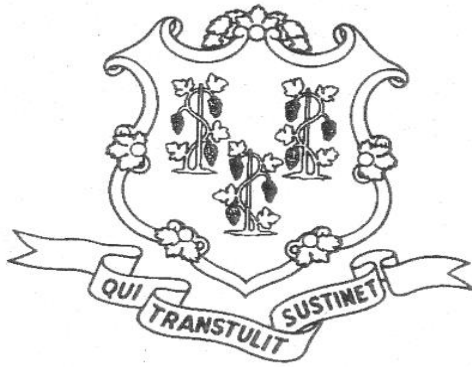


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2018

Name of Facility (as licensed) Holiday Manor, Inc.	
Address (No. & Street, City, State, Zip Code) 29 Cottage St., Manchester, CT 06040-5415	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input checked="" type="checkbox"/> Residential Care Home	
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018

License Numbers:	CCNH	RHNS	Residential Care Home 1843HA	Medicare Provider
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Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) Holiday Manor, Inc.	License No. 1843HA	Report for Year Ended 9/30/2018	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Holiday Manor, Inc. [facility name], for the cost report period beginning October 1, 2017 and ending September 30, 2018, 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) Peter Booth			Printed Name (Owner)		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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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 Holiday Manor, Inc.		Period Covered:	From 10/1/2017	To 9/30/2018
Address of Facility 29 Cottage St., Manchester, CT 06040-5415				
Report Prepared By CJLC LLC		Phone Number 860-610-9009	Date 1/29/2019	
Item	Total	CCNH	RHNS	Residential Care Home
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-649-4700		Report for Year Ended 9/30/2018		Page 2	of 37
Name of Facility (as shown on license) Holiday Manor, Inc.			Address (No. & Street, City, State, Zip) 29 Cottage St., Manchester, CT 06040-5415		
License Numbers:	CCNH	RHNS	Residential Care Home 1843HA	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 Peter Booth			Nursing Home Administrator's License No.:		
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		

**General Information and Questionnaire
 Corporate Owners**

Name of Facility Holiday Manor, Inc.	License No. 1843HA	Report for Year Ended 9/30/2018	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	
Holiday Manor, Inc.	29 Cottage St., Manchester, CT 06040-5415		CT	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Peter Booth	29 Cottage St., Manchester, CT 06040-5415	President	1000	
Names of Stockholders Owning at Least 10% of Shares				
Peter Booth	29 Cottage St., Manchester, CT 06040-5415	President	1000	

General Information and Questionnaire Individual Proprietorship

Name of Facility Holiday Manor, Inc.	License No. 1843HA	Report for Year Ended 9/30/2018	Page 3B	of 37
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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 Holiday Manor, Inc.	License No. 1843HA	Report for Year Ended 9/30/2018	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Farbooth, LLC	29 Cottage St., Manchester, CT 06040-5415	<input type="radio"/>	<input checked="" type="radio"/>		Rental of Real Estate	22/9	35,562	35,562
Boothfar, LLC	39 Cottage St., Manchester, CT 06040-5415	<input type="radio"/>	<input checked="" type="radio"/>		Rental of Office Space	22/9	12,000	12,000
Peter Booth	29 Cottage St., Manchester, CT 06040-5415	<input type="radio"/>	<input checked="" type="radio"/>		Loaning of Funds	34/B3	176,511	176,511
Peter Booth	29 Cottage St., Manchester, CT 06040-5415	<input type="radio"/>	<input checked="" type="radio"/>		Administrator	10/A2	55,596	55,596
Karen Booth	29 Cottage St., Manchester, CT 06040-5415	<input type="radio"/>	<input checked="" type="radio"/>		Clerical	10/A4	15,078	15,078
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" 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 Holiday Manor, Inc.	License No. 1843HA	Report for Year Ended 9/30/2018	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

Not Applicable

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

Not Applicable

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.

Not Applicable

**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 Holiday Manor, Inc.			License No. 1843HA		Report for Year Ended 9/30/2018		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 checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input checked="" 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 Holiday Manor, Inc.	License No. 1843HA	Report for Year Ended 9/30/2018	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm 1 CJLC LLC 2 3 4	Address (No. & Street, City, State, Zip Code) 225 Pitkin Street, East Hartford, CT 06108
--	---

Services Provided by This Firm (*describe fully*)

1 Medicaid Cost Report, Accounting Services and Tax prep.	\$ 7,385
2	\$
3	\$
4	\$
Charge for Services Provided	
\$ 7,385	

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

Legal Services Information

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

Address (*No. & Street, City, State, Zip Code*)
 1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	\$
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 Pg 15/1e

Schedule of Resident Statistics

Name of Facility Holiday Manor, Inc.		License No. 1843HA			Report for Year Ended 9/30/2018				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	24			24	24			24	24				24
B. On last day of THIS report period	24			24	24			24	24				24
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	24			24	22			22	24				24
3. Total Number of Days Care Provided During Period													
A. Medicare													
B. Medicaid (Conn.)													
C. Medicaid (other states)													
D. Private Pay													
E. State SSI for RCH	7,831			7,831	5,623			5,623	2,208				2,208
F. Other (Specify)													
G. Total Care Days During Period (3A thru F)	7,831			7,831	5,623			5,623	2,208				2,208
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)	7,831			7,831	5,623			5,623	2,208				2,208

Schedule of Resident Statistics (Cont'd)

Name of Facility Holiday Manor, Inc.			License No. 1843HA			Report for Year Ended 9/30/2018			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	Residential Care Home	Lost			Gained			CCNH	RHNS	Residential Care Home	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days								CCNH	RHNS	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	RHNS	CCNH	RHNS	CCNH	RHNS	Residential Care Home	R.C.H.	ICF-MR				
No. of Residents									24				
Per Diem Rate													
a. One bed rm.							90.00	85.21					
b. Two bed rms.								85.21					
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	Residential Care Home		
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													

Report of Expenditures - Salaries & Wages

Name of Facility Holiday Manor, Inc.	License No. 1843HA	Report for Year Ended 9/30/2018	Page 10	of 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)					55,596	2,080
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)					15,078	778
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers					41,506	3,428
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers					33,724	2,785
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers					25,941	2,142
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers					5,188	428
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					140,083	11,569
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers					12,971	1,071
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>					330,087	24,281

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

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

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

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

Name of Facility				License No.	Report for Year Ended			Page	of	
Holiday Manor, Inc.				1843HA	9/30/2018			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										
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).										
Karen Booth (10/1/17 to 9/30/18)			15,078 \		Clerical/Bookkeeping	778	A4	Wells Fargo Bank		

* 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	
Holiday Manor, Inc.				1843HA	9/30/2018			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***										
Peter Booth (10/1/17 to 9/30/18)			55,596		Administrator	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.

Annual Report of Long-Term Care Facility

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Holiday Manor, Inc.	1843HA	9/30/2018	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 Holiday Manor, Inc.		License No. 1843HA	Report for Year Ended 9/30/2018	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 checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
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		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" 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
Holiday Manor, Inc.	1843HA	9/30/2018		15	37
Item	Total	CCNH	RHNS	Residential Care Home	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 10,413				10,413
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 7,549				7,549
4. Social Security (F.I.C.A.)	\$ 25,253				25,253
5. Health Insurance	\$				
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 7,707				7,707
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 19,879				19,879
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	\$ 7,385				7,385
e. Legal (<i>Services should be fully described on Page 7</i>)	\$				
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 2,990				2,990
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 1,436				1,436
2. Cellular Phones	\$ 1,628				1,628
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 693				693
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$				
Subtotal	\$ 84,931				84,931

* 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**

Holiday Manor, Inc.
9/30/2018

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
Total	\$ -	\$ -	\$ -

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

Name of Facility Holiday Manor, Inc.	License No. 1843HA	Report for Year Ended 9/30/2018	Page 16	of 37
Item	Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:	84,931			84,931
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	\$			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 10,375			10,375
7. Other (<i>Specify</i>) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 236			236
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$			
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	\$			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$			
10. Contributions*** See Attached Schedule	\$			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$			
12. Administrative Management Services**	\$			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 5,927			5,927
C-14 Total Administrative & General Expenditures	\$ 101,469			101,469

* 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
Total Dues	\$ -	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
Licenses			\$ 85
Payroll Processing Fees			\$ 5,284
Bank Service Fees			\$ 554
Unallowable Expenses			\$ 3
Total Other Administrative and General	\$ -	\$ -	\$ 5,927

Schedule C-1 - Management Services*

Name of Facility Holiday Manor, Inc.	License No. 1843HA	Report for Year Ended 9/30/2018	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 Holiday Manor, Inc.		License No. 1843HA	Report for Year Ended 9/30/2018	Page 18	of 37
Item		Total	CCNH	RHNS	Residential Care Home
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$	45,756			45,756
2. Non-Food Supplies	\$	892			892
3. Other (Specify) _____	\$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)					
c. Other (Specify) _____					
2D. Total Dietary Expenditures (2a + b + c + d)		\$	46,648		46,648
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.

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

Name of Facility Holiday Manor, Inc.		License No. 1843HA	Report for Year Ended 9/30/2018	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. \$	691		691
	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. Other (Specify)	\$			
3D.	Total Laundry Expenditures (3a + b + c)	\$	691		691
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.

*** 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
Holiday Manor, Inc.		1843HA	9/30/2018		20	37
Item			Total	CCNH	RHNS	Residential Care Home
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
1.	Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	9,698			9,698
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$				
C.	Other (<i>Specify</i>)		\$			
4D.	Total Housekeeping Expenditures (4a + b + c)		\$ 9,698			9,698
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	\$	1,872			1,872
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (<i>Specify</i>)**** See Attached Schedule	\$	1,344			1,344
5M.	Total Resident Care Expenditures (5a - 5j)		\$ 3,216			3,216

* 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
Internet			\$ 1,344
Total Other Resident Care	\$ -	\$ -	\$ 1,344

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

Name of Facility Holiday Manor, Inc.			License No. 1843HA		Report for Year Ended 9/30/2018			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
N/A		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" 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 Holiday Manor, Inc.	License No. 1843HA	Report for Year Ended 9/30/2018			Page 22	of 37
Item	Total	CCNH	RHNS	Residential Care Home		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 26,023				26,023	
b. Heat	\$ 21,039				21,039	
c. Light & Power	\$ 11,295				11,295	
d. Water	\$ 3,498				3,498	
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$					
f. Other (<i>itemize</i>) See Attached Schedule	\$					
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 61,856				61,856	
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 8,517				8,517	
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 8,517				8,517	
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 10,497				10,497	
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 10,497				10,497	
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 47,562				47,562	
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 12,438				12,438	
c. Personal property taxes	\$ 1,217				1,217	
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 80,231				80,231	

* 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
Total Other Repairs and Maintenance	\$ -	\$ -	\$ -



Holiday Manor, Inc.
9/30/2018

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:				
Total additions for Leasehold Improvement		\$ -		\$ - *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Holiday Manor, Inc.			License No. 1843HA		Report for Year Ended 9/30/2018			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. Organization Expense	12	1996	60 months	10,060	10,060	SL			
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	164,615	135,651	SL		10,497	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									10,497
D. Total Amortization									10,497

* 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 Holiday Manor, Inc.	License No. 1843HA	Report for Year Ended 9/30/2018	Page 25	of 37
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11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?*

Yes No

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

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

Description	Total				
1. Date Land Purchased					
2. Date Structure Completed					
3. If NOT Original Owner, Date of Purchase	12/04/97				
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	24				
6. Square Footage	6,143				
7. Acquisition Cost					
a. Land					
b. Building					

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	12/04/96			
c. Interest Rate for the Cost Year	16.00%			
d. Term of Mortgage (number of years)	15			
e. Amount of Principal Borrowed	225,000			
f. Principal balance outstanding as of _____	PAID OFF			
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	License No.	Report for Year Ended	Page	of
Holiday Manor, Inc.	1843HA	9/30/2018	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)

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

Name of Facility Holiday Manor, Inc.		License No. 1843HA		Report for Year Ended 9/30/2018		Page of 27 37	
Item				Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (<i>Specify</i>)				\$			
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 (<i>Specify</i>)				\$	259		259
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	259		259
14. Insurance							
a. Insurance on Property (buildings only)				\$	12,229		12,229
b. Insurance on Automobiles				\$	1,515		1,515
c. Insurance other than Property (as specified above)							
1. Umbrella (<i>Blanket Coverage</i>)				\$			
2. Fire and Extended Coverage				\$			
3. Other (<i>Specify</i>)				\$			
14d. Total Insurance Expenditures (14a + b + c)				\$	13,744		13,744
15. Total All Expenditures (A-13 thru C-14)				\$	647,897		647,897

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Holiday Manor, Inc.				1843HA	9/30/2018	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.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 908			908
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.	16	L6	Automobile Expense (e.g. personal use)	\$ 4,150			4,150
18.			Unallowable Advertising *	\$			
19.	15	1j	Income Tax / Corporate Business Tax	\$ 443			443
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ (1,595)			(1,595)
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)				\$ 3,905			3,905

* 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
16	m13	Unallowable Expenses			\$ 3
22	6B	Heat - Oil FA Finding 9% office heat			\$ 1,709
22	10B	Real Estate Taxes - Allow 50% 39 Cottage Street			\$ (3,426)
27	14A	Property Insurance - Allow 50% 39 Cottage Street			\$ (435)
16	m13	Bank Service Fees			\$ 554
Total Other A&G Adjustments			\$ -	\$ -	\$ (1,595)

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

Name of Facility				License No.	Report for Year Ended	Page	of
Holiday Manor, Inc.				1843HA	9/30/2018	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward				\$ 3,905			3,905
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.	22	7d	Depreciation on Unallowable Motor Vehicles	\$ 3,408			3,408
37.	22	10c	Unallowable Property and Real Estate Taxes	\$ 355			355
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.	27	14b	Property Insurance	\$ 606			606
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 8,274			8,274

*** 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.

Holiday Manor, Inc.
9/30/2018

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			\$ -	\$ -	\$ -

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
Holiday Manor, Inc.	1843HA	9/30/2018			30	37
Item	Total	CCNH	RHNS	Residential Care Home		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 654,676			654,676		
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	\$					
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.)	\$ 654,676			654,676		
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>)	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$					
V. Total Other Revenue (1 thru 8)	\$					
VI. Total All Revenue (III +V)	\$ 654,676			654,676		

* 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
Total Interest Income			\$ -	\$ -	\$ -

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
Holiday Manor, Inc.	1843HA	9/30/2018	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	7,545
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	45,427
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	16,989
a. _____				
b. _____				
c. _____				
d. See Schedule		16,989		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	69,961
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
4. Leasehold Improvements	*Historical Cost <u>164,618</u>		\$	18,470
	Accum. Depreciation <u>146,148</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>20,095</u>		\$	
	Accum. Depreciation <u>20,095</u>	Net		
7. Motor Vehicles	*Historical Cost <u>34,074</u>		\$	(0)
	Accum. Depreciation <u>34,074</u>	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	18,469

* 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 Holiday Manor, Inc.	License No. 1843HA	Report for Year Ended 9/30/2018	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	88,430
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	10,060		
	Accum. Depreciation	10,060	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	1,600

See Schedule			1,600	
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	1,600
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	90,030

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

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
		Prepaid- Insurance	\$ 16,989
Total Prepaid Expenses			\$ 16,989

Schedule of Other Current Assets (itemized) Page 31 Line A8

Page Ref	Line Ref	Description	
Total Other Current Assets (Itemize)			\$ -

Schedule of Other Fixed Assets (Itemize) Page 31 Line B9

Page Ref	Line Ref	Description	
Total Other Other Fixed Assets (Itemize)			\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Other Assets	\$ 1,600
Total Other Assets			\$ 1,600

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

Schedule of Other Current Liabilities (Itemize) Page 33 Line A12

Page Ref	Line Ref	Description	
		Accrued Expenses	\$ 17,349
		Due to DSS	\$ 88,197
Total Other Current Liabilities (Itemize)			\$ 105,546

Schedule of Other Long-Term Liabilities (itemize) Page 34 Line B4

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			\$ -

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of	
Holiday Manor, Inc.	1843HA	9/30/2018	33	37	
Account			Amount		
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable			\$	(1)	
2. Notes Payable (<i>itemize</i>)			\$		

See Schedule					
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)			\$	8,096	
Name of Lender	Purpose	Amount	Date Due		
Chase Auto Financing	Auto Loan	8,096			
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)			\$	5,993	
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$		
6. Accrued Payroll Taxes Payable			\$	590	
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>)			\$	105,546	

See Schedule				105,546	
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	120,224	

* 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 Holiday Manor, Inc.	License No. 1843HA	Report for Year Ended 9/30/2018	Page 34	of 37
Account			Amount	
Total Brought Forward:			120,224	
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>)				\$ 176,511
Name and Address of Lender	Amount	Loan Date		
Peter E. Booth	176,511	On Demand		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 176,511
C. Total All Liabilities (Lines A-13 + B-5)				\$ 296,735

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

Name of Facility	License No.	Report for Year Ended	Page	of
Holiday Manor, Inc.	1843HA	9/30/2018	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 (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(214,484)
6. Gain or Loss for Period			\$	6,778
	10/1/2017	thru	9/30/2018	
7. Total Net Worth			\$	(206,705)
C. Total Reserves and Net Worth			\$	(206,705)
D. Total Liabilities, Reserves, and Net Worth			\$	90,030

H. Changes in Total Net Worth

Name of Facility Holiday Manor, Inc.	License No. 1843HA	Report for Year Ended 9/30/2018	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2017			\$	(213,484)
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	654,676
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	647,897
D. Net Income or Deficit			\$	6,778
E. Balance			\$	(206,706)
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount	
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period		09/30/18	\$	(206,706)

I. Preparer's/Reviewer's Certification

Name of Facility Holiday Manor, Inc.	License No. 1843HA	Report for Year Ended 9/30/2018	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				
CJLC LLC				
Address Address			Phone Number	
225 Pitkin Street, East Hartford, CT 06108			860-610-9009	
Annual Report Contact			Phone Number	
CJLC			860-610-9009	
Annual Report Contact Email Address				
annualreports@cjlc.com				

Error Check

Level	Item	Reported as	
	Page 22 - Movable Depreciation	8,517 is inconsistent with Page 23	8,517
	Page 23 - Historical Cost of Motor Vehicles	34,074 is inconsistent with Page 31	34,074
	Page 23 - Historical Cost of Movable Eq.	20,095 is inconsistent with Page 31	20,095
	Page 23 - Accumulated Dep. of Motor Vehicles	34,074 is inconsistent with Page 31	34,074
	Page 23 - Accumulated Dep. of Movable Eq.	20,095 is inconsistent with Page 31	20,095
	Page 24 - Historical Cost of Organization Expense	10,060 is inconsistent with Page 32	10,060
	Page 24 - Accumulated Amort. of Org. Expense	10,060 is inconsistent with Page 32	10,060
	Page 24 - Historical Cost of Leasehold Imp.	164,615 is inconsistent with Page 31	164,618
	Page 24 - Accumulated Amort. of Leasehold Imp.	146,148 is inconsistent with Page 31	146,148
-	Page 35 - Total Liabilities, Reserves and Net Worth	90,030 Total Assets	90,030

General Information

Cover

Name of Facility
Holiday Manor, Inc.

Type of Facility and License Number(s)

License Number

Medicaid Provider Number

Report for Year Beginning
10/1/2016

Medicare Provider Number

Page 1

Printed Name (Administrator)
Peter Booth

Page 1A

Report Prepared By
CJLC LLC

Page 1B

Type of Ownership (Check appropriate box)

If this facility opened or closed during report year

Has there been any change in ownership or operati

--

Name of Administrator
Peter Booth

Nursing Home Administrator's License No.

Other Operators/Owners who are Assistant Admin

Name

Legal Name of Partnership/LLC

Name of Partners/Members
N/A

Legal Name of Corporation

Holiday Manor, Inc.

Name of Directors, Officers

Peter Booth

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Names of Stockholders Owning at Least 10% of Sh
--

Peter Booth

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If this facility is owned or operated as an individual

Owner(s) of Facility

N/A

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Are any individuals receiving compensation from the facility for their ability to control, ownership, family or business associations?

Are any individuals or companies which provide goods or services, real property or the loaning of funds to this facility, related to common ownership, control, or business associations of the facility or officials of this facility?

Name of Related Individual or Company
Farbooth, LLC

Boothfar, LLC

Peter Booth

Peter Booth

Karen Booth

1 **In the preparation of this Report, were all costs allocated appropriately?**

Not Applicable

2 **Explain the allocation of related company expenses.**

Not Applicable

3 **Did the Facility appropriately allocate and self-disburse costs (e.g., for Supportive Care Services, etc.) If "No," explain fully why such costs were not allocated appropriately?**

Not Applicable

A Include all long-term leases for motor vehicles and

Name and Address of Lessor
N/A

The records of this facility for the period covered b

Is the accounting basis for this period the same as f

--

Name of Accounting Firm

1	CJLC LLC
2	Shein, Cohen, Palmer & Company
3	Karen Rogers
4	

Services Provided by This Firm (describe fully)

1	Medicaid Cost Report and Accounting Services
2	Tax Services
3	Audit Services
4	

Are these charges reflected in the expenditure port

Pg 15/1d

Name of Legal Firm or Independent Attorney

1	
2	
3	
4	
5	

Services Provided by This Firm

1	
2	
3	
4	
5	

Are these charges reflected in the expenditure port

Pg 15/1e

Are time records maintained by all individuals rece

Name & Address of Individual
N/A

Name & Address of Individual or Company Supplying Service	
N/A	

2H	Is the cost of employee meals included in 2E?
2I	Did you receive revenue from employees?
2J	Where is the revenue received reported in the Cost

2K Is the cost of meals provided to persons other than (Members, Guests) included in 2E?

2L Is any revenue collected from these people?

2M Where is the revenue received reported in the Cost

2N Is cost of food (other than meals, e.g., snacks at mo provided to employees included in 2E?

2O Is any revenue collected from employees?

2P Where is the revenue received reported in the Cost

3G Is cost of employee laundry included in 3E?

3H Did you receive revenue from employees?

3I Where is the revenue received reported in the Cost

3J Is cost of laundry provided to persons other than employees included in 3E?

3K Did you receive revenue from these people?

3L Where is the revenue received reported in the Cost

Is the property either owned by the Facility or leased

	Description
11A1	Date Land Purchased
11A2	Date Structure Completed
11A3	If NOT Original Owner, Date of Purchase
11A4	Date of Initial Licensure
11A5	Total Licensed Bed Capacity
11A6	Square Footage
11A7a	Original Cost - Land
11A7b	Original Cost - Building
	Part B - Owner and Related Parties
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 _____
<i>Complete if Mortgage was Refinanced During Current Year</i>	
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	
C	Arms-length leases
	Arms-length leases
	Arms-length leases
	Arms-length leases
	Arms-length leases

Printed Name of Preparer
CJLC LLC
Address of Preparer
225 Pitkin Street, East Hartford, CT 06108
Phone Number of Preparer
860-610-9009



Address	Phone Number
29 Cottage St., Manchester, CT 06040-5415	860-649-4700



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Report for Year Ending
9/30/2017

Printed Name (Owner)

Phone Number	Date
860-610-9009	1/29/2018



provide:	Date Opened
	Date Closed

on during this report year? If "Yes," explain fully.



Business Address	State(s) in Which Incorporated
29 Cottage St., Manchester, CT 06040-5415	CT
Business Address	Title
29 Cottage St., Manchester, CT 06040-5415	President

Officers	
29 Cottage St., Manchester, CT 06040-5415	President

If proprietorship, provide the following information:

ne facility related through marriage,
ociation?

oods or services, including the rental of
ted through family association,
n to any of the owners, operators, or

Business Address	Also Provides Goods / Services to Non-Related Parties
29 Cottage St., Manchester, CT 06040-5415	
Percentage Non-Related	0.00%

39 Cottage St., Manchester, CT 06040-5415	
Percentage Non-Related	0.00%

29 Cottage St., Manchester, CT 06040-5415	
Percentage Non-Related	0.00%

29 Cottage St., Manchester, CT 06040-5415	
Percentage Non-Related	0.00%

29 Cottage St., Manchester, CT 06040-5415	
Percentage Non-Related	0.00%

Percentage Non-Related	0.00%

Percentage Non-Related	

Percentage Non-Related	0.00%

Percentage Non-Related	0.00%

located as required? If "No," explain fully why such allocation was not

and attach copy of appropriate supporting data.

**allow direct and indirect costs to non-nursing home cost centers? (e.g., A
allocation was not made.**

equipment that have not been capitalized. Short-term leases or as needed

Description of Items Leased	Date of Lease

y this report were maintained on the following basis:

or the previous period? If "No," explain.

[Empty rectangular box]

- 1
- 2
- 3
- 4

	Charge for Service Provided
	6,710
	1,300
	822

on of this report? If Yes, specify expense classification and line number

[Empty rectangular box]

Address	Telephone Number

	Charge for Service Provided

on of this report? If Yes, specify expense classification and line number

[Empty rectangular box]

iving compensation?

Full Explanation of Services	Explanation of Relationship

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Cost of Management Services	Full Description of Management Service Provided

Report?

employees or residents (i.e., Board	
Report?	

Monthly staff meetings, board meetings)	
Report?	

Report?	

employees or residents included in 3E?	
Report?	

ed from a Related Party?	
--------------------------	--

Total
12/4/1997
24
6,143

1st Mortgage	2nd Mortgage
Fixed	
12/4/1996	
16.00%	
15	

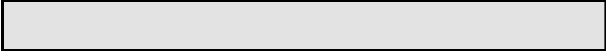
225,000	
PAID OFF	

nt Cost Year

Name and Address of Lessor	Property Leased



1843HA



No. Shares Held by Each	
	1,000
	1,000

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

If "Yes", provide the following information:

Description of Goods / Services Provided	Indicate Where Costs are Included in Annual Report Page# / Line#	Cost Reported
Rental of Real Estate	22/9	36,512
Rental of Office Space	22/9	12,000
Loaning of Funds	34/B3	176,511
Administrator	10/A2	55,459

Clerical	10/A4	15,031
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made.

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Assisted Living, Home Health, Outpatient Services, Adult Day

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[Blank header area]

ed rentals should not be included in these amounts.

Term of Lease	Annual Amount of Lease	Amount Claimed

Total 0

Is a Mileage Log Book Maintained for All Leased Vehicles ?

[Redacted]

Address of Accounting Firm

225 Pitkin Street, East Hartford, CT 06108

20 Tower Lane #3, Avon, CT 06001

New Hampshire

[Redacted]

r. [Redacted]

[Redacted]

r. [Redacted]

[Redacted]

Related to Owners, Operators, Officers

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Indicate Where Costs are Included in Annual Report Page #/Line #	

If yes, specify amt.	
(Page/Line Item)	

If yes, specify cost.	
If yes, specify amt.	
(Page/Line Item)	

If yes, specify cost.	
If yes, specify amt.	
(Page/Line Item)	

If yes, specify cost.	
If yes, specify amt.	
(Page/Line Item)	

If yes, specify cost.	
If yes, specify amt.	
(Page/Line Item)	

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

3rd Mortgage	4th Mortgage

Date of Lease	Term of Lease	Annual Amount of Lease

Actual Cost to the Related Party
36,512

12,000

176,511

55,459

15,031

0

Related to Owners

--