

# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2019

Name of Facility (as licensed) Manchester Manor Health Care Center	
Address (No. & Street, City, State, Zip Code) 385 West Center St., Manchester, CT 06040	
Type of Facility <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)	
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019

License Numbers:	CCNH 2237-C	RHNS	(Specify)	Medicare Provider 07-5333
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Medicaid Provider Numbers:	CCNH 8417	RHNS	ICF-IID
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**For Department Use Only**

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

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### General Information

Name of Facility (as licensed) Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2019	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 Manchester Manor Health Care Center [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, 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) Jonah Kraus			Printed Name (Owner) Paul Liistro		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires  / /	
Address of Notary Public					

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Manchester Manor Health Care Center	Period Covered:	From 10/1/2018	To 9/30/2019	
Address of Facility 385 West Center St., Manchester, CT 06040				
Report Prepared By CJLC LLC	Phone Number 860-610-9009	Date 2/11/2020		
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. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

**General Information and Questionnaire**  
**Type of Facility - Organization Structure**

Phone No. of Facility 860-646-0129		Report for Year Ended 9/30/2019		Page 2	of 37
Name of Facility (as shown on license) Manchester Manor Health Care Center			Address (No. & Street, City, State, Zip) 385 West Center St., Manchester, CT 06040		
License Numbers:		CCNH 2237-C	RHNS	(Specify)	Medicare Provider No. 07-5333
Type of Facility (Check appropriate box(es))					
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input type="checkbox"/> (Specify)	
Type of Ownership (Check appropriate box)					
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input checked="" type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust					
If this facility opened or closed during report year provide:			Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No   If "Yes," explain fully.					
<b>Administrator</b>					
Name of Administrator Jonah Kraus			Nursing Home Administrator's License No.:	1716	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		





**General Information and Questionnaire**  
**Individual Proprietorship**

Name of Facility	License No.	Report for Year Ended	Page	of
Manchester Manor Health Care Center	2237-C	9/30/2019	3B	37
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 Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2019	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	%**				
Manchester Manor Realty, LLP	385 West Center St., Manchester, CT 06040	<input type="radio"/>	<input checked="" type="radio"/>		Rent	22/9	543,760	543,760
Vernon Manor Health Care	180 Regan Road, Vernon, CT 06066	<input type="radio"/>	<input checked="" type="radio"/>		Shared Office Staff	10/A4	172,976	172,976
Arbors of Hop Brook	403 West center St, Manchester, CT 06040	<input type="radio"/>	<input checked="" type="radio"/>		Common Pension Plan	15 / 1A7	83,754	83,754
Arbors of Hop Brook	403 West center St, Manchester, CT 06040	<input type="radio"/>	<input checked="" type="radio"/>		Shared Operational Staff	10/A4	369	369
Vernon Manor Health Care Center	180 Regan Road, Vernon, CT 06066	<input type="radio"/>	<input checked="" type="radio"/>		Shared Operational Staff	10/12	2,304	59,976
Arbors of Hop Brook	403 West center St, Manchester, CT 06040	<input type="radio"/>	<input checked="" type="radio"/>		Morgan Stanley LOC Interest	27/12D	181	181
Arbors of Hop Brook	403 West center St, Manchester, CT 06040	<input type="radio"/>	<input checked="" type="radio"/>		Shared Insurance Plan	15/1A5	602,886	602,886
		<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 Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2019	Page 5	of 37
If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:				
Item	Method of Allocation			
Dietary	Number of meals served to residents			
Laundry	Number of pounds processed			
Housekeeping	Number of square feet serviced			
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants			
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist ( <i>See listing page 13</i> )			
Maintenance and operation of plant	Square feet			
Property costs (depreciation)	Square feet			
Employee health and welfare	Gross salaries			
Management services	Appropriate cost center involved			
All other General Administrative expenses	Total of Direct and Allocated Costs			
The preparer of this report must answer the following questions applicable to the cost information provided.				
1. In the preparation of this Report, were all costs allocated as required? <input checked="" type="radio"/> Yes <input type="radio"/> 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.)				
<input checked="" type="radio"/> Yes <input type="radio"/> No    If "No," explain fully why such allocation was not made.				

### General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility			License No.	Report for Year Ended			Page	of
Manchester Manor Health Care Center			2237-C	9/30/2019			6	37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
MailFinance 385 West Center St, Manchester, CT 06040	<input type="radio"/>	<input checked="" type="radio"/>	Postage Machine	07/23/18	63 months	2,799	2,799	
Pitney Bowes PO Box 856460, Louisville, KY 40285	<input type="radio"/>	<input checked="" type="radio"/>	Carriage House Postage Machine Allocation 40%	08/13/13	63 months	1,835	800	
Novareus US, Inc. 111 North Canal, Suite 165, Chicago, IL 60606	<input type="radio"/>	<input checked="" type="radio"/>	Airborne Infection Control	02/01/14		16,080	4,850	
	<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"/>						
<b>Is a Mileage Log Book Maintained for All Leased Vehicles ?</b>							<input type="radio"/> Yes	<input checked="" type="radio"/> No
<b>Total ***</b>							8,449	

\* 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 Manchester Manor Health Care Cen	License No. 2237-C	Report for Year Ended 9/30/2019	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 William T Craig CPA, LLC 3 4	Address (No. & Street, City, State, Zip Code) 225 Pitkin Street, East Hartford, CT 06108 140-16 Masons Island Rd, Ste 2a, Mystic, CT 06355
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Services Provided by This Firm (*describe fully*)

1 Cost Reporting, Financial Statements, Reimbursement Consulting	\$ 20,102
2 Tax Returns, Corporate Matters	\$ 7,300
3	\$
4	\$
	Charge for Services Provided \$ 27,402

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 Jackson Lewis, LLP 2 Murtha Cullina, LLP 3 4 5	Telephone Number (914)514-6060 (860)240-6000
--	--

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

- 1 PO Box 416019, Boston, MA 02241  
 2 185 Asylum St., Hartford, CT 06103  
 3  
 4  
 5

Services Provided by This Firm (*describe fully*)

1 Employment Matters	\$ 2,641
2 Collections and Resident Issues	\$ 4,761
3	\$
4	\$
5	\$
	Charge for Services Provided \$ 7,402

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 Manchester Manor Health Care Center		License No. 2237-C			Report for Year Ended 9/30/2019				Page 8	of 37			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	126	126			126	126			126	126			
B. On last day of THIS report period	126	126			126	126			126	126			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	113	113			113	113			119	119			
B. As of midnight of THIS report period	112	112			119	119			112	112			
3. Total Number of Days Care Provided During Period													
A. Medicare	5,651	5,651			4,263	4,263			1,388	1,388			
B. Medicaid (Conn.)	25,082	25,082			18,880	18,880			6,202	6,202			
C. Medicaid (other states)													
D. Private Pay	7,166	7,166			5,475	5,475			1,691	1,691			
E. State SSI for RCH													
F. Other (Specify) Insurance	4,293	4,293			2,840	2,840			1,453	1,453			
G. Total Care Days During Period (3A thru F)	42,192	42,192			31,458	31,458			10,734	10,734			
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	108	108			66	66			42	42			
5. <b>Total Resident Days (3G + 4A + 4B)</b>	42,300	42,300			31,524	31,524			10,776	10,776			

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

Name of Facility Manchester Manor Health Care Center			License No. 2237-C			Report for Year Ended 9/30/2019			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <span style="float: right;"><input type="radio"/> Yes <input checked="" type="radio"/> No</span>													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	(Specify)		
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare	Medicaid		Self-Pay			Other State Assisted						
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR					
No. of Residents	12	70		30									
Per Diem Rate													
a. One bed rm.	RUGS	218.26		545.00									
b. Two bed rms.				445.00									
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									4,114	4,114			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									20,989	20,989			
D. <b>Total Physical Therapy Treatments</b>									25,103	25,103			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									373	373			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									2,108	2,108			
D. <b>Total Speech Therapy Treatments</b>									2,481	2,481			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									3,121	3,121			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									21,959	21,959			
D. <b>Total Occupational Therapy Treatments</b>									25,080	25,080			

### Report of Expenditures - Salaries & Wages

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2019	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	(Specify)	Hours
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	100,157	1,686				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	540,880	23,348				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	542,925	29,935				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	179,344	14,655				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	147,849	6,334				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	65,184	4,676				
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	249,116	4,603				
b. RN						
1. Direct Care	1,415,597	38,436				
2. Administrative**	206,645	5,043				
c. LPN						
1. Direct Care	1,130,207	36,651				
2. Administrative**	187,511	5,362				
d. Aides and Attendants	2,015,785	123,362				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	146,062	8,032				
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	210,794	6,484				
n. Marketing						
o. Other (Specify) See Attached Schedule	35,417	1,676				
<i>A-13. Total Salary Expenditures</i>	<i>7,173,474</i>	<i>310,282</i>				

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

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

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

**Schedule of Other Salaries and Wages (Page 10)**

Position	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Medical Records Assistant	\$ 35,417	1,676				
<b>Total</b>	\$ 35,417	1,676	\$ -	-	\$ -	-

**Schedule of Other Fees (Page 13)**

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Medical Staff	\$ 63,200	569				
<b>Total</b>	\$ 63,200	569	\$ -	-	\$ -	-



**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	
Manchester Manor Health Care Center				2237-C	9/30/2019			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section I - Operators/Owners</b>										
<b>Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).</b>										

\* 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	
Manchester Manor Health Care Center				2237-C	9/30/2019			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section III - Administrators***</b>										
William Nelson (10/1/18 to 6/1/19)	80,505			Standard	Responsible for daily operations of facility	1,331	A2			
Jonah Kraus (7/29/19 to 9/30/19)	19,652			Standard	Responsible for daily operations of facility	355	A2			
<b>Section IV - Assistant Administrators</b>										

\*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

\*\* Include **all** other employment worked during the cost year.

\*\*\* If more than one Administrator is reported, include dates of employment for each.

**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended	Page	of		
Manchester Manor Health Care Center	2237-C	9/30/2019	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian						
2. Dentist	8,020	213				
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	536,983	11,277				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	36,000	189				
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	99,178	1,639				
b. Other						
10. Occupational Therapist						
a. Resident Care	525,668	10,165				
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	63,200	569				
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>1,269,049</b>	<b>24,051</b>				

\* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.

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

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

**Report of Expenditures**  
**Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis\***

Name of Facility Manchester Manor Health Care Center		License No. 2237-C	Report for Year Ended 9/30/2019	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
RehabCare Group, Inc. 680 S 4th St, Louisville, KY 40202	Therapy Services	<input type="radio"/>	<input checked="" type="radio"/>		
GeriDent Solutions, LLC P.O. Box 290539, Wethersfield, Connecticut	Dental Services	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Wayne Pauleka 251 Wickham Rd., Glastonbury, CT 06033	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Elmo Vallanueva 506 Cromwell Ave., Rocky Hill, CT 06067	Assistant Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Guardino	Assistant Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Starling Physician	CHF & COPD Doctors	<input type="radio"/>	<input checked="" type="radio"/>		
Healthpro Heritage	Therapy Services	<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"/>		

\* 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
Manchester Manor Health Care Center	2237-C	9/30/2019	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 176,002	176,002		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 82,283	82,283		
4. Social Security (F.I.C.A.)	\$ 529,844	529,844		
5. Health Insurance	\$ 602,886	602,886		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 83,754	83,754		
8. Uniform Allowance	\$ 14,488	14,488		
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*	\$ 84,142	84,142		
d. Accounting and Auditing	\$ 27,402	27,402		
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 7,402	7,402		
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$			
g. Office Supplies	\$ 41,334	41,334		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 52,272	52,272		
2. Cellular Phones	\$ 7,690	7,690		
i. Appraisal ( <i>Specify purpose and         attach copy</i> )*	\$			
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$			
k. Other Taxes ( <i>Not related to property - See Page 22</i> )				
1. Income*	\$			
2. Other ( <i>Specify</i> ) See Attached Schedule	\$ 500	500		
3. Resident Day User Fee	\$			
<b>Subtotal</b>	\$ 1,709,999	1,709,999		

\* 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**

Manchester Manor Health Care Center  
9/30/2019

Attachment Page 15

**Schedule of Other Employee Benefits**

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

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**Schedule of Other Taxes**

Description	CCNH	RHNS	(Specify)
Business Entity Tax	\$ 500		
<b>Total</b>	\$ 500	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended		Page	of
Manchester Manor Health Care Center	2237-C	9/30/2019		16	37
Item	Total	CCNH	RHNS	(Specify)	
<b>Subtotals Brought Forward:</b>		1,709,999	1,709,999		
i. Travel and Entertainment					
1. Resident Travel and Entertainment	\$ 6,563	6,563			
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$ 41,100	41,100			
4. Employee Travel	\$ 6,149	6,149			
5. Education Expenses Related to Seminars and Conventions	\$ 9,457	9,457			
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$ 1,763	1,763			
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$ 17,933	17,933			
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 22,900	22,900			
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 6,808	6,808			
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 9,784	9,784			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 233	233			
9. Subscriptions	\$ 3,805	3,805			
10. Contributions*** See Attached Schedule	\$ 781	781			
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$ 221,031	221,031			
12. Administrative Management Services**	\$				
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 17,882	17,882			
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 2,076,188	2,076,188			

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

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

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

**Schedule of Other Travel and Entertainment**

Description	CCNH	RHNS	(Specify)
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
Advertising	\$ 22,900		
<b>Total Other Advertising</b>	\$ 22,900	\$ -	\$ -

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
C.A.H.C.F. INC.	\$ 8,936		
ALTCFM	\$ 213		
SHRM	\$ 92		
ACHCA	\$ 310		
Diane Alves	\$ 234		
<b>Total Dues</b>	\$ 9,784	\$ -	\$ -

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
Contributions	\$ 781		
<b>Total Contributions</b>	\$ 781	\$ -	\$ -

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
Employment Screening	\$ 5,196		
License Fees	\$ 2,415		
Bank Fees	\$ 3,315		
Employee Physicals	\$ 6,467		
Prof Services - Collections	\$ 490		
<b>Total Other Administrative and General</b>	\$ 17,882	\$ -	\$ -



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

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2019	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 #

**\* 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 Manchester Manor Health Care Center		License No. 2237-C	Report for Year Ended 9/30/2019	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
<b>2. Dietary</b>					
<b>a. In-House Preparation &amp; Service</b>					
1.	Raw Food	\$ 291,702	291,702		
2.	Non-Food Supplies	\$ 47,940	47,940		
3.	Other (Specify) _____	\$			
<b>b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)</b>					
<b>c. Other (Specify) _____</b>					
	Vending Machine	\$ 9,898	9,898		
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>		\$ 349,540	349,540		
<b>2F. Dietary Questionnaire</b>		<b>Total</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
<b>G. Resident Meals: Total no. of meals served per day:*</b>					
<b>H. Is cost of employee meals included in 2E?    <input type="radio"/> Yes                      <input checked="" type="radio"/> No</b>					
<b>I. Did you receive revenue from employees?    <input type="radio"/> Yes                      <input checked="" type="radio"/> No                      If yes, specify amt.</b>					
<b>J. Where is the revenue received reported in the Cost Report? (Page/Line Item)</b>					
<b>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.</b>					
<b>L. Is any revenue collected from these people?    <input type="radio"/> Yes                      <input checked="" type="radio"/> No                      If yes, specify amt.</b>					
<b>M. Where is the revenue received reported in the Cost Report? (Page/Line Item)</b>					
<b>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.</b>					
<b>O. Is any revenue collected from employees?    <input type="radio"/> Yes                      <input checked="" type="radio"/> No                      If yes, specify amt.</b>					
<b>P. Where is the revenue received reported in the Cost Report? (Page/Line Item)</b>					

\* 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 Manchester Manor Health Care Center		License No. 2237-C	Report for Year Ended 9/30/2019	Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*		Lbs.			
1.	Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	11,113	11,113	
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) Supplies		\$	16,642	16,642	
<b>3D. Total Laundry Expenditures (3a + b + c)</b>		\$	<b>27,755</b>	<b>27,755</b>	
<b>3F. Laundry Questionnaire</b>					
G.	Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
H.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
I.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

\* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.  
 All allocations should add to total recorded in 3E.  
 \*\*\* 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
Manchester Manor Health Care Center		2237-C	9/30/2019		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
	1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	69,231	69,231		
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> )			\$			
<b>4D. Total Housekeeping Expenditures (4a + b + c)</b>			\$ 69,231	69,231		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from	\$	303,400	303,400		
	b. Medicine Cabinet Drugs	\$	56,835	56,835		
	c. Medical and Therapeutic Supplies	\$	375,868	375,868		
	d. Ambulance/Limousine***	\$				
	e. Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	87,470	87,470		
	f. X-rays and Related Radiological Procedures***	\$	3,262	3,262		
	g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
	h. Laboratory***	\$				
	i. Recreation	\$	12,572	12,572		
	j. Direct Management Services*	\$				
	k. Indirect Management Services*	\$				
	l. Other (Specify)**** See Attached Schedule	\$	15,322	15,322		
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>			\$ 854,731	854,731		

\* 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)
Rehab Supplies	\$ 15,322		
<b>Total Other Resident Care</b>	\$ 15,322	\$ -	\$ -

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

Name of Facility Manchester Manor Health Care Center			License No. 2237-C		Report for Year Ended 9/30/2019				Page of 21   37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
ADP	100 Corporate Dr, Windsor, CT 06095	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Services	54,982			16	m11
Wescom Solutions	3500 American Blvd W. Suite 155, Bloomington	<input type="radio"/>	<input checked="" type="radio"/>		Point Click Care	32,614			16	m11
		<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	License No.	Report for Year Ended			Page	of
Manchester Manor Health Care Center	2237-C	9/30/2019			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 207,162	207,162				
b. Heat	\$ 30,751	30,751				
c. Light & Power	\$ 99,257	99,257				
d. Water	\$ 40,508	40,508				
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 8,449	8,449				
f. Other ( <i>itemize</i> )	\$ 51,810	51,810				
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$ 437,937</b>	<b>437,937</b>				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$ 8,979	8,979				
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$ 39,125	39,125				
d. Movable Equipment	\$ 95,061	95,061				
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$ 143,165</b>	<b>143,165</b>				
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 174,664	174,664				
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$ 174,664</b>	<b>174,664</b>				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 543,760	543,760				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 139,177	139,177				
c. Personal property taxes	\$ 21,949	21,949				
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$ 1,022,715</b>	<b>1,022,715</b>				

\* 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	(Specify)
Waste Removal	\$ 34,200		
Snow Removal	\$ 17,609		
<b>Total Other Repairs and Maintenance</b>	\$ 51,810	\$ -	\$ -

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### Depreciation Schedule

Name of Facility Manchester Manor Health Care Center			License No. 2237-C			Report for Year Ended 9/30/2019			Page 23	of 37	
Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals			
<b>A. Land Improvements</b>											
1. Acquired prior to this report period	397,907		397,907	293,507			8,979				
2. Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)											
A-4. Subtotal									8,979		
<b>B. Building and Building Improvements</b>											
1. Acquired prior to this report period											
2. Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)											
B-4. Subtotal											
<b>C. Non-Movable Equipment</b>											
1. Acquired prior to this report period	687,594		687,594	250,366			39,125				
2. Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)	36,113										
C-4. Subtotal									39,125		
	Is a mileage logbook maintained?	Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year							
<b>D. Movable Equipment</b>											
1. Motor Vehicles (Specify name, model and year of each vehicle)											
a.											
b.											
c.											
d.											
2. Movable Equipment											
a. Acquired prior to this report period											
b. Disposals (attach schedule)											
c. Acquired during this report period (attach schedule)											
D-3. Subtotal											
<b>E. Total Depreciation</b>											

Manchester Manor Health Care Center  
9/30/2019

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

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

\*Ties to Page 23, Line A3

\*\*Ties to Page 23, Line A2

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

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

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

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

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
11/1/2018	Steamcraft Ultra 5 Convection Steamer	\$ 15,657	10	
11/1/2018	Ice Machine	\$ 2,673	10	
4/30/2019	Air Handler and Condensing Unit	\$ 7,467	10	
6/14/2019	C-9 Air Handler and Condensing Unit	\$ 10,316	10	
<b>Total additions for Non-Movable Equipment</b>		\$ 36,113		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ - **

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2

## Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
5/31/2019	Windows 10 Computers	\$ 11,218	5	
<b>Total additions for Movable Equipment</b>		\$ 11,218		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Movable Equipment</b>		\$ -		\$ - **

\*Ties to Page 23, Line D2c

\*\*Ties to Page 23, Line D2b

## Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
6/30/2019	13 Sprinkler Pendants	\$ 1,935	15	
9/27/2019	Antifreeze Loop Backflow	\$ 4,879	10	
9/1/2019	Vinyl Flooring Rm 1020	\$ 880	10	
9/12/2019	Vinyl Flooring Rm 1004	\$ 885	10	
9/17/2019	Vinyl Flooring Rm 1017	\$ 885	10	
9/19/2019	Vinyl Flooring Rm 1021	\$ 880	10	
1/1/2019	Gutters	\$ 16,000	15	
7/23/2019	Awning	\$ 5,248	10	
<b>Total additions for Leasehold Improvement</b>		\$ 31,592		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Amortization Schedule\***

Name of Facility			License No.		Report for Year Ended			Page	of
Manchester Manor Health Care Center			2237-C		9/30/2019			24	37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period	Var	Var	Var	6,246,337	2,717,067			174,664	
2. Disposals (attach schedule)	Var	Var	Var						
3. Acquired during this report period (attach schedule)				31,592					
C-4. Subtotal									174,664
<b>D. Total Amortization</b>									174,664

\* 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 Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2019	Page 25	of 37
<b>11. Property Questionnaire</b>				
<b>Part A</b>				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description	Total			
1. Date Land Purchased	01/01/70			
2. Date Structure Completed	01/01/70			
3. If <b>NOT</b> Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	126			
6. Square Footage	42,099			
7. Acquisition Cost				
a. Land	42,000			
b. Building	424,160			
<b>Part B - Owner and Related Parties</b>	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Variable			
b. Date Mortgage Obtained	08/23/11			
c. Interest Rate for the Cost Year	Libor + 2%			
d. Term of Mortgage (number of years)	20			
e. Amount of Principal Borrowed	1,800,000			
f. Principal balance outstanding as of				
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
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				
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

**Note:** Be sure required copies of leases are attached to Page 25 and real estate taxes paid by lessor are included on Page 22, Item 10b.

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

Name of Facility		License No.	Report for Year Ended			Page	of
Manchester Manor Health Care Center		2237-C	9/30/2019			26	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. <b>Total Building Interest Expense</b> (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		Page	of
Manchester Manor Health Care Ce		2237-C		9/30/2019		27	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)				\$	1,213	1,213	
Vendor Interest							
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>				\$	1,213	1,213	
14. Insurance							
a. Insurance on Property (buildings only)				\$	51,070	51,070	
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$			
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$	51,070	51,070	
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$	13,332,903	13,332,903	

### D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Manchester Manor Health Care Center				2237-C	9/30/2019	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.	13	B10	Occupational Therapy	\$ 525,668	525,668		
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 84,142	84,142		
10.	15	1d	Accounting	\$ 2,000	2,000		
10a.			Legal	\$ 5,624	5,624		
11.	30	IV3	Telephone	\$ 741	741		
12.	15	1h2	Cellular Telephone	\$ 6,250	6,250		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	L3	Gifts, flowers and coffee shops	\$ 41,100	41,100		
15.	16	15	Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$ 9,457	9,457		
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	16	Automobile Expense (e.g. personal use)	\$ 1,763	1,763		
18.	16	m3	Unallowable Advertising *	\$ 22,900	22,900		
19.	15	k2	Income Tax / Corporate Business Tax	\$ 250	250		
20.	16	m10	Fund Raising / Contributions	\$ 781	781		
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 2,320	2,320		
<b>Page 18 - Dietary Expenditures</b>							
24.	30	IV8	Meals to employees, guests and others who are not residents	\$ 5,398	5,398		
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 708,393	708,393		

\* 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)
<b>Total Other Salaries Adjustment</b>			\$ -	\$ -	\$ -

**Schedule of Fees Adjustments**

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

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m8a	Chamber of Commerce Dues	\$ 233		
16	m13	Prof Services - Collections	\$ 490		
30	IV4	Rental of TV Income	\$ 1,598		
<b>Total Other A&amp;G Adjustments</b>			\$ 2,320	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
Manchester Manor Health Care Center				2237-C	9/30/2019	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 708,393	708,393		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5a2	Prescription Drugs	\$ 303,400	303,400		
28.			Ambulance/Limousine	\$			
29.	20	5f	X-rays, etc	\$ 3,262	3,262		
30.			Laboratory	\$			
31.	20	5c	Medical Supplies	\$ 102,881	102,881		
32.	20	5e2	Oxygen (non emergency)	\$ 87,470	87,470		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 15,322	15,322		
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$			
43.	30	IV5	Interest Income on Account Rec.	\$ 42	42		
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 1,220,771	1,220,771		

\*\*\* 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.

Manchester Manor Health Care Center  
9/30/2019

**Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Supplies - Rehabilitative	\$ 15,322		
<b>Total Other Ancillary Costs</b>			\$ 15,322	\$ -	\$ -

**Schedule of Excess Movable Equipment Depreciation**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Excess Movable Equipment Depreciation</b>			\$ -	\$ -	\$ -

**Schedule of Other Property Adjustments**

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

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

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Unallowable Building Interest</b>			\$ -	\$ -	\$ -

## F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Manchester Manor Health Care Center	2237-C	9/30/2019			30	37
Item	Total	CCNH	RHNS	(Specify)		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 10,902,172	10,902,172				
b. Medicaid Room and Board Contractual Allowance **	\$ (5,455,559)	(5,455,559)				
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 2,809,618	2,809,618				
b. Medicare Room and Board Contractual Allowance **	\$ 564,084	564,084				
4. a. Private-Pay Residents and Other	\$ 5,340,038	5,340,038				
b. Private-Pay Room and Board Contractual Allowance **	\$ (253,522)	(253,522)				
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 174,874	174,874				
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$ 172,322	172,322				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$ 26	26				
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$ 751,274	751,274				
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$ 372,317	372,317				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (19,380)	(19,380)				
4. a. Speech Therapy - Medicare	\$ 125,616	125,616				
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$ 87,361	87,361				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 777,540	777,540				
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$ 402,775	402,775				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other ( <i>Specify</i> ) - Medicare	\$ (1,524,596)	(1,524,596)				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ (885,013)	(885,013)				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 14,341,947	14,341,947				
<b>IV. Other Revenue*</b>						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$ 741	741				
4. Rental of Television and Cable Services	\$ 1,598	1,598				
5. Interest Income ( <i>Specify</i> )	\$ 42	42				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$ 265	265				
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 2,646	2,646				
<b>VI. Total All Revenue</b> (III +V)	\$ 14,344,593	14,344,593				

\* 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)
	Med A & Med B Ancillaries	\$ 214,485		
	Med A & Med B Contractual Allowances	\$ (1,739,080)		
<b>Total Other Resident Revenue - Medicare</b>		<b>\$ (1,524,596)</b>	<b>\$ -</b>	<b>\$ -</b>

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

**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
	Managed Care Ancillaries	\$ 133,313		
	Managed Care Contractual Allowances	\$ (1,018,325)		
	Medicaid Ancillary Contractual Allowance			
<b>Total Other Resident Revenue</b>		<b>\$ (885,013)</b>	<b>\$ -</b>	<b>\$ -</b>

**Interest Income**

**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30 A1	Interest Income - Reserves		\$ 24		
30 A2	Interest Income - AR		\$ 18		
<b>Total Interest Income</b>			<b>\$ 42</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
18 2 d	Vending Income	\$ 5,398		
	Dividend Income	\$ 8,832		
	Miscellaneous Income	\$ 880		
	Gain/Loss on Sale of Fixed Assets	\$ (14,845)		
<b>Total Other Revenue</b>		<b>\$ 265</b>	<b>\$ -</b>	<b>\$ -</b>

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Manchester Manor Health Care Center	2237-C	9/30/2019	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	922,071
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,025,732
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	51,173
a. _____				
b. _____				
c. _____				
d. See Schedule		51,173		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	17,533
_____				
_____				
See Schedule		17,533		
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	2,016,509
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	397,907		
	Accum. Depreciation	302,486	Net	95,421
3. Buildings	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	
4. Leasehold Improvements	*Historical Cost	6,277,929		
	Accum. Depreciation	2,891,732	Net	3,386,197
5. Non-Movable Equipment	*Historical Cost	723,706		
	Accum. Depreciation	289,490	Net	434,216
6. Movable Equipment	*Historical Cost	960,204		
	Accum. Depreciation	884,023	Net	76,182
7. Motor Vehicles	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
_____				
See Schedule				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	3,992,016

\* 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 Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2019	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	6,008,525
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 <b>Total Leasehold or Like Properties</b> (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 ( <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> )			\$	
_____				
_____				
See Schedule				
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$	6,008,525

\* 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 Manchester Manor Health Care Center		License No. 2237-C	Report for Year Ended 9/30/2019	Page 33	of 37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	776,029
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> )				\$	309,670
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> )				\$	112,479
_____					
_____					
See Schedule					112,479
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>				\$	<b>1,198,178</b>

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

(Carry Total forward to next page)

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

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2019	Page 34	of 37
Account				Amount
Total Brought Forward:				1,198,178
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 1,198,178

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

Name of Facility	License No.	Report for Year Ended	Page	of
Manchester Manor Health Care Center	2237-C	9/30/2019	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
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>B. Net Worth</b>				
1. Owner's Capital			\$	3,798,657
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	
6. Gain or Loss for Period			\$	1,011,690
	10/1/2018	thru 9/30/2019		
7. Total Net Worth			\$	4,810,347
<b>C. Total Reserves and Net Worth</b>			\$	4,810,347
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	6,008,525

### H. Changes in Total Net Worth

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2019	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2018			\$	6,822,528
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$	14,344,593
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$	13,332,903
D. Net Income or Deficit			\$	1,011,690
E. Balance			\$	7,834,218
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. <b>Balance at End of Period</b>			\$	7,834,218
				09/30/19

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

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2019	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
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				