State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2018

Name of Facility (as licensed) Greentree Manor & Nursing Rehabilitation Center		
Address (No. & Street, City, State, Zip Code) 4 Greentree Drive, Waterford, CT 06385		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☑ Other		
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018	

License Numbers:	CCNH	RHNS	Other	Medicare Provider
	842C			07-5113A

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	8425		

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)	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitation Center	842C	9/30/2018	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Greentree Manor & Nursing Rehabilitation Center [facility name], for the cost report period beginning October 1, 2017 and ending September 30, 2018, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Ted Vinci			Printed Name (Owner) Martin Sbriglio	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Greentree Manor & Nursing Rehabilitation Center	Period Covered:		From 10/1/2017	To 9/30/2018
Address of Facility 4 Greentree Drive, Waterford, CT 06385				
Report Prepared By Ryders Health Management	Phone Number 203-381-1327		Date 2/12/2019	

Item	Total	CCNH	RHNS	Other
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.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-381-1327	9/30/2018	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Greentree Manor & Nursing Rehabilitation Center	4 Greentree Drive, Waterford, CT 06385

	CCNH	RHNS	Other	Medicare Provider No.
License Numbers:	842C			07-5113A

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Ted Vinci	

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

Name	License No.:
N/A	

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
N/A		

Name of Partners/Members	Business Address	Title	% Owned
N/A			

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Greentree Manor Nursing & Rehabilitation Center	4 Greentree Drive, Waterford, CT 06385	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Martin Sbriglio, RN, NHA	4 Greentree Drive, Waterford, CT 06385	Owner	50
Robert Sbriglio, MD, MPH	4 Greentree Drive, Waterford, CT 06385	Owner	25
Kenneth Kopchik, MBA, NHA	4 Greentree Drive, Waterford, CT 06385	Owner	25
Names of Stockholders Owning at Least 10% of Shares			
Martin Sbriglio, RN, NHA	4 Greentree Drive, Waterford, CT 06385	Owner	50
Robert Sbriglio, MD, MPH	4 Greentree Drive, Waterford, CT 06385	Owner	25
Kenneth Kopchik, MBA, NHA	4 Greentree Drive, Waterford, CT 06385	Owner	25

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitation Center	842C	9/30/2018	3B	37

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

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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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	%**				
Ryders Health Management	88 Ryders Lane, Stratford, CT 06614	○	⊙		Financial and Management Support	16, m12	280,674	280,674
Greentree Properties	4 Greentree Dr., Waterford, CT 06385	○	⊙		Rental of Real Estate	22/9	600,000	600,000
attachment in balance sheet pages	Various	○	⊙		Loans to/from facililties	Pgs 31-34	See detail in b	See detail in balance she
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

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

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

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

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

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

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

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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
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
GE Capital, PO Box 642111, Pittsburgh, PA 15264-2111	○	⊙	Copier and printers	03/18/15	60 months	8,869	8,869
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
						Total ***	8,869

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

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
** Attach copies of newly acquired leases.
*** Amount should agree to Page 22, Line 6e.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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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	Address (No. & Street, City, State, Zip Code)
1 Marcum, LLP	555 Long Wharf Drive, New Haven, CT 06511
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Financial statements, tax returns, reimbursement representation	$ 14,318
2		$
3		$
4		$
		Charge for Services Provided $ 14,318

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

⊙ Yes ○ No Page 15, line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Kainen, Escalara & McHale	
2 Joe D'Agostino	
3 Murtha Cullina	
4 Seiger Gfeller Laurie LLP	
5 Misc	

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	Hench Case - disallow	$ 30,256
2	Corporate matters - disallow	$ 1,950
3	Health care regulatory matters, general matters	$ 11,773
4	Collections - disallow	$ 1,404
5	CHUBB, Treasurer, State of CT - disallow	$ 13,991
		Charge for Services Provided $ 59,374

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

⊙ Yes ○ No Page 15, line 1e

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total Other	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Other	Total	CCNH	RHNS	Other
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	90	90			90	90			90	90		
B. On last day of THIS report period	90	90			90	90			90	90		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	83	83			83	83			87	87		
B. As of midnight of THIS report period	87	87			87	87			87	87		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,099	2,099			1,599	1,599			500	500		
B. Medicaid (Conn.)	21,889	21,889			16,242	16,242			5,647	5,647		
C. Medicaid (other states)												
D. Private Pay	3,177	3,177			2,440	2,440			737	737		
E. State SSI for RCH												
F. Other (Specify)	2,205	2,205			1,566	1,566			639	639		
G. Total Care Days During Period (3A thru F)	29,370	29,370			21,847	21,847			7,523	7,523		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	384	384			303	303			81	81		
B. Other Bed Reserve Days	6	6			3	3			3	3		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	29,760	29,760			22,153	22,153			7,607	7,607		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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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	Other	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Other	

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	Other
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	Other	R.C.H.	ICF-MR
No. of Residents	7	64		16				
Per Diem Rate								
a. One bed rm.	Various	224.73		476 - 461				
b. Two bed rms.				455 - 426				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	Other
A. Medicare - Part B	1,583	1,583		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	9,938	9,938		
D. ***Total Physical Therapy Treatments***	11,521	11,521		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	186	186		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	358	358		
D. ***Total Speech Therapy Treatments***	544	544		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,281	2,281		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	11,590	11,590		
D. ***Total Occupational Therapy Treatments***	13,871	13,871		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Other	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)	108,011	2,332				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	217,186	11,655				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	58,066	2,117				
c. Dietary Workers	339,867	16,275				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	181,475	22,804				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	51,117	2,101				
b. Other Maintenance Workers	47,526	3,084				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	29,341	1,828				
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	99,237	2,242				
b. RN						
1. Direct Care	675,412	19,474				
2. Administrative**	206,267	5,912				
c. LPN						
1. Direct Care	777,071	28,618				
2. Administrative**						
d. Aides and Attendants	1,263,174	85,190				
e. Physical Therapists	-128					
f. Speech Therapists						
g. Occupational Therapists	-102					
h. Recreation Workers	86,125	4,130				
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	81,423	3,180				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	4,221,069	210,944				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		Other	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		Other	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Therapy Management Consultant	$ (600)					
Managed Care Consulting	$ 5,966	80				
Total	$ 5,366	80	$ -	-	$ -	-

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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
Greentree Manor & Nursing Rehabilitation Center	842C	9/30/2018	11	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Other							
Section I - Operators/Owners										
Martin Sbriglio, RN, NHA								Ryders Health Management, 88 Ryders Lane, Stratford, CT 06614	2,118	130,000
Robert Sbriglio, MD, MPH								Lord Chamberlain, 7003 Main St., Stratford, CT 06614	2,012	130,000
Kenneth Kopchik, MBA, NHA								Mystic Healthcare, 475 High St., Mystic, CT 06355	2,175	115,052
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).										
Mrs. Margaret Sbriglio, NHA								Ryders Health Management, 88 Ryders Lane, Stratford, CT 06614	1,052	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.

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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
Greentree Manor & Nursing Rehabilitation Center	842C	9/30/2018	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Other							
Section III - Administrators* **										
Alan Bates - 10/1/17 - 5/30/18	75,211			Non Discriminatory	Administrative	1,677	A2			
Ted Vinci - 5/31/18 - 9/30/18	32,800			Non Discriminatory	Administrative	655	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.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitation Center	842C	9/30/2018	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Other	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	4,712	94				
3. Pharmacist	4,399	88				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	217,404	4,348				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	49,200	490				
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	400	4				
9. Speech Therapist						
a. Resident Care	30,123	602				
b. Other						
10. Occupational Therapist						
a. Resident Care	271,984	5,440				
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	5,366	80				
B-13 Total Fees Paid in Lieu of Salaries	583,588	11,146				

* 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitation Center	842C	9/30/2018	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Healthdrive Dental, 888 Worchester St., Wellesley MA 02482	Dental Consultant	○	⊙	
Dr. Lauren Doherty, IPC Hospialists of New England, PO Box 92284, Los Angeles, CA 90009	Medical Director, Medical Staff	○	⊙	
Dr. Willia Coleman, PO Box 2081, Salem, CT 06420	Medical Staff	○	⊙	
Dr. Michael Feltes, 31 Vauxhall St., New London, CT 06320	Medical Staff	○	⊙	
Dr. John Figueiredo, 1973 Highland Ave., Cheshire, CT 06410	Medical Staff	○	⊙	
Patricia Halvordson, 287 Judd Ave., Mystic, CT 06355	Dietician	○	⊙	
HealthPro, 307 International Circle, Suite 100, Hunt Valley, MD 21030	PT, ST, OT & Therapy Consultant	○	⊙	
Laura Clark, 122 Chestnut Hill Rd., Colchester, CT 06415	MDS Consultant	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitation Cente	842C	9/30/2018	15	37

Item		Total	CCNH	RHNS	Other
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	211,197	211,197		
2. Disability Insurance	$				
3. Unemployment Insurance	$				
4. Social Security (F.I.C.A.)	$	382,746	382,746		
5. Health Insurance	$	308,283	308,283		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	6,709	6,709		
(not-owners and not-operators)					
8. Uniform Allowance	$	18,853	18,853		
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	96,136	96,136		
d. Accounting and Auditing	$	14,318	14,318		
e. Legal (*Services should be fully described on Page 7)*	$	59,374	59,374		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	14,324	14,324		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	20,043	20,043		
2. Cellular Phones	$	1,675	1,675		
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	$	546,583	546,583		
Subtotal	$	1,680,492	1,680,492		

* 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**

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Other
Total	$ -	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	Other
Total	$ -	$ -	$ -

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitation Center	842C	9/30/2018	16	37

Item		Total	CCNH	RHNS	Other
Subtotals Brought Forward:		1,680,492	1,680,492		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	10	10		
2. Holiday Parties for Staff	$	7,279	7,279		
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	6,352	6,352		
5. Education Expenses Related to Seminars and Conventions	$	5,374	5,374		
6. Automobile Expense (*not purchase or depreciation*)	$	56	56		
7. Other (*Specify*)	$	4,283	4,283		
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	6,231	6,231		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	14,801	14,801		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$	12,960	12,960		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$	14	14		
7. Postage	$	4,387	4,387		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	7,464	7,464		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	1,185	1,185		
10. Contributions*** See Attached Schedule	$	250	250		
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	73,401	73,401		
12. Administrative Management Services**	$	280,674	280,674		
13. Other (*Specify*) See Attached Schedule	$	38,467	38,467		
C-14 Total Administrative & General Expenditures	$	2,143,680	2,143,680		

* 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	Other
Meals & Entertainment	$ 4,283		
Total Other Travel and Entertainment	$ 4,283	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	Other
Adv & Pub Rel Donations	$ 14,801		
Total Other Advertising	$ 14,801	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	Other
CAHCF	$ 6,842		
COC	$ 533		
ICNC	$ 40		
American Express	$ 49		
Total Dues	$ 7,464	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	Other
Donations	$ 250		
Total Contributions	$ 250	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	Other
Fees & Licenses	$ 4,598		
Physician Care - Employees	$ 17,659		
Bank Charges	$ 4,150		
Bank Charges Lease	$ 509		
Fines & Penalties	$ 9,660		
Unemployment tax management	$ 1,478		
A/R assistance - not collections	$ 413		
Total Other Administrative and General	$ 38,467	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
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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	280,674	Financial and Managerial Support	Page 16, Line 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.**

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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
Greentree Manor & Nursing Rehabilitation Center	842C	9/30/2018	18 | 37

Item		Total	CCNH	RHNS	Other
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	182,713	182,713		
2. Non-Food Supplies	$	22,372	22,372		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	205,085	205,085		

2F. Dietary Questionnaire	Total	CCNH	RHNS	Other
G. Resident Meals: Total no. of meals served per day:*				

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Greentree Manor & Nursing Rehabilitation Center	842C	9/30/2018	19 | 37

Item		Total	CCNH	RHNS	Other
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. $	370	370		
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)*	$	90,211	90,211		
c. Other (*Specify*) Laundry Supplies	$	5,976	5,976		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	96,557	96,557		

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

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

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

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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
Greentree Manor & Nursing Rehabilitation Cen	842C	9/30/2018	20	37

Item			Total	CCNH	RHNS	Other
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	35,793	35,793		
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	35,793	35,793		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	137,651	137,651		
b. Medicine Cabinet Drugs		$	46,600	46,600		
c. Medical and Therapeutic Supplies		$				
d. Ambulance/Limousine***		$	19,482	19,482		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	24,292	24,292		
f. X-rays and Related Radiological Procedures***		$	8,139	8,139		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	28,395	28,395		
i. Recreation		$	16,957	16,957		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	300,008	300,008		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	581,524	581,524		

* 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	Other
Physician Care Patients	$ 17,934		
Medical Supplies	$ 204,965		
Medical Supplements	$ 31,844		
Medical Waste	$ (193)		
Medical Equipment	$ 3,412		
Medical Equipment Rental	$ 22,211		
Medical Supplies - medicare	$ 399		
Therapy Equipment	$ 4,145		
OT - Part A	$ 379		
OT - Managed Care	$ 217		
PT Supplies	$ 14,135		
OT Supplies	$ 561		
Total Other Resident Care	$ 300,008	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitation Center	842C	9/30/2018	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	Other	Pg	Line
ADP	1 ADP Plaza, Milford, CT 06460	○	⊙		Payroll processing services	21,313			16	m11
Point Click Care	PO Box 8500, Philadelphia, PA 19178	○	⊙		Computer software support services	18,875			16	m11
Allwaste, Inc	PO Box 2472, Hartford, CT 06146	○	⊙		Disposal of garbage	20,100			22	6a
United Textile Rental Services	Pkwy, Mt Vernon, NY 10550-1724	○	⊙		Laundry Services	87,690			19	3b
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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).

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

Name of Facility	License No.	Report for Year Ended	Page of
Greentree Manor & Nursing Rehabilitation Ce	842C	9/30/2018	22 | 37

Item		Total	CCNH	RHNS	Other
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	123,226	123,226		
b. Heat	$	53,231	53,231		
c. Light & Power	$	88,135	88,135		
d. Water	$	42,882	42,882		
e. Equipment Lease (*Provide detail on page 6*)	$	8,869	8,869		
f. Other (*itemize*)	$				
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	316,342	316,342		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	187,565	187,565		
c. Non-Movable Equipment	$	11,642	11,642		
d. Movable Equipment	$	7,116	7,116		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	206,323	206,323		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$				
9. Rental payments on leased real property less real estate taxes included in item 10b	$	600,000	600,000		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	69,668	69,668		
c. Personal property taxes	$	5,070	5,070		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	881,061	881,061		

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

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitation Center	842C	9/30/2018	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	7,214,399		7,214,399	2,800,384	S/L	Various	187,565	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								187,565
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	402,989		402,989	378,167	S/L	Various	7,736	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	39,057		39,057		S/L	Various	3,906	
C-4. Subtotal								11,642

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.		X	10	2003	37,699		37,699	37,699				
b.		X	5	1998	28,601		28,601	28,601				
c.		X	12	2008	31,531		31,531	31,531				
d.		X	11	2010	3,000		3,000	3,000				
2. Movable Equipment												
a. Acquired prior to this report period					522,967		522,967	498,452	S/L	Various	3,066	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					20,251		20,251		S/L	Various	4,050	
D-3. Subtotal												7,116
E. ***Total Depreciation***												206,323

Schedule of Land Improvements Acquired during this report period

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

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

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

Schedule of Building Improvements Acquired during this report period

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

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

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

Schedule of Non-Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
4/1/2018	Generator transfer switch	$ 13,334	10	$ 1,333	
4/1/2018	Phone equip	$ 1,859	10	$ 186	
5/1/2018	Transfer switch	$ 13,366	10	$ 1,337	
5/1/2018	Washers	$ 4,507	10	$ 451	
5/1/2018	Circulator	4205.28	10	$ 421	
8/1/2018	HVAC	1786.16	10	$ 179	
Total additions for Non-Movable Equipmen		$ 39,057		$ 3,906	*
Deletions:					

Total deletions for Non-Movable Equipmen		$ -		$ -	**

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

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

Schedule of Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/1/2017	Telehealth	$ 828	5	$ 166	
10/1/2017	Storage cart	$ 42	5	$ 8	
6/1/2018	Finger scan & time clock	$ 4,279	5	$ 856	
6/1/2018	Website development	$ 516	5	$ 103	
8/1/2018	Website development	$ 516	5	$ 103	
8/1/2018	Finger scan & time clock	$ 1,721	5	$ 344	
9/1/2018	Website development	$ 551	5	$ 110	
9/1/2018	Website development	$ 516	5	$ 103	
9/1/2018	Finger scan & time clock	$ 533	5	$ 107	
12/1/2017	Lift & Scale	$ 2,522	5	$ 504	
1/1/2018	Bed	2510.36	5	$ 502	
10/1/2017	Lift & Scale	1739.89	5	$ 348	
6/1/2018	Telehealth	833.84	5	$ 167	
9/1/2018	Beds	3141.52	5	$ 628	
Total additions for Movable Equipmen		$ 20,251	5	$ 4,050	*
Deletions:					
Total deletions for Movable Equipmen		$ -		$ -	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report peri

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

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
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Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1. Goodwill	5	1998	15 Years	50,000	16,534				
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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilita	842C	9/30/2018	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	05/04/98
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	90
6. Square Footage	25,029
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Variable	Variable		
b. Date Mortgage Obtained	04/26/11	07/18/13		
c. Interest Rate for the Cost Year	Variable	Variable		
d. Term of Mortgage (number of years)	10 Years	5 Years		
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Greentree Manor & Nursing Rehabili	842C	9/30/2018	26 | 37

Item		Total	CCNH	RHNS	Other
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*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Greentree Manor & Nursing Rehabi	842C	9/30/2018	27 | 37

Item	Total	CCNH	RHNS	Other
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*) $	2,496	2,496		
Interest Expense				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	2,496	2,496		
14. Insurance				
a. Insurance on Property (buildings only) $	12,814	12,814		
b. Insurance on Automobiles $	1,435	1,435		
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	47,843	47,843		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	62,092	62,092		
15. ***Total All Expenditures (A-13 thru C-14)*** $	9,129,288	9,129,288		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Greentree Manor & Nursing Rehabilitation Center	842C	9/30/2018	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $				
10.			Accounting $				
10a.			Legal $				
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.			Unallowable Advertising * $				
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $				
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $				
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $				

* 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	Other
Total Other Salaries Adjustment			$ -	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Other Fees Adjustments			$ -	$ -	$ -

Schedule of Other A&G Adjustments

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Greentree Manor & Nursing Rehabilitation Center	842C	9/30/2018	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
			Subtotals Brought Forward $				
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $				
28.			Ambulance/Limousine $				
29.			X-rays, etc $				
30.			Laboratory $				
31.			Medical Supplies $				
32.			Oxygen (non emergency) $				
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $				
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			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)***			$				

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

Attachment Page 29

Schedule of Other Ancillary Costs

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

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Other Property Adjustments			$ -	$ -	$ -

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Other Adjustments			$ -	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitatio	842C	9/30/2018	30	37

Item		Total	CCNH	RHNS	Other
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	8,523,468	8,523,468		
b. Medicaid Room and Board Contractual Allowance **	$	(4,062,229)	(4,062,229)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	886,766	886,766		
b. Medicare Room and Board Contractual Allowance **	$	355,087	355,087		
4. a. Private-Pay Residents and Other	$	2,955,070	2,955,070		
b. Private-Pay Room and Board Contractual Allowance **	$	(772,180)	(772,180)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	112,358	112,358		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(112,358)	(112,358)		
c. Prescription Drugs - Non-Medicare	$	65,883	65,883		
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	$	191,423	191,423		
b. Physical Therapy - Medicare Contractual Allowance **	$	(191,423)	(191,423)		
c. Physical Therapy - Non-Medicare	$	228,340	228,340		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	14,861	14,861		
b. Speech Therapy - Medicare Contractual Allowance **	$	(14,861)	(14,861)		
c. Speech Therapy - Non-Medicare	$	35,336	35,336		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	233,260	233,260		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(233,260)	(233,260)		
c. Occupational Therapy - Non-Medicare	$	291,598	291,598		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	0	0		
b. Other *(Specify)* - Non-Medicare	$	5,920	5,920		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	8,513,059	8,513,059		
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 *(Specify)*	$	12	12		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	7,000	7,000		
V. Total Other Revenue (1 thru 8)	$	7,012	7,012		
VI. Total All Revenue (III +V)	$	8,520,071	8,520,071		

* *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	Other
	Oxygen - Med A	$ 5,144		
	X-Ray - Med A	$ 6,071		
	Lab - Med A	$ 25,048		
	Contractuals	$ (36,262)		
Total Other Resident Revenue - Medicare		$ 0	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Other
	X-Ray - Managed Care	$ 943		
	Oxygen - Private	$ 68		
	Oxygen - managed Care	$ 1,039		
	Lab - Private Ins	$ 149		
	Lab - Managed Care	$ 3,721		
Total Other Resident Revenue		$ 5,920	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	Other
	Interest Income		$ 12		
Total Interest Income			$ 12	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Other
	Bad Debt Recovery	$ 7,000		
Total Other Revenue		$ 7,000	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitat	842C	9/30/2018	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 8,252
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 759,292
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 32,266
a. Prepaid Expenses		31,487		
b. Prepaid Insurance		778		
c.				
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 16,143
Medicaid Advances		12,810		
Refunds		3,333		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 815,952
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost	7,220,605		$ 4,232,654
	Accum. Depreciation	2,987,950	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	434,404		$ 44,595
	Accum. Depreciation	389,809	Net	
6. Movable Equipment	*Historical Cost	531,087		$ 25,872
	Accum. Depreciation	505,215	Net	
7. Motor Vehicles	*Historical Cost	100,831		$ 2,501
	Accum. Depreciation	98,330	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 19,774
Computer Software		19,774		
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 4,325,396

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitat	842C	9/30/2018	32	37

Account				Amount
		Total Brought Forward:	$	5,141,348
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	50,000		
	Accum. Depreciation	16,534 Net	$	33,466
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*)			$	379,975
See Schedule		379,975		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)			$	413,442
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$	5,554,790

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

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
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	
		Due from Aaron Manor	$ 2,510
		Due from Douglas Manor	$ 11,730
		Due from Lord Chamberlain	$ 546
		Due from Mystic Healthcare	$ 245,897
		Due from Ryders Health Management	$ 52,152
		Due from Lighthouse Home Health	$ 68,534
		Due from GT Realty	$ (1,394)
Total Other Assets			$ 379,975

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	
		Due to Aaron Manor	$ 80,839
		Due to Chamberlain Manor	$ 115,000
		Due to Cheshire House	$ 81,184
		Due to Lord Chamberlain	143110.84
		Due to Mystic Healthcare	24220.44
		Due to GT Realty	3205549.22
Total Other Current Liabilities (Itemize)			$ 3,649,904

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitation Ce	842C	9/30/2018	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 726,647
	2. Notes Payable (*itemize*)				$
	See Schedule				
	3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
	Name of Lender	Purpose	Amount	Date Due	
	4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 88,775
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$
	7. Medicare Final Settlement Payable				$
	8. Medicare Current Financing Payable				$
	9. Mortgage Payable (*Current Portion*)				$
	10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
	11. Accrued Income Taxes*				$
	12. Other Current Liabilities (*itemize*)				$ 521,000
	Patient Fund	17,566	Accrued PTO	79,278	
	Accrued Expense	54,312			
	Accrued User Fee	364,003			
	Aflac	5,840	See Schedule		
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 1,336,421

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitation C	842C	9/30/2018	34	37

Account	Amount
Total Brought Forward:	1,336,421
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ 280,000

Name and Address of Lender	Amount	Loan Date
Robert Sbriglio MD	140,000	
Martin Sbriglio	140,000	

4. Other Long-Term Liabilities (*itemize*)	$ 3,649,904
See Schedule 3,649,904	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 3,929,904
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 5,266,325

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

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilita	842C	9/30/2018	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$ 1,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 896,682
	6. Gain or Loss for Period 10/1/2017 thru 9/30/2018	$ (609,218)
	7. Total Net Worth	$ 288,464
C.	***Total Reserves and Net Worth***	$ 288,464
D.	***Total Liabilities, Reserves, and Net Worth***	$ 5,554,789

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitati	842C	9/30/2018	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2017			$ 897,682
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 8,520,071
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 9,129,288
D.	Net Income or Deficit			$ (609,217)
E.	Balance			$ 288,465
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period*** 09/30/18			$ 288,465

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitation	842C	9/30/2018	37	37

Check appropriate category

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

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

Addres Address	Phone Number
88 Ryders Lane, Stratford, CT 06614	203-381-1327