents and Other	$	31,920			31,920
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 *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	627,766			627,766
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	350			350
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	350			350
V. Total Other Revenue (1 thru 8)	$	701			701
VI. Total All Revenue (III +V)	$	628,467			628,467

* *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

Page Ref	Account	Account Balance	CCNH	RHNS	Residential Care Home
Total Interest Income			$ -	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
	UHF Rebates			$ 350
Total Other Revenue		$ -	$ -	$ 350

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-31 Rev. 6/95

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 160,940
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 35,038
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 20,681
a. Prepaid insurance		20,681		
b.				
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 216,659
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	243,603		$ 16,595
	Accum. Depreciation	227,008	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	56,961		$
	Accum. Depreciation	56,961	Net	
7. Motor Vehicles	*Historical Cost	17,751		$ 2,219
	Accum. Depreciation	15,532	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ (1)
Rounding		(1)		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 18,813

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

(*Carry Total forward to next page*)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-32 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	32	37

Account				Amount
			Total Brought Forward:	$ 235,472
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 235,472

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-33 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 53,820
	2. Notes Payable (*itemize*)				$
	3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
	Name of Lender	Purpose	Amount	Date Due	
	4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 56,172
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 3,380
	7. Medicare Final Settlement Payable				$
	8. Medicare Current Financing Payable				$
	9. Mortgage Payable (*Current Portion*)				$
	10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
	11. Accrued Income Taxes*				$
	12. Other Current Liabilities (*itemize*)				$ (3,014)
	Due to owner (3,234)				
	Payroll CCSPC 220				
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 110,359

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

(Carry Total forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	34	37

Account	Amount
Total Brought Forward:	110,359
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$ 2,044

Name of Lender	Purpose	Amount	Date Due
TD Auto	Company van	2,044	48 month term

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 2,044
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 112,403

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-35 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	35	37

Account		Amount
A.	**Reserves**	
	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 (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$ 1,000
	5. Cumulated Earnings	$ 110,829
	6. Gain or Loss for Period 10/1/2016 thru 9/30/2017	$ 11,240
	7. Total Net Worth	$ 123,069
C.	***Total Reserves and Net Worth***	$ 123,069
D.	***Total Liabilities, Reserves, and Net Worth***	$ 235,472

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-36 Rev. 6/95

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2016			$ 111,829
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 628,116
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 616,878
D.	Net Income or Deficit			$ 11,238
E.	Balance			$ 123,067
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Rounding 2			
	2. Other (*itemize*)			
F-3.	Total Additions			$ 2
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period*** 09/30/17			$ 123,069

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-37 Rev. 9/2002

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
GILMORE MANOR, INC.	1777	9/30/2017	37	37

Check appropriate category

☐ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☑ Residential Care Home

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer

CATHERINE J FOLEY

Address	Phone Number
1381 MAIN STREET, GLASTONBURY, CT 06033	860-633-4411

Level	Item	Reported as		
	Page 24 - Accumulated Amort. of Leasehold Imp.	227,008	is inconsistent with Page 31	227,008
-	Page 35 - Total Liabilities, Reserves and Net Wort	235,472	Total Assets	235,472