

State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2020

Name of Facility (as licensed) Bel-Air Manor Nursing & Rehabilitation Center	
Address (No. & Street, City, State, Zip Code) 256 New Britain Ave, Newington, CT 06111	
Type of Facility	
<input checked="" 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 type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020

License Numbers:	CCNH 3108C	RHNS	(Specify)	Medicare Provider 07-5393
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Medicaid Provider Numbers:	CCNH 21080	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) Bel-Air Manor Nursing & Rehabilitation Center	License No. 3108C	Report for Year Ended 9/30/2020	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 Bel-Air Manor Nursing & Rehabilitation Center [facility name], for the cost report period beginning October 1, 2019 and ending September 30, 2020, 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) Marianne Herold		Printed Name (Owner) Martin Sbriglio		
Subscribed and Sworn to before me:	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 Bel-Air Manor Nursing & Rehabilitation Center	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 256 New Britain Ave, Newington, CT 06111				
Report Prepared By Ryders Health Management	Phone Number 203-381-1327	Date 11/10/2020		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. 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 203-381-1327	Report for Year Ended 9/30/2020	Page 2
Name of Facility (as shown on license) Bel-Air Manor Nursing & Rehabilitation Center		Address (No. & Street, City, State, Zip) 256 New Britain Ave, Newington, CT 06111	
License Numbers:	CCNH 3108C	RHNS	(Specify)
Medicare Provider No. 07-5393			
Type of Facility (Check appropriate box(es))			
<input checked="" 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 type="checkbox"/> (Specify)			
Type of Ownership (Check appropriate box)			
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust			
If this facility opened or closed during report year provide:		Date Opened	Date Closed
Has there been any change in ownership or operation during this report year?		<input type="radio"/> Yes	<input checked="" type="radio"/> No
		If "Yes," explain fully.	
Administrator Name of Administrator Marianne Herold			
		Nursing Home Administrator's License No.:	001304
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name N/A		License No.:	

General Information and Questionnaire Partners/Members

General Information and Questionnaire
Corporate Owners

Name of Facility Bel-Air Manor Nursing & Rehabilitation Center	License No. 3108C	Report for Year Ended 9/30/2020	Page of 3A 37
If this facility is owned or operated as a corporation, provide the following information:			
Legal Name of Corporation Bel-Air Manor Nursing & Rehabilitation Center	Business Address 256 New Britain Ave, Newington, CT 06111	State(s) in Which Incorporated CT	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Dr. Robert Sbriglio, MD, MPH, 2009 Trust	256 New Britain Ave, Newington, CT 06111	Member	25
Martin Sbriglio, RN, 2009 Trust	256 New Britain Ave, Newington, CT 06111	Member	25
Dr. Robert Sbriglio, MD, MPH	256 New Britain Ave, Newington, CT 06111	Member	25
Martin Sbriglio, RN	256 New Britain Ave, Newington, CT 06111	Member	25
Names of Stockholders Owning at Least 10% of Shares			
Dr. Robert Sbriglio, MD, MPH, 2009 Trust	256 New Britain Ave, Newington, CT 06111	Member	25
Martin Sbriglio, RN, 2009 Trust	256 New Britain Ave, Newington, CT 06111	Member	25
Dr. Robert Sbriglio, MD, MPH	256 New Britain Ave, Newington, CT 06111	Member	25
Martin Sbriglio, RN	256 New Britain Ave, Newington, CT 06111	Member	25

State of Connecticut

Annual Report of Long-Term Care Facility

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General Information and Questionnaire
Individual Proprietorship

Name of Facility Bel-Air Manor Nursing & Rehabilitation Center	License No. 3108C	Report for Year Ended 9/30/2020	Page of 3B 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

General Information and Questionnaire

Related Parties*

Name of Facility Bel-Air Manor Nursing & Rehabilitation Center		License No. 3108C	Report for Year Ended 9/30/2020			Page 4	of 37	
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input checked="" type="radio"/> Yes <input type="radio"/> 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?				<input checked="" type="radio"/> Yes <input type="radio"/> 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	%**				
See Attached		<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"/>					

* 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 Bel-Air Manor Nursing & Rehabilitation Center	License No. 3108C	Report for Year Ended 9/30/2020	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

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

General Information and Questionnaire Leases (Excluding Real Property)

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

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

⊕ No

Total *** 12,500

* 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 Bel-Air Manor Nursing & Rehabili	License No. 3108C	Report for Year Ended 9/30/2020	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 Yes If "No," explain.
previous period? No

Independent Accounting Firm

Name of Accounting Firm 1 Marcum, LLP 2 3 4	Address (No. & Street, City, State, Zip Code) 555 Long Wharf Dr., New Haven, CT
--	--

Services Provided by This Firm (*describe fully*)

1 Corp tax returns and services. Annual review of the financial statements.	\$ 14,370
2	\$
3	\$
4	\$
	Charge for Services Provided \$ 14,370

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

Yes No |15/1d

Legal Services Information

Name of Legal Firm or Independent Attorney 1 See Attached 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 |15/1e

Bel-Air Manor
 Legal Fees
 9/30/2020

Vendor	Description	Amount	Allowable	
			Yes	No
Madsen, Prestley & Parenteau	Settlement	\$ 10,000.00		\$ 10,000.00
State Marshall	Conservatorship	110.00	110.00	
Treasurer, State of CT	Conservatorship	500.00	500.00	
DMC Law LLC	Various Matter	502.50	502.50	
Joe D'Agostino	Various Matter	8,160.68	2,000.00	6,160.68
Kainen , Escalera & McHale	General Consultation	30,687.27	4,000.00	26,687.27
American Express	ERISA Paperwork	36.00	36.00	
Seiger Gfeller Laurie, LLP	Collections	2,272.81		2,272.81
Murtha Cullina	Healthcare Regulatory	1,638.61	1,638.61	
Total		\$ 53,907.87	\$ 8,787.11	\$ 45,120.76

Schedule of Resident Statistics

Name of Facility Bel-Air Manor Nursing & Rehabilitation Center			License No. 3108C				Report for Year Ended 9/30/2020				Page 8	of 37
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity					71	71						
A. On last day of PREVIOUS report period	71	71										
B. On last day of THIS report period	71	71							71	71		
2. Number of Residents					67	67						
A. As of midnight of PREVIOUS report period	67	67										
B. As of midnight of THIS report period	61	61							61	61		
3. Total Number of Days Care Provided During Period					3,296	3,296			1,142	1,142		
A. Medicare	4,438	4,438										
B. Medicaid (Conn.)	12,678	12,678			9,889	9,889			2,789	2,789		
C. Medicaid (other states)												
D. Private Pay	2,669	2,669			2,061	2,061			608	608		
E. State SSI for RCH												
F. Other (Specify)	2,493	2,493			1,742	1,742			751	751		
G. Total Care Days During Period (3A thru F)	22,278	22,278			16,988	16,988			5,290	5,290		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds					90	90			23	23		
A. Medicaid Bed Reserve Days	113	113										
B. Other Bed Reserve Days	54	54			41	41			13	13		
5. Total Resident Days (3G + 4A + 4B)	22,445	22,445			17,119	17,119			5,326	5,326		

Schedule of Resident Statistics (Cont'd)

Name of Facility Bel-Air Manor Nursing & Rehabilitation Cent	License No. 3108C	Report for Year Ended 9/30/2020	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?

 Yes No

If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change	
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)		
				(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.

1st change	Change in Resident Days			CCNH	RHNS	(Specify)
	CCNH	RHNS	(Specify)	CCNH	RHNS	(Specify)
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	(Specify)	R.C.H.	ICF-MR
No. of Residents	14	30		17				
Per Diem Rate								
a. One bed rm.	Various			497 - 466				
b. Two bed rms.		253.48		456 - 424				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

TOTAL CCNH RHNS (Specify)

A. Medicare - Part B		2,556	2,556	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other		15,922	15,922	
D. Total Physical Therapy Treatments		18,478	18,478	

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		635	635	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other		1,775	1,775	
D. Total Speech Therapy Treatments		2,410	2,410	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		1,579	1,579	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other		14,548	14,548	
D. Total Occupational Therapy Treatments		16,127	16,127	

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
Bel-Air Manor Nursing & Rehabilitation Center	3108C	9/30/2020		10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes <input type="radio"/> No			
Item	CCNH	Hours	RHNS	Hours	(Specify)
Total Cost and 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)	106,796	2,299			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	167,982	7,851			
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor	49,852	1,983			
c. Dietary Workers	263,284	17,201			
6. Housekeeping Service					
a. Head Housekeeper	56,772	2,747			
b. Other Housekeeping Workers	145,887	9,908			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	53,921	1,952			
b. Other Maintenance Workers	29,476	1,859			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers	38,931	2,560			
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	129,696	2,306			
b. RN					
1. Direct Care	806,318	20,834			
2. Administrative**	240,061	6,091			
c. LPN					
1. Direct Care					
2. Administrative**	620,314	19,008			
d. Aides and Attendants	1,143,703	63,286			
e. Physical Therapists	427,278	12,043			
f. Speech Therapists	88,478	1,784			
g. Occupational Therapists	174,784	5,027			
h. Recreation Workers	86,317	4,427			
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	158,251	5,599			
n. Marketing					
o. Other (Specify)					
See Attached Schedule	46,460	2,388			
A-13. Total Salary Expenditures	4,834,563	191,151			

* 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)

Schedule of Other Fees (Page 13)

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

Name of Facility Bel-Air Manor Nursing & Rehabilitation Center			License No. 3108C		Report for Year Ended 9/30/2020			Page 11	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Dr. Robert Sbriglio, MD, MPH								Lord Chamberlain, 7003 Main St., Stratford, CT 06614	2,080	131,226
Martin Sbriglio, RN, NHA								Ryders Health Management, 88 Ryders Lane, Suite 208, Stratford, CT 06614	2,970	130,000
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).										
Margaret Sbriglio, LPN, NHA								Ryders Health Management, 88 Ryders Lane, Suite 208, Stratford, CT 06614	1,040	26,000

* 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
Bel-Air Manor Nursing & Rehabilitation Center				3108C		9/30/2020			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Marianne Herold	106,796			Non Discriminatory	Administrative	2,299	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.

B. Report of Expenditures - Professional Fees

Name of Facility Bel-Air Manor Nursing & Rehabilitation Center	License No. 3108C	Report for Year Ended 9/30/2020		Page 13	of 37
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify) 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	17,695	354			
2. Dentist	3,500	70			
3. Pharmacist	3,842	77			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	66,000	440			
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) Medical Staff	800	8			
9. Speech Therapist					
a. Resident Care					
b. Other					
10. Occupational Therapist					
a. Resident Care	720	10			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	10,000				
2. Administrative***					
b. LPN					
1. Direct Care					
2. Administrative***					
c. Aides					
d. Other					
12. Other (Specify) See Attached Schedule	90,216	927			
B-13 Total Fees Paid in Lieu of Salaries	192,772	1,886			

* 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*

* 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
		9/30/2020		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 194,999	194,999			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$				
4. Social Security (F.I.C.A.)	\$ 397,634	397,634			
5. Health Insurance	\$ 546,003	546,003			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 12,924	12,924			
8. Uniform Allowance	\$ 17,862	17,862			
9. Other (Specify) See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 75,270	75,270			
d. Accounting and Auditing	\$ 14,370	14,370			
e. Legal (Services should be fully described on Page 7)	\$ 53,908	53,908			
f. Insurance on Lives of Owners and Operators (Specify)*	\$				
g. Office Supplies	\$ 16,410	16,410			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 19,886	19,886			
2. Cellular Phones	\$ 4,196	4,196			
i. Appraisal (Specify purpose and attach copy)*	\$				
j. Corporation Business Taxes (franchise tax)	\$ 250	250			
k. Other Taxes (Not related to property - See Page 22)					
1. Income*	\$				
2. Other (Specify) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 330,959	330,959			
Subtotal	\$ 1,684,671	1,684,671			

* 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**

Attachment Page 15

Schedule of Other Employee Benefits

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Total	\$ -	\$ -	\$ -

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

Name of Facility Bel-Air Manor Nursing & Rehabilitation Center	License No. 3108C	Report for Year Ended 9/30/2020		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
<i>Subtotals Brought Forward:</i>		1,684,671	1,684,671		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	13,642	13,642		
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	800	800		
5. Education Expenses Related to Seminars and Conventions	\$	1,289	1,289		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$	11,447	11,447		
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	2,584	2,584		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	13,948	13,948		
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	\$	5,162	5,162		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	5,794	5,794		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	842	842		
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>)	\$	66,341	66,341		
12. Administrative Management Services**	\$	288,695	288,695		
13. Other (<i>Specify</i>) See Attached Schedule	\$	44,465	44,465		
<i>C-14 Total Administrative & General Expenditures</i>	\$	2,139,679	2,139,679		

* Do not include Subscriptions, which should go in item 9.

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Meals & Entertainment	\$ 11,447		
Total Other Travel and Entertainment	\$ 11,447	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Adv. & Pub Relations	\$ 13,948		
Total Other Advertising	\$ 13,948	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 4,991		
American Express	\$ 93		
AHCA	\$ 710		
Total Dues	\$ 5,794	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Total Contributions	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Physician Care - Employee	\$ 11,156		
Bank Charges	\$ 6,880		
Bank Charges - Lease	\$ 484		
Fines & Penalties	\$ 6,960		
Manager Training Consultant	\$ 16,153		
Unemployment Tax Management	\$ 1,302		
Elevator Renewal	\$ 480		
CLIA Lab Program	\$ 180		
Food License	\$ 425		
Barber & Beauty License	\$ 100		
Business Annual Report	\$ 170		
Pool License	\$ 175		
Total Other Administrative and General	\$ 44,465	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Bel-Air Manor Nursing & Rehabilitation	3108C	9/30/2020	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 #
Ryders Health Management, 88 Ryders Lane, Suite 208, Stratford, CT 06614	288,695	Financials and Managerial Support	16/m12

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bel-Air Manor Nursing & Rehabilitation Center	3108C	9/30/2020	18	37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 155,397	155,397		
2. Non-Food Supplies	\$ 26,466	26,466		
3. Other (Specify) _____	\$ _____			
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ _____			
c. Other (Specify) _____	\$ _____			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 181,863	181,863		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				
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 meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
K. Is any revenue collected 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)				
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
O. 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 Bel-Air Manor Nursing & Rehabilitation Center	License No. 3108C	Report for Year Ended 9/30/2020		Page of 19 37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	5,202	5,202	
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 (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$	49,944	49,944	
c. Other (Specify) Laundry Supplies	\$	941	941	
3D. Total Laundry Expenditures (3a + b + c)	\$	56,087	56,087	
3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
K. 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 3D.

*** 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
		9/30/2020		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced				
a. In-House Care	by Personnel				
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	32,987	32,987		
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel				
	Amt. \$				
C. Other (Specify)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	32,987	32,987		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	241,985	241,985		
b. Medicine Cabinet Drugs	\$	38,234	38,234		
c. Medical and Therapeutic Supplies	\$				
d. Ambulance/Limousine***	\$	66,969	66,969		
e. Oxygen					
1. For Emergency Use	\$	24,443	24,443		
2. Other***	\$	16,018	16,018		
f. X-rays and Related Radiological Procedures***	\$	25,973	25,973		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	102,479	102,479		
i. Recreation	\$	19,762	19,762		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (Specify)**** See Attached Schedule	\$	257,455	257,455		
5M. Total Resident Care Expenditures (5a - 5j)	\$	793,319	793,319		

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

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Physician Care - Patients	\$ 13,631		
Medical Supplies	\$ 188,340		
Medical Supplements	\$ 19,604		
Medical Waste	\$ 233		
Medical Equipment	\$ 781		
Medical Equipment - Rental	\$ 18,360		
PT Supplies	\$ 16,507		
Total Other Resident Care	\$ 257,455	\$ -	\$ -

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

* 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 Bel-Air Manor Nursing & Rehabilitation Cent	License No. 3108C	Report for Year Ended 9/30/2020			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	123,662	123,662			
b. Heat	\$	31,204	31,204			
c. Light & Power	\$	113,016	113,016			
d. Water	\$	34,763	34,763			
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$	12,500	12,500			
f. Other <i>(itemize)</i>	\$					
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	315,144	315,144			
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$					
b. Building & Building Improvements	\$	115,815	115,815			
c. Non-Movable Equipment	\$	44,215	44,215			
d. Movable Equipment	\$	20,122	20,122			
*7e. Total Depreciation Costs (7a + b + c + d)	\$	180,152	180,152			
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other <i>(Specify)</i>	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	360,000	360,000			
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	101,361	101,361			
c. Personal property taxes	\$	12,627	12,627			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	654,140	654,140			

* 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

Depreciation Schedule

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
11/2/2019	Window Replacement	\$ 2,348		
1/9/2020	Roof	\$ 3,031		
1/29/2020	Sprinklers	\$ 6,442		
Total additions for Land Improvement		\$ 11,822	\$ -	*
Deletions:				
Total deletions for Land Improvement		\$ -	\$ -	**

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

*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:				
10/22/2019	Taco Pump	\$ 2,630		
7/29/2020	AC Compressor	\$ 3,710		
7/31/2020	AC Compressor	2527.73		
Total additions for Non-Movable Equipment		\$ 8,868	\$ -	*
Deletions:				
Total deletions for Non-Movable Equipment		\$ -	\$ -	**

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/16/2019	Dual Bedside Station	\$ 3,079		
10/23/2019	Lift Chair	\$ 660		
1/7/2020	Computers	999.68		
2/14/2020	Recliner Chair	461.57		
8/7/2020	Lift Chair	1910.05		
Total additions for Movable Equipment		\$ 7,110	\$ -	*
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 Improvements		\$ -	\$ -	*
Deletions:				
Total deletions for Leasehold Improvements		\$ -	\$ -	**

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Bel-Air Manor Nursing & Rehabilitation Center			License No. 3108C		Report for Year Ended 9/30/2020			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility Bel-Air Manor Nursing & Rehabilitati	License No. 3108C	Report for Year Ended 9/30/2020	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				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	71			
6. Square Footage				
7. Acquisition Cost				
a. Land	7,000			
b. Building	108,929			

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	08/01/18			
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)	25			
e. Amount of Principal Borrowed	4,665,000			
f. Principal balance outstanding as of 9/30/2020	4,320,308			

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 9/30/2020			Page 26	of 37
Item		Total	CCNH	RHNS	(Specify)	
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	License No.	Report for Year Ended 9/30/2020			Page 27	of 37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		\$				
12. D. Other Interest Expense (Specify)		\$	6,072	6,072		
Interest Exp & Finance Charges						
13. Total All Interest Expense (12B7 + 12C3 + 12D)		\$	6,072	6,072		
14. Insurance						
a. Insurance on Property (buildings only)		\$	11,755	11,755		
b. Insurance on Automobiles		\$				
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$	51,555	51,555		
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$				
14d. Total Insurance Expenditures (14a + b + c)		\$	63,310	63,310		
15. Total All Expenditures (A-13 thru C-14)		\$	9,269,935	9,269,935		

D. Adjustments to Statement of Expenditures

Name of Facility Bel-Air Manor Nursing & Rehabilitation Center			License No. 3108C	Report for Year Ended 9/30/2020		Page 28	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	g	Occupational Therapy	\$ 174,784	174,784		
4.			Other - See attached Schedule	\$ 9,834	9,834		
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$ 720	720		
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 75,270	75,270		
10.			Accounting	\$			
10a.			Legal	\$ 45,121	45,121		
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.	16	L7	Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$ 11,447	11,447		
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m3	Unallowable Advertising *	\$ 13,948	13,948		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 7,802	7,802		
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)			\$ 338,926	338,926			

* All except "Help Wanted".

(Carry Subtotal forward to next page)

** Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	A12o	Respiratory Therapy Salaries	\$ 9,834		
Total Other Salaries Adjustment			\$ 9,834	\$ -	\$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m8	Chamber of Commerce	\$ 842		
16	m13	Fines & Penalties	\$ 6,960		
Total Other A&G Adjustments			\$ 7,802	\$ -	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-29 Rev. 9/2018

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

Name of Facility			License No.	Report for Year Ended		Page of	
Bel-Air Manor Nursing & Rehabilitation Center			3108C	9/30/2020		29 37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 338,926	338,926		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$			
28.	20	5d	Ambulance/Limousine	\$ 66,969	66,969		
29.	20	5f	X-rays, etc	\$ 25,973	25,973		
30.	20	5h	Laboratory	\$ 102,479	102,479		
31.			Medical Supplies	\$			
32.	20	50	Oxygen (non emergency)	\$ 24,443	24,443		
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.			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)				\$ 558,790	558,790		

*** 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.

Schedule of Other Ancillary Costs

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Schedule of Other - Indirect Adjustments

Attachment Page 29

Schedule of Other - Miscellaneous Administrative Adjustments

Schedule of Other - Direct Adjustments

Schedule of Unallowable Building Interest

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended 9/30/2020			Page 30	of 37
Item		Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 5,188,258	5,188,258				
b. Medicaid Room and Board Contractual Allowance **	\$ (2,077,217)	(2,077,217)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 2,013,717	2,013,717				
b. Medicare Room and Board Contractual Allowance **	\$ 570,999	570,999				
4. a. Private-Pay Residents and Other	\$ 2,502,384	2,502,384				
b. Private-Pay Room and Board Contractual Allowance **	\$ (703,948)	(703,948)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 258,788	258,788				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (258,788)	(258,788)				
c. Prescription Drugs - Non-Medicare	\$ 32,923	32,923				
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	\$ 334,786	334,786				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (334,786)	(334,786)				
c. Physical Therapy - Non-Medicare	\$ 466,471	466,471				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 90,132	90,132				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (90,132)	(90,132)				
c. Speech Therapy - Non-Medicare	\$ 109,642	109,642				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 350,503	350,503				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (350,503)	(350,503)				
c. Occupational Therapy - Non-Medicare	\$ 199,644	199,644				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$ 0	0				
b. Other (<i>Specify</i>) - Non-Medicare	\$ 2,602	2,602				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 8,305,476	8,305,476				
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>)	\$ 787	787				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 104	104				
V. Total Other Revenue (1 thru 8)	\$ 891	891				
VI. Total All Revenue (III +V)	\$ 8,306,367	8,306,367				

* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

** Facility should report all contractual allowances and/or payer discounts.

Schedule of Other Resident Revenue - Medicare**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
	Oxygen - Medicare	\$ 14,680		
	X-Ray - Medicare	\$ 32,668		
	Lab - Medicare	\$ 88,532		
	Contractuals - Medicare	\$ (135,880)		
Total Other Resident Revenue - Medicare		\$ 0	\$ -	\$ -

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

Page Ref	Description	CCNH	RHNS	(Specify)
	Oxygen - Managed Care	\$ 14		
	X-Ray - Managed Care	\$ 1,005		
	Lab - Managed Care	\$ 1,629		
	Lab - Private Insurance	\$ (46)		
Total Other Resident Revenue		\$ 2,602	\$ -	\$ -

Interest Income**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Income	\$ 787			
Total Interest Income		\$ 787	\$ -	\$ -	

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Misc Income	\$ 104		
Total Other Revenue		\$ 104	\$ -	\$ -

G. Balance Sheet

Name of Facility Bel-Air Manor Nursing & Rehabilitation	License No. 3108C	Report for Year Ended 9/30/2020	Page 31	of 37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$ 1,223,001	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 1,057,529	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$ 100,125	
a. Prepaid Expenses	95,465			
b. Prepaid Insurance	2,228			
c. Prepaid Corporate Taxes	2,432			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$ (1,152,772)	
Medicaid Adv(\$57,000) Medicare Adv(\$583,460)	(640,460)			
Loans & Exchanges	(519,901)			
Refunds	7,588			
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$ 1,227,883	
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	7,605,173	\$ 2,389,069	
	Accum. Depreciation	5,216,104 Net		
5. Non-Movable Equipment	*Historical Cost	594,667	\$ 167,514	
	Accum. Depreciation	427,153 Net		
6. Movable Equipment	*Historical Cost	636,024	\$ 65,703	
	Accum. Depreciation	570,321 Net		
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$ 2,622,286	

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref Line Ref Description

Total Prepaid Expenses		\$ -

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

Total Other Assets			\$ 837,912

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

Total Other Current Liabilities (Itemize)			\$ -

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

Page Ref Line Ref Description

Total Other Current Liabilities (Itemize)			\$ 3,612,259

G. Balance Sheet (cont'd)

Name of Facility Bel-Air Manor Nursing & Rehabilitation	License No. 3108C	Report for Year Ended 9/30/2020	Page 32	of 37
Account		Amount		
Total Brought Forward:			\$	3,850,169
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)			\$	837,912
See Schedule	837,912			
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	837,912
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	4,688,081

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

G. Balance Sheet (cont'd)

Name of Facility Bel-Air Manor Nursing & Rehabilitation Cent	License No. 3108C	Report for Year Ended 9/30/2020	Page 33	of 37
Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				\$ 477,360
2. Notes Payable (<i>itemize</i>)				\$
See Schedule				
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$
Name of Lender		Purpose	Amount	Date Due
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$ 145,112
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$
6. Accrued Payroll Taxes Payable				\$
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>)				\$ 1,285,489
PPP Loan				888,200 Accrued Expenses 25,554
Patient Fund				24,980 Accrued PTO 116,226
FSA Liability				(1,313) Accrued User Fee 211,218
AFLAC - Individual				20,624 See Schedule
A-13. Total Current Liabilities (Lines A1 thru 12)				\$ 1,907,961

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

G. Balance Sheet (cont'd)

Name of Facility Bel-Air Manor Nursing & Rehabilitation Ce	License No. 3108C	Report for Year Ended 9/30/2020	Page 34	of 37
Account			Amount	
Total Brought Forward:			1,907,961	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)			\$	
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable			\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)			\$	3,871,482
Due to Aaron Manor	158,470			
Due to Chamberlain Healthcare	84,425			
Due to Douglas Manor	16,328			
See Schedule	3,612,259			
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$	3,871,482
C. Total All Liabilities (Lines A-13 + B-5)			\$	5,779,443

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bel-Air Manor Nursing & Rehabilitation	3108C	9/30/2020	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				\$ 750
3. Paid-in Surplus				\$
4. Treasury Stock				\$
5. Cumulated Earnings				\$ (128,543)
6. Gain or Loss for Period 10/1/2019 thru 9/30/2020				\$ (963,569)
7. Total Net Worth				\$ (1,091,362)
C. Total Reserves and Net Worth				\$ (1,091,362)
D. Total Liabilities, Reserves, and Net Worth				\$ 4,688,081

H. Changes in Total Net Worth

Name of Facility Bel-Air Manor Nursing & Rehabilitation	License No. 3108C	Report for Year Ended 9/30/2020	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2019			\$	
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	
D. Net Income or Deficit			\$	
E. Balance			\$	
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 (No., City, State, Zip)		Title	Amount	
2. Other Withdrawals (<i>Specify</i>)			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period	09/30/20		\$	

I. Preparer's/Reviewer's Certification

Name of Facility Bel-Air Manor Nursing & Rehabilitation	License No. 3108C	Report for Year Ended 9/30/2020	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		

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		
Elizabeth Maglio		
Address		Phone Number
88 Ryders Lane, Stratford, CT 06614		203-381-1327
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number
Elizabeth Maglio		203-381-1327
Contact Email Address		
emaglio@rydershealth.com		