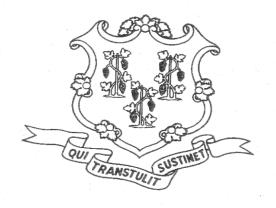
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2020

• `		fame of Facility (as licensed)									
Manchester Manor Health Care Center											
Address (No. & Street, C 385 West Center St., Ma	City, State, Z	(ip Code)									
Type of Facility											
Chronic and Convalescent ☑ Nursing Home only □ (CCNH)			Rest Home with Nursing Supervision only □ (Specify) (RHNS)								
Report for Year Beginning 10/1/2019			Report for Yea 9/30/2020	r Ending							
T. N. 1											
License Numbers: CCNH 2237-C			RHNS	RHNS (Specify)			Medicare Provider 07-5333				
Medicaid Provider Numb	bers:	CC 8417	NH	RH	INS	ICF-IID		F-IID			
For Department Use O	nly										
*	igned and Notarized	Date Received	Sequence N Assign		Signed a	nd Notarize	ed	Date Received			

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Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property Depreciation Schedule Amortization Schedule C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire C. Expenditures Other than Salaries (Cont'd) - Interest C. Expenditures Other than Salaries (Cont'd) - Interest C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance D. Adjustments to Statement of Expenditures D. Adjustments to Statement of Expenditures (Cont'd) F. Statement of Revenue G. Balance Sheet G. Balance Sheet (Cont'd)	C.	Expenditures Other than Salaries (Cont'd) - Dietary	18
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property Depreciation Schedule Amortization Schedule C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire C. Expenditures Other than Salaries (Cont'd) - Interest C. Expenditures Other than Salaries (Cont'd) - Interest C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance D. Adjustments to Statement of Expenditures D. Adjustments to Statement of Expenditures (Cont'd) F. Statement of Revenue G. Balance Sheet G. Balance Sheet (Cont'd)	C.	Expenditures Other than Salaries (Cont'd) - Laundry	19
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property Depreciation Schedule Amortization Schedule C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire C. Expenditures Other than Salaries (Cont'd) - Interest C. Expenditures Other than Salaries (Cont'd) - Interest C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance D. Adjustments to Statement of Expenditures D. Adjustments to Statement of Expenditures (Cont'd) F. Statement of Revenue G. Balance Sheet G. Balance Sheet (Cont'd)	C.	Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
C.Expenditures Other than Salaries (Cont'd) - Maintenance and Property22Depreciation Schedule23Amortization Schedule24C.Expenditures Other than Salaries (Cont'd) - Property Questionnaire25C.Expenditures Other than Salaries (Cont'd) - Interest26C.Expenditures Other than Salaries (Cont'd) - Interest and Insurance27D.Adjustments to Statement of Expenditures28D.Adjustments to Statement of Expenditures (Cont'd)29F.Statement of Revenue30G.Balance Sheet31G.Balance Sheet (Cont'd)32G.Balance Sheet (Cont'd)33G.Balance Sheet (Cont'd) - Reserves and Net Worth35H.Changes in Total Net Worth36		Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
Amortization Schedule C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire C. Expenditures Other than Salaries (Cont'd) - Interest C. Expenditures Other than Salaries (Cont'd) - Interest C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance D. Adjustments to Statement of Expenditures D. Adjustments to Statement of Expenditures Cont'd) F. Statement of Revenue 30 G. Balance Sheet 31 G. Balance Sheet (Cont'd) 32 G. Balance Sheet (Cont'd) 33 G. Balance Sheet (Cont'd) 33 G. Balance Sheet (Cont'd) 34 G. Balance Sheet (Cont'd) - Reserves and Net Worth 35 H. Changes in Total Net Worth	C.	Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
C.Expenditures Other than Salaries (Cont'd) - Property Questionnaire25C.Expenditures Other than Salaries (Cont'd) - Interest26C.Expenditures Other than Salaries (Cont'd) - Interest and Insurance27D.Adjustments to Statement of Expenditures28D.Adjustments to Statement of Expenditures (Cont'd)29F.Statement of Revenue30G.Balance Sheet31G.Balance Sheet (Cont'd)32G.Balance Sheet (Cont'd)33G.Balance Sheet (Cont'd)34G.Balance Sheet (Cont'd) - Reserves and Net Worth35H.Changes in Total Net Worth36		Depreciation Schedule	23
C.Expenditures Other than Salaries (Cont'd) - Interest26C.Expenditures Other than Salaries (Cont'd) - Interest and Insurance27D.Adjustments to Statement of Expenditures28D.Adjustments to Statement of Expenditures (Cont'd)29F.Statement of Revenue30G.Balance Sheet31G.Balance Sheet (Cont'd)32G.Balance Sheet (Cont'd)33G.Balance Sheet (Cont'd)34G.Balance Sheet (Cont'd) - Reserves and Net Worth35H.Changes in Total Net Worth36		Amortization Schedule	24
C.Expenditures Other than Salaries (Cont'd) - Interest and Insurance27D.Adjustments to Statement of Expenditures28D.Adjustments to Statement of Expenditures (Cont'd)29F.Statement of Revenue30G.Balance Sheet31G.Balance Sheet (Cont'd)32G.Balance Sheet (Cont'd)33G.Balance Sheet (Cont'd) - Reserves and Net Worth35H.Changes in Total Net Worth36	C.	Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
D.Adjustments to Statement of Expenditures28D.Adjustments to Statement of Expenditures (Cont'd)29F.Statement of Revenue30G.Balance Sheet31G.Balance Sheet (Cont'd)32G.Balance Sheet (Cont'd)33G.Balance Sheet (Cont'd)34G.Balance Sheet (Cont'd) - Reserves and Net Worth35H.Changes in Total Net Worth36	C.	Expenditures Other than Salaries (Cont'd) - Interest	26
D.Adjustments to Statement of Expenditures (Cont'd)29F.Statement of Revenue30G.Balance Sheet31G.Balance Sheet (Cont'd)32G.Balance Sheet (Cont'd)33G.Balance Sheet (Cont'd)34G.Balance Sheet (Cont'd) - Reserves and Net Worth35H.Changes in Total Net Worth36	C.	Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
F.Statement of Revenue30G.Balance Sheet31G.Balance Sheet (Cont'd)32G.Balance Sheet (Cont'd)33G.Balance Sheet (Cont'd)34G.Balance Sheet (Cont'd) - Reserves and Net Worth35H.Changes in Total Net Worth36	D.	Adjustments to Statement of Expenditures	28
G.Balance Sheet31G.Balance Sheet (Cont'd)32G.Balance Sheet (Cont'd)33G.Balance Sheet (Cont'd)34G.Balance Sheet (Cont'd) - Reserves and Net Worth35H.Changes in Total Net Worth36	D.	Adjustments to Statement of Expenditures (Cont'd)	29
G.Balance Sheet (Cont'd)32G.Balance Sheet (Cont'd)33G.Balance Sheet (Cont'd)34G.Balance Sheet (Cont'd) - Reserves and Net Worth35H.Changes in Total Net Worth36	F.	Statement of Revenue	30
G.Balance Sheet (Cont'd)33G.Balance Sheet (Cont'd)34G.Balance Sheet (Cont'd) - Reserves and Net Worth35H.Changes in Total Net Worth36	G.	Balance Sheet	31
G.Balance Sheet (Cont'd)34G.Balance Sheet (Cont'd) - Reserves and Net Worth35H.Changes in Total Net Worth36	G.	Balance Sheet (Cont'd)	32
G.Balance Sheet (Cont'd) - Reserves and Net Worth35H.Changes in Total Net Worth36	G.	Balance Sheet (Cont'd)	33
H. Changes in Total Net Worth 36	G.	Balance Sheet (Cont'd)	34
<u> </u>	G.	Balance Sheet (Cont'd) - Reserves and Net Worth	35
I. Preparer's/Reviewer's Certification 37	H.	Changes in Total Net Worth	36
	I.	Preparer's/Reviewer's Certification	37

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Manchester Manor Health Care Center	2237-C	9/30/2020	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 Manchester Manor Health Care Center [facility name], for the cost report period beginning October 1, 2019 and ending September 30, 2020, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)	orn State of	Date	Signed (Owner)	Date
Printed Name (Administrator)			Printed Name (Owner)	
Paul Liistro			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

Data Required for Real Wage Adjus		Page 1A	of 37		
Name of Facility	Period Covered:			From	То
Manchester Manor Health Care Center				10/1/2019	9/30/2020
Address of Facility					
385 West Center St., Manchester, CT 06040					
Report Prepared By		Phone Num		Date	
CJLC LLC		860-610-90	09	2/12/2021	
Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$				
2. Laundry wages paid	\$				
3. Housekeeping wages paid	\$				
4. Nursing wages paid	\$				
5. All other wages paid	\$				
6. Total Wages Paid	\$				
7. Total salaries paid	\$				
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire Type of Facility - Organization Structure

				cility	Report for Ye	ar Ended			of
N		860	-646-0129	0 (9/30/2020	. 7'	2		37
Name of Facility (as shown on license) Manchester Manor Health Care Center			,		Street, City, Sto St., Manchesto		040		
Manchester Manor Health Care Center	CCNH		RHNS	enter	(Specify)	er, C 1 00	Medicare F	Provid	ler No
License Numbers:	2237-C		KIINS		(Specify)		07-5333	10110	ici ivo.
Type of Facility (Check appropriate box(es							07 0000		
☐ Chronic and Convalescent Nursing Home only (CCNH)			t Home with			(Specify))		
Type of Ownership (Check appropriate box	.)								
O Proprietorship O LLC O	Partnership	0	Profit Corp.	0	Non-Profit Co	rp. O	Government	0	Trust
If this facility opened or closed during repo	rt year provid	e:		Date	e Opened	Date Clo	osed		
Has there been any change in ownership									
or operation during this report year?		0	Yes	•	No	If "Yes,"	explain full	y.	
Administrator					T				
Name of Administrator					Nursing Ho		521		
Paul Liistro					Administrat		531		
Other Operators/Owners who are assistant a	administrators	(ful	1 or part time	of th		NO.:			
Name	idiiiiiisti di Ois	(IuI	r or part time,	<i>)</i> 01 t1	License l	No.:			

CSP-3 Rev. 10/2005

General Information and Questionnaire Partners/Members

Name of Facility	G .	License No.	Report for Y	Page 3	of 37	
Manchester Manor Health Car	e Center	2237-C	9/30/2020	9/30/2020		
Legal Name of Part		Business		/or Town(s) in Registered		
Arbors of Hop Brook, Limited	Partnership	403 W Center S Manchester, C		СТ		
Name of Partners/Members	Business A	ddress		Title	% Ov	vned
Manchester Manor Three LLC	27 Hartford Turnpike, 06066	Vernon, CT	General Par	General Partner		
Paul Liistro	385 West Center St., N 06040	Manchester, CT	Limited Par	Limited Partner		
Brian Liistro	385 West Center St., N 06040	Manchester, CT	Limited Par	tner	39	.5

CSP-3A Rev. 10/2005

General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Yea	r Ended	Page	of		
Manchester Manor Health Care Center	2237-C	9/30/2020		3A	37		
If this facility is owned or operated as a corp	ooration, provide	the following info	rmation:				
Legal Name of Corporation	Busir	ness Address	State(s) in W	State(s) in Which Incorporated			
Name of Directors, Officers	Busir	ness Address	Title	No. Sl			
,				Held by	y Each		
N/A							
IVA							
Names of Stockholders Owning at Least							
10% of Shares							
	+						
	+						
	1						

CSP-3B Rev. 10/2005

General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page of
Manchester Manor Health Care Center	2237-C	9/30/2020	3B 37
If this facility is owned or operated as an individ	ual proprietorship, j	provide the following inform	ation:
0	wner(s) of Facility		
N/A			

General Information and Questionnaire Related Parties*

Name of Facility		License			Report for Year Ended		Page	of
Manchester Manor Heal	th Care Center		2237-C	i	9/30/2020		4	37
	eiving compensation from the far rol, ownership, family or busine	•		_	Yes • No	If "Yes," provide the complete the inform		
including the rental of prelated through family a	ompanies which provide goods roperty or the loaning of funds t ssociation, common ownership, owners, operators, or officials of	o this fa	icility, , or busi	ness	• Yes • No	If "Yes," provide th	ne following	information:
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties Yes No %**			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
Manchester Manor Realty, LLP	385 West Center St., Manchester, CT 06040	0	•		Rent	22/9	543,761	543,761
Vernon Manor Health Care	180 Regan Road, Vernon, CT 06066 403 West center St, Manchester, CT	0	•		Shared Office Staff	10/A4	57,509	57,509
Arbors of Hop Brook	06040	0	•		Common Pension Plan	15 / 1A7	75,773	75,773
Arbors of Hop Brook	403 West center St, Manchester, CT 06040	0	•		Shared Insurance Plan	15/1A5	452,384	452,384
Vernon Manor Health Care Center	180 Regan Road, Vernon, CT 06066	0	•		Shared Operational Staff	10/12	16,615	16,615
		0	•					
		0	•					
		0	•					
		0	•					

^{*} 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

· · · · · · · · · · · · · · · · · · ·	License No).	Report for Year Ended	Page	OI
Manchester Manor Health Care Center	2237-0		9/30/2020	5	37
If the facility is licensed as CDH and/or RCH o	r provides A	AIDS or TB	I services with special Medicai	id rates,	costs
must be allocated to CCNH and RHNS as follow	ws:		-		
Item			Method of Allocation	<u></u>	
Dietary		Number of	meals served to residents		
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					
Manchester Manor Health Care Center 2237-C 9/30/2020 5 37 If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows: Item					
• •	Number of	hours of routine care provided	by EA	СН	
Nursing		employee o	classification, i.e., Director (or	Charge	Nurse),
		Registered	Nurses, Licensed Practical Nu	rses, Ai	des and
	ter 2237-C 9/30/2020 5 37 d/or RCH or provides AIDS or TBI services with special Medicaid rates, costs NS as follows: Method of Allocation				
Direct Resident Care Consultants		Number of	hours of resident care provide	d by EA	СH
		specialist	(See listing page 13)	•	
Property costs (depreciation)		Square feet	t		
Employee health and welfare		Gross salar	ries		
Management services Appropriate cost center involved					
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 foll	owing ques	tions applic	able to the cost information pro	ovided.	
1. In the preparation of this Report, were all	O 1/	0 N	If "No," explain fully why suc	h alloca	ation was
In the preparation of this Report, were all O Ves O No. If "No," explain fully why such allocation was					
Aundry Housekeeping Number of pounds processed Number of square feet serviced 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 espacialist (See listing page 13) Maintenance and operation of plant Square feet Property costs (depreciation) Supply Employee health and welfare 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. I. In the preparation of his Report, were all costs allocated as required? Yes No No If "No," explain fully why such allocation was not made. B. 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 lifting the properties of the					
3. Did the Facility appropriately allocate and se	elf-disallow	direct and i	ndirect costs to non-nursing ho	ome cos	t centers?
(e.g., Assisted Living, Home Health, Outpati	ient Service	s, Adult Da	y Care Services, etc.)		
	_	_	If "No " evolain fully why suc	sh allocs	ation was
	• Yes	O No	. 1	anocc	mon was
			not muo.	cation, i.e., Director (or Charge Nurse), Licensed Practical Nurses, Aides and of resident care provided by EACH ting page 13) center involved def Allocated Costs the cost information provided. "explain fully why such allocation was aide." ropriate supporting data. costs to non-nursing home cost centers Services, etc.) "explain fully why such allocation was aide."	
Number of meals served to residents Number of pounds processed Number of square feet serviced Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse Registered Nurses, Licensed Practical Nurses, Aides an Attendants Number of hours of resident care provided by EACH employee classification, i.e., Director (or Charge Nurse Registered Nurses, Licensed Practical Nurses, Aides an Attendants Number of hours of resident care provided by EACH specialist (See listing page 13) Square feet services (See listing page 13) Square feet Gross salaries Interpret costs (depreciation) Square feet Gross salaries Appropriate cost center involved Other General Administrative expenses Total of Direct and Allocated Costs expenser of this report must answer the following questions applicable to the cost information provided. In the preparation of this Report, were all Orect of No If "No," explain fully why such allocation of mot made. Explain the allocation of related company expenses and attach copy of appropriate supporting data. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost center (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.) Or Yes Or No If "No," explain fully why such allocation or No					

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 Y	Report for Year Ended			
Manchester Manor Health Care Center			2237-C	9/30/2020	6	37		
		ed * to						
		ners,						
	_	ators,		D-4f	Т	Annual	A	4
Name and Address of Lessor	Yes	icers No	Description of Items Leased	Date of Lease**	Term of Lease	Amount of Lease	Amo Clair	
MailFinance			Postage Machine	Lease	Lease	01 Lease	Clair	ilicu
385 West Center St, Manchester, CT 06040	0	•	Ü	07/23/18	63 months	2,057	2,057	
	0	•						
	0	•						
	0	•						
	0	•						
	0	•						
	0	•						
	0	•						
	0	•						
	0	•						
Is a Mileage Log Book Maintained for All	Leased V	ehicles	? O Yes	. ⊙	No	Total ***	2,057	

Is a Mileage Log Book Maintained for All Leased Vehicles?

^{*} 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	License No.	Report for Year Ended		Page	of
Manchester Manor Health Care Cer	2237-C	9/30/2020		7	37
The records of this facility for the p	period covered by this report	were maintained on the following basis:			
	Modified Cash				
Is the accounting basis for this					
*	Yes	If "No," explain.			
previous period?	No				
Independent Accounting Firm					
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)			
1 CJLC, LLC		225 Pitkin Street, East Hartford, CT 0610			
2 William T Craig CPA, LLC		140-16 Masons Island Rd, Ste 2a, Mystic	, CT 06355	5	
3					
4					
Services Provided by This Firm (de					
1 Cost Reporting, Financial Statements	s, Reimbursement Consulting		\$	20,102	
2 Tax Returns, Corporate Matters			\$	6,300	
3			\$		
4			\$		
			Charge fo	r Services Pı	rovided
			•	26,402	
Are These Charges Reflected in the Evnen	diture Portion of This Report? If V	es, Specify Expense Classification and Line No.	Þ	20,402	
	Pg 15/1d	es, specify Expense Classification and Ellie 170.			
Legal Services Information	1 8 10/14				
Name of Legal Firm or Independen	t Attorney		Telephone	Number	
1 Jackson Lewis, LLP			(914)514-		
2 Murtha Cullina, LLP			(860)240-		
3			(000)210	0000	
4					
5					
Address (No. & Street, City, State, 1	Zip Code)				
1 PO Box 416019, Boston, MA (
2 185 Asylum St., Hartford, CT					
3					
4					
5					
Services Provided by This Firm (de	escribe fully)				
1 Employment Matters			\$	942	
2 Regulatory and Resident Issues			\$	2,858	
3			\$		
4			\$		
5			\$		
			Charge for	r Services Pı	rovided
			\$	3,800	
Are These Charges Reflected in the Evnen	diture Portion of This Report? If V	es, Specify Expense Classification and Line No.	Φ.	3,000	
• Yes O No	Pg 15/1e	es, speerly Expense Classification and Elife 140.			

Schedule of Resident Statistics

Name of Facility			License N	No.				r Year Ende	ed		Page	of
Manchester Manor Health Care Center			22	37-C			9/30/2020	0			8	37
						Period 10/	'1 Thru 6/	30	Period 7/1 Thru			30
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
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		
Number of Residents A. As of midnight of PREVIOUS report period	112	112			112	112			80	80		
B. As of midnight of THIS report period	84	84			80	80			84	84		
3. Total Number of Days Care Provided During Period												
A. Medicare	5,103	5,103			3,719	3,719			1,384	1,384		
B. Medicaid (Conn.)	20,603	20,603			16,620	16,620			3,983	3,983		
C. Medicaid (other states)												
D. Private Pay	6,364	6,364			5,080	5,080			1,284	1,284		
E. State SSI for RCH												
F. Other (Specify) Insurance	4,354	4,354			3,224	3,224			1,130	1,130		
G. Total Care Days During Period (3A thru F)	36,424	36,424			28,643	28,643			7,781	7,781		
Total Number of Days Not Included in Figures in 3G 4. for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	299	299			269	269			30	30		
B. Other Bed Reserve Days	82	82			71	71			11	11		
5. Total Resident Days (3G + 4A + 4B)	36,805	36,805			28,983	28,983			7,822	7,822		

CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Facility License No. Re								Report	t for Year	Ended		Page	of		
Manchester N	lanor H	ealth Ca	re Center	22	237-С					9/30/202	0		9	37	
	•	_	in the certified l		pacity du	ring t	the repo	ort yea	ar?	0	Yes	•	No		
		Place of	f Change		Cł	nange	in Bed	s		Ca	pacity Afte	er Change			
Date of	CCNH	RHNS	(Specify)		Lost		(Gaine	d			_			
Changa										1					
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	Reason for Chang		
	•	_	in certified bed 90 days following	-	-	g the r	report y	ear (a	s repor	ted in iter	n 4 above)	provide the nu	mber of		
			Change in R	esider	nt Days					CC	CNH	RHNS	(Spe	ecify)	
1st chan															
2nd char 3rd chan															
4th chan															
		dents an	d Rates on Sept	ember	30 of Co	st Ye	ar								
			Medicare		Medi					Se	elf-Pay		Other State Assis		
	Item		CCNH	C	CNH	RI	HNS	CC	CNH	RI	INS	(Specify)	R.C.H.	ICF-MR	
No. of R		3	12		51				21						
Per Dien a. One b			DUGG		210.40				545.00						
b. Two			RUGS		218.40				545.00 445.00						
c. Three									445.00						
bed 1															
			al Therapy Trea	tment	S					ТО	TAL	CCNH	RHNS	(Specify)	
A.	Medica	id (Evel	lusive of Part B								1,172	1,172			
Б.			e Treatments	,											
			Treatments							1	3	3			
C.	Other										5,527	5,527			
			Therapy Treate								6,702	6,702			
			Therapy Treati	nents											
	Medica										409	409			
В.			lusive of Part B) e Treatments	ve of Part B)											
			Treatments								1	1			
C.	Other	iorative	Treatments								1,929	1,929			
		peech T	Therapy Treatm	ents						1	2,339	2,339			
			ational Therapy		ments										
A.	Medica	re - Par	t B								1,041	1,041			
B.		,	lusive of Part B))											
			e Treatments												
	2. Resi	torative	Treatments								2	4,000			
)ccupati	ional Therapy T	reatn	nents					1	4,909 5,952	4,909 5,952			
D.	1 omi C	лирин	onai incrupy i	·cuill						1	3,732	3,732			

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility Manchester Manor Health Care Center	License No. 2237-C		Report for Yea 9/30/2020	r Ended	Page 10	of 37
	<u> </u>		ı			37
Are time records maintained by all individuals receiving co	mpensation?	•	Yes		No	
			Total Cost a	and Hours		
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
 Operators/Owners (Complete also Sec. I of Schedule A1) 						
2. Administrator(s) (Complete also Sec. III						
of Schedule A1)	91,618	1,541				
3. Assistant Administrator (Complete also Sec. IV						
of Schedule A1)						
4. Other Administrative Salaries (telephone	557.565	21.002				
operator, clerks, receptionists, etc.) 5. Dietary Service	557,565	21,992				
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	515,252	26,519				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	195,765	14,253				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance b. Other Maintenance Workers	149,786	6,243				
8. Laundry Service	149,780	0,243				
a. Supervisor						
b. Other Laundry Workers	69,772	4,532				
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	255,782	4,428				
b. RN		-,,				
1. Direct Care	1,354,512	35,096				
2. Administrative**	281,165	4,310				
c. LPN						
1. Direct Care	1,166,119	36,170				
Administrative** d. Aides and Attendants	89,128 1,923,626	4,512 106,278				
e. Physical Therapists	1,923,020	100,276				
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	153,547	8,006				
i. Physicians						
Medical Director Hilipotion Provings						
Utilization Review Resident Care***	+					
4. Other (Specify)						
(
j. Dentists						
k. Pharmacists						
1. Podiatrists	101 == :					
m. Social Workers/Case Management	191,724	5,811				
n. Marketing o. Other (Specify)						
See Attached Schedule	13,170	649				
A-13. Total Salary Expenditures	7,008,530	280,340				

^{*} 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		RH	NS	(Specify)		
Position		\$	Hours	\$	Hours	\$	Hours
Medical Records Assistant	\$	13,170	649				
Total	\$	13,170	649	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RH	INS	(Spe	cify)	
Service		\$	Hours	\$	Hours	\$	Hours
Medical Staff	\$	29,200	309				
Total	\$	29,200	309	\$ -	-	\$ -	-

.....

CSP-11 Rev. 10/2005

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

Name of Facility				License No.	Report for	Year Ended		Page	of	
Manchester Manor Health Care Co	enter			2237-C		9/30/2020			11	37
		Salary Paid	1	Fringe Benefits and/or Other Payments	Full Description of	Total Hours	Line Where Claimed on	Name and Address of All	Total Hours	Compensation
Name	CCNH	RHNS	(Specify)	(describe fully)	Services Rendered	Worked	Page 10	Other Employment**	Worked	Received
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

^{*} 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.

CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)				License No.		Report for Y	ear Ended		Page	of
Manchester Manor Health Care C	enter			2237-C		9/30/2020			12	37
		Salary Pai	d	Fringe Benefits and/or Other Payments	Full Description of	Total Hours	Line Where	Name and Address of All	Total Hours	Compensation
Name	CCNH	RHNS	(Specify)	(describe fully)	Services Rendered	Worked	Page 10	Other Employment**	Worked	Received
Section III - Administrators***										
Jonah Kraus (10/1/19 to 6/4/20)	90,178			Standard	Responsible for daily operations of facility	1,541	A2			
Paul Liistro (6/5/20-9/30/20)	Unpaid			Standard	Responsible for daily operations of facility	680	A2			
Section IV - Assistant Administrators										

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

^{**} Include <u>all</u> other employment worked during the cost year.

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

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.		Report for Y		Page	of
Manchester Manor Health Care Center	2237	7-C	9/30/2020		13	37
			Total Cost	and Hours		
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee						
for service basis in lieu of salary						
(For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	6,391	88				
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	409,017	5,738				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	57,300	226				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
 Infection Control Committee (Quarterly meetings) 						
2. Pharmaceutical Committee						
(Quarterly meetings)						
Staff Development Committee						
(Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	92,610	1,104				
b. Other						
10. Occupational Therapist						
a. Resident Care	382,946	6,816				
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	29,200	309				
B-13 Total Fees Paid in Lieu of Salaries	977,464	14,281				

^{*} 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 Yo 9/30/2020	ear Ended	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Operato	* to Owners, ors, Officers	,		
Healthpro Heritage, 307 International Circle Ste 100, Hunt Valley, MD 21030	Therapy Services	Yes O	No •			
GeriDent Solutions, LLC P.O. Box 290539, Wethersfield, Connecticut	Dental Services	0	•			
Dr. Wayne Paulekas 251 Wickham Rd., Glastonbury, CT 06033	Medical Director	0	•			
Dr. Elmo Villanueva 506 Cromwell Ave., Rocky Hill, CT 06067	Assistant Medical Director	0	•			
Dr. Guardino, PO Box 150472, Hartford, CT 06115-0472	Assistant Medical Director	0	•			
Dr John Wenceslao, 17 Stone Hill Drive, Rocky Hill, CT 06067	Medical Staff	0	•			
		0	•			
		0	•			
		0	•			
		0	•			
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		0	•			
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		0	•			
		0	•			
		0	•			

^{*} Use additional sheets if necessary.

^{**} Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Manchester Manor Health Care Center 2237-C 9/30/2020 15 37	Name of Facility	License No.	Report for Y	ear Ended	Page	of
1. Administrative and General a. Employee Health & Welfare Benefits 1. Workmen's Compensation 2. Disability Insurance 3. Unemployment Insurance 3. Unemployment Insurance 4. Social Security (F.I.C.A.) 5. Health Insurance 6. Life Insurance (employees only) 6. (not-owners and not-operators) 7. Pensions (Non-Diseriminatory) 7. Pensions (Non-Diseriminatory) 8. Uniforn Allowance 9. Other (Specify) 8. Sea Attached Schedule 8. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)* c. Bad Debts* 5. Is 153,268 6. Legal (Services should be fully described on Page 7) 7. Insurance on Lives of Owners and Operators (Operators (Discriminatory))* 8. Uniforn Allowance 9. Other (Specify)		er 2237-C	•		•	37
1. Administrative and General a. Employee Health & Welfare Benefits 1. Workmen's Compensation 2. Disability Insurance 3. Unemployment Insurance 3. Unemployment Insurance 4. Social Security (F.I.C.A.) 5. Health Insurance 6. Life Insurance (employees only) 6. (not-owners and not-operators) 7. Pensions (Non-Diseriminatory) 7. Pensions (Non-Diseriminatory) 8. Uniforn Allowance 9. Other (Specify) 8. Sea Attached Schedule 8. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)* c. Bad Debts* 5. Is 153,268 6. Legal (Services should be fully described on Page 7) 7. Insurance on Lives of Owners and Operators (Operators (Discriminatory))* 8. Uniforn Allowance 9. Other (Specify)						
1. Administrative and General a. Employee Health & Welfare Benefits 1. Workmen's Compensation 2. Disability Insurance 3. Unemployment Insurance 3. Unemployment Insurance 4. Social Security (F.I.C.A.) 5. Health Insurance 6. Life Insurance (employees only) 6. (not-owners and not-operators) 7. Pensions (Non-Diseriminatory) 7. Pensions (Non-Diseriminatory) 8. Uniforn Allowance 9. Other (Specify) 8. Sea Attached Schedule 8. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)* c. Bad Debts* 5. Is 153,268 6. Legal (Services should be fully described on Page 7) 7. Insurance on Lives of Owners and Operators (Operators (Discriminatory))* 8. Uniforn Allowance 9. Other (Specify)						
a. Employee Health & Welfare Benefits 1. Workmen's Compensation \$ 158,581 158,581 2. Disability Insurance \$ 3. Unemployment Insurance \$ 73,735 73,735 4. Social Security (F.I.C.A.) \$ 510,075 5. Health Insurance \$ 452,384 452,384 6. Life Insurance (employees only)			Total	CCNH	RHNS	(Specify)
1. Workmen's Compensation S 158,581 158,581						
2. Disability Insurance 3. Unemployment Insurance 3. Unemployment Insurance 4. Social Security (F.I.C.A.) 5. Health Insurance 6. Life Insurance (employees only) 6. Life Insurance (employees only) 7. Pensions (Non-Discriminatory) 8. Uniform Allowance 9. 75,773 75,773 75,773 8. Uniform Allowance 9. Other (Specify) See Attached Schedule 9. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)* 6. Bad Debts* 9. Legal (Services should be fully described on Page 7) 9. Office (Specify) 9. See Attached Schedule 10. Eagl (Services should be fully described on Page 7) 9. The supplies 10. Telephone and Cellular Phones 11. Telephone & Pagers 12. Cellular Phones 13. Appraisal (Specify purpose and attach copy) ** 14. Cother Taxes (Not related to property - See Page 22) 14. Income* 15. Corporation Business Taxes (franchise tax) 16. Cother Taxes (Not related to property - See Page 22) 16. Income* 17. Corporation Business Taxes (franchise tax) 18. Cother Taxes (Not related to property - See Page 22) 19. See Attached Schedule 20. Cellular Dougle See Tasked Schedule 30. Resident Day User Fee	a. Employee Health & Welfare l	Benefits				
3. Unemployment Insurance \$ 73,735 73,735 4. Social Security (F.I.C.A.) \$ 510,075 510,075 5. Health Insurance \$ 452,384 452,384 452,384 6. Life Insurance (employees only) (not-owners and not-operators) \$ 7. Pensions (Non-Discriminatory) \$ 75,773 75,773 (not-owners and not-operators) \$ 8. Uniform Allowance \$ 7,516 7,516 9. Other (Specify) \$ See Attached Schedule \$ \$ See Attached Sc		1	\$ 158,581	158,581		
4. Social Security (F.I.C.A.) \$ 510,075 510,075 5 5. Health Insurance \$ 452,384 452,384	2. Disability Insurance		\$			
5. Health Insurance 6. Life Insurance (employees only) (not-owners and not-operators) 7. Pensions (Non-Discriminatory) (not-owners and not-operators) 8. Uniform Allowance 9. Other (Specify) See Attached Schedule b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)* c. Bad Debts* 4. Accounting and Auditing 4. Accounting and Auditing 5. Legal (Services should be fully described on Page 7) 7. Sand Department (Specify)* g. Office Supplies 7. Telephone and Cellular Phones 1. Telephone and Cellular Phones 1. Telephone and Cellular Phones 1. Appraisal (Specify purpose and attach copy)* j. Corporation Business Taxes (franchise tax) k. Other Taxes (Not related to property - See Page 22) 1. Income* 9. Colber (Specify) See Attached Schedule 9. Resident Day User Fee	3. Unemployment Insurance		\$ 73,735	73,735		
6. Life Insurance (employees only)	4. Social Security (F.I.C.A.)		\$ 510,075	510,075		
(not-owners and not-operators) 7. Pensions (Non-Discriminatory) (not-owners and not-operators) 8. Uniform Allowance 9. Other (Specify) See Attached Schedule b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)* c. Bad Debts* 4. Accounting and Auditing 4. Accounting and Auditing 5. Accounting and Auditing 6. Legal (Services should be fully described on Page 7) 7. Jane 19 Jane	5. Health Insurance		\$ 452,384	452,384		
7. Pensions (Non-Discriminatory)	6. Life Insurance (employee	s only)				
(not-owners and not-operators) 8. Uniform Allowance \$ 7,516 7,516 9. Other (Specify) \$ See Attached Schedule b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)* c. Bad Debts* \$ 153,268 153,268 153,268 d. Accounting and Auditing \$ 26,402 26,402 e. Legal (Services should be fully described on Page 7) \$ 3,800 3,800 f. Insurance on Lives of Owners and Operators (Specify)* g. Office Supplies \$ 42,612 42,612 d. Telephone and Cellular Phones 1. Telephone & Pagers \$ 56,502 56,502	(not-owners and not-opera	ators)	\$			
8. Uniform Allowance \$ 7,516 7,516 9. Other (Specify) \$ See Attached Schedule	7. Pensions (Non-Discrimina	atory)	\$ 75,773	75,773		
9. Other (Specify) See Attached Schedule b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)* c. Bad Debts* s. 153,268 153,268 153,268 d. Accounting and Auditing s. 26,402 26,402 e. Legal (Services should be fully described on Page 7) s. 3,800 3,800 f. Insurance on Lives of Owners and Operators (Specify)* g. Office Supplies s. 42,612 42,612 h. Telephone and Cellular Phones 1. Telephone & Pagers s. 56,502 56,502 2. Cellular Phones s. 56,128 6,128 i. Appraisal (Specify purpose and attach copy)* j. Corporation Business Taxes (franchise tax) s. k. Other Taxes (Not related to property - See Page 22) 1. Income* 2. Other (Specify) s. 20 20 See Attached Schedule 3. Resident Day User Fee	(not-owners and not-opera	ators)				
See Attached Schedule b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)* c. Bad Debts* d. Accounting and Auditing e. Legal (Services should be fully described on Page 7) f. Insurance on Lives of Owners and Operators (Specify)* g. Office Supplies f. Telephone and Cellular Phones 1. Telephone & Pagers 2. Cellular Phones i. Appraisal (Specify purpose and attach copy)* j. Corporation Business Taxes (franchise tax) k. Other Taxes (Not related to property - See Page 22) 1. Income* 2. Other (Specify) See Attached Schedule 3. Resident Day User Fee	8. Uniform Allowance		\$ 7,516	7,516		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)* c. Bad Debts* d. Accounting and Auditing e. Legal (Services should be fully described on Page 7) f. Insurance on Lives of Owners and Operators (Specify)* g. Office Supplies h. Telephone and Cellular Phones 1. Telephone & Pagers 1. Telephone & Pagers 2. Cellular Phones i. Appraisal (Specify purpose and attach copy)* j. Corporation Business Taxes (franchise tax) k. Other Taxes (Not related to property - See Page 22) 1. Income* 2. Other (Specify) See Attached Schedule 3. Resident Day User Fee	9. Other (<i>Specify</i>)		\$			
Profit Sharing Plans for Owners and Operators (Discriminatory)* c. Bad Debts* d. Accounting and Auditing e. Legal (Services should be fully described on Page 7) f. Insurance on Lives of Owners and Operators (Specify)* g. Office Supplies f. Telephone and Cellular Phones f. Telephone & Pagers f. Telephone	See Attached Schedule					
Operators (Discriminatory)*	b. Personal Retirement Plans, Pe	ensions, and	\$			
c. Bad Debts* \$ 153,268 153,268 d. Accounting and Auditing \$ 26,402 26,402 e. Legal (Services should be fully described on Page 7) \$ 3,800 3,800 f. Insurance on Lives of Owners and Operators (Specify)* \$ 42,612 42,612 g. Office Supplies \$ 42,612 42,612 h. Telephone and Cellular Phones \$ 56,502 56,502 2. Cellular Phones \$ 6,128 6,128 i. Appraisal (Specify purpose and attach copy)* \$ 6,128 6,128 j. Corporation Business Taxes (franchise tax) \$ 8 k. Other Taxes (Not related to property - See Page 22) \$ 20 20 1. Income* \$ 20 20 See Attached Schedule \$ 3. Resident Day User Fee \$ 3	Profit Sharing Plans for Owne	ers and				
d. Accounting and Auditing e. Legal (Services should be fully described on Page 7) f. Insurance on Lives of Owners and Operators (Specify)* g. Office Supplies h. Telephone and Cellular Phones 1. Telephone & Pagers 2. Cellular Phones i. Appraisal (Specify purpose and attach copy)* j. Corporation Business Taxes (franchise tax) k. Other Taxes (Not related to property - See Page 22) 1. Income* 2. Other (Specify) See Attached Schedule 3. Resident Day User Fee	Operators (Discriminatory)*					
d. Accounting and Auditing e. Legal (Services should be fully described on Page 7) f. Insurance on Lives of Owners and Operators (Specify)* g. Office Supplies h. Telephone and Cellular Phones 1. Telephone & Pagers 2. Cellular Phones i. Appraisal (Specify purpose and attach copy)* j. Corporation Business Taxes (franchise tax) k. Other Taxes (Not related to property - See Page 22) 1. Income* 2. Other (Specify) See Attached Schedule 3. Resident Day User Fee						
e. Legal (Services should be fully described on Page 7) \$ 3,800 3,800 f. Insurance on Lives of Owners and	c. Bad Debts*		\$ 153,268	153,268		
f. Insurance on Lives of Owners and Operators (Specify)* g. Office Supplies \$ 42,612 42,612 h. Telephone and Cellular Phones 1. Telephone & Pagers \$ 56,502 56,502 2. Cellular Phones \$ 6,128 6,128 i. Appraisal (Specify purpose and attach copy)* j. Corporation Business Taxes (franchise tax) k. Other Taxes (Not related to property - See Page 22) 1. Income* 2. Other (Specify) See Attached Schedule 3. Resident Day User Fee	d. Accounting and Auditing		\$ 26,402	26,402		
Operators (Specify)* g. Office Supplies \$ 42,612 42,612 h. Telephone and Cellular Phones 1. Telephone & Pagers \$ 56,502 56,502 2. Cellular Phones \$ 6,128 6,128 i. Appraisal (Specify purpose and attach copy)* j. Corporation Business Taxes (franchise tax) \$ k. Other Taxes (Not related to property - See Page 22) 1. Income* 2. Other (Specify) \$ 20 20 See Attached Schedule 3. Resident Day User Fee	e. Legal (Services should be full	y described on Page 7)	\$ 3,800	3,800		
g. Office Supplies \$ 42,612 42,612 h. Telephone and Cellular Phones 1. Telephone & Pagers \$ 56,502 56,502 2. Cellular Phones	f. Insurance on Lives of Owners	and	\$			
h. Telephone and Cellular Phones 1. Telephone & Pagers 2. Cellular Phones 3. Appraisal (Specify purpose and attach copy)* j. Corporation Business Taxes (franchise tax) k. Other Taxes (Not related to property - See Page 22) 1. Income* 2. Other (Specify) See Attached Schedule 3. Resident Day User Fee	Operators (Specify)*					
1. Telephone & Pagers \$ 56,502 56,502 2. Cellular Phones \$ 6,128 6,128 56,202 56,502 5	g. Office Supplies		\$ 42,612	42,612		
2. Cellular Phones \$ 6,128 6,128 i. Appraisal (Specify purpose and attach copy)* j. Corporation Business Taxes (franchise tax) \$ k. Other Taxes (Not related to property - See Page 22) 1. Income* 2. Other (Specify) \$ 20 20 See Attached Schedule 3. Resident Day User Fee \$	h. Telephone and Cellular Phone	es				
i. Appraisal (Specify purpose and attach copy)* j. Corporation Business Taxes (franchise tax) k. Other Taxes (Not related to property - See Page 22) 1. Income* 2. Other (Specify) See Attached Schedule 3. Resident Day User Fee \$	1. Telephone & Pagers		\$ 56,502	56,502		
j. Corporation Business Taxes (franchise tax) \$ k. Other Taxes (Not related to property - See Page 22) 1. Income* \$ 2. Other (Specify) \$ See Attached Schedule 3. Resident Day User Fee \$	2. Cellular Phones		\$ 6,128	6,128		
j. Corporation Business Taxes (franchise tax) \$ k. Other Taxes (Not related to property - See Page 22) 1. Income* \$ 2. Other (Specify) \$ See Attached Schedule 3. Resident Day User Fee \$	i. Appraisal (Specify purpose ar	nd	\$			
k. Other Taxes (Not related to property - See Page 22) 1. Income* 2. Other (Specify) See Attached Schedule 3. Resident Day User Fee \$ 20 20	attach copy)*					
k. Other Taxes (Not related to property - See Page 22) 1. Income* 2. Other (Specify) See Attached Schedule 3. Resident Day User Fee \$ 20 20						
1. Income* \$ 20 20 See Attached Schedule \$ 3. Resident Day User Fee \$	j. Corporation Business Taxes (franchise tax)	\$			
2. Other (Specify) \$ 20 20 See Attached Schedule 3. Resident Day User Fee \$	k. Other Taxes (Not related to p.	roperty - See Page 22)				
See Attached Schedule 3. Resident Day User Fee \$	1. Income*		\$			
See Attached Schedule 3. Resident Day User Fee \$	2. Other (<i>Specify</i>)		\$ 20	20		
· · · · · · · · · · · · · · · · · · ·						
	3. Resident Day User Fee		\$			
	·		\$ 1,566,796	1,566,796		

^{*} 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 9/30/2020

Attachment Page 15

Schedule of Other Employee Benefits

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

.....

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
CT Secretary of State Filing Fee	\$ 20		
Total	\$ 20	\$ -	\$ -

.....

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

Name of Facility	·			Year Ended	Page	of
Manchester Manor Health Care Center 2237-C			9/30/2020		16	37
Item			Total	CCNH	RHNS	(Specify)
Subtotal	ls Brought Forwa	rd:	1,566,796	1,566,796		
Travel and Entertainment						
Resident Travel and Entertainment		\$	2,034	2,034		
2. Holiday Parties for Staff		\$				
3. Gifts to Staff and Residents		\$	42,272	42,272		
4. Employee Travel		\$	7,499	7,499		
5. Education Expenses Related to Seminars an	d Conventions	\$	(90)	(90)		
6. Automobile Expense (not purchase or depre	eciation)	\$	1,755	1,755		
7. Other (<i>Specify</i>)		\$				
See Attached Schedule						
m. Other Administrative and General Expenses						
1. Advertising Help Wanted (all such expenses	s)	\$	51,832	51,832		
2. Advertising Telephone Directory (all such e	expenses)***	\$				
3. Advertising Other (Specify)***		\$	21,529	21,529		
See Attached Schedule						
4. Fund-Raising***		\$				
5. Medical Records		\$				
6. Barber and Beauty Supplies (if this service)	is supplied	\$				
directly and not by contract or fee for service						
7. Postage		\$	6,553	6,553		
* 8. Dues and Membership Fees to Professional		\$	10,321	10,321		
Associations (Specify)						
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other Non-A	Allowable Org.***	\$	233	233		
9. Subscriptions		\$	5,799	5,799		
10. Contributions***		\$	5,943	5,943		
See Attached Schedule						
11. Services Provided by Contract (Specify and	Complete	\$	211,359	211,359		
Schedule C-2, Page 21 for each firm or indi	ividual)					
12. Administrative Management Services**		\$				
13. Other (Specify)		\$	10,949	10,949		
See Attached Schedule						
C-14 Total Administrative & General Expenditures		\$	1,944,784	1,944,784		

^{*} 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)
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	(CCNH	RHNS	(Specify)
Advertising	\$	21,529		
Total Other Advertising	\$	21,529	\$ -	\$ -

Schedule of Dues

Description	C	CCNH	RHNS	S	(Specify)
C.A.H.C.F. INC.	\$	6,708			
ALTCFM	\$	229			
ACHCA	\$	1,936			
ACHA	\$	1,448			
Total Dues	\$	10,321	\$	-	\$ -
					•

Schedule of Contributions

Description	C	CNH	RHNS	(Specify)
Contributions	\$	5,943		
Total Contributions	\$	5,943	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH		RHNS		(Specify	v)
Employement Screening	\$	2,559				
License Fees	\$	1,913				
Bank Fees	\$	3,562				
Employee Physicals	\$	2,218				
Prof Services - Collections	\$	697				
		•				
Total Other Administrative and General	\$	10,949	\$	-	\$	-

Schedule C-1 - Management Services*

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2020	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)

Mon	ne of Facility	Licens	a No	Report for Y	oon Endad	Daga	o f
	ne of Facility inchester Manor Health Care Center	Licens		_		Page	of
Mai	ichester Manor Health Care Center		2237-C	9/30/2020	1	18	37
	Item		Total	CCNH	RHNS	(S ₁	pecify)
2.	Dietary						
	a. In-House Preparation & Service						
	1. Raw Food	\$		263,728			
	2. Non-Food Supplies	\$		11,361			
	3. Other (Specify)						
	b. Purchased Services (by contract other	5					
	than through Management Services)						
	(Complete Schedule C-2 att. Page 21)						
	c. Other (Specify)		23,897	23,897			
	Supplies						
2D.	Total Dietary Expenditures $(2a + b + c + d)$	\$	298,987	298,987			
2F.	Dietary Questionnaire		Total	CCNH	RHNS	(S ₁	pecify)
G.	Resident Meals: Total no. of meals served per	day:*					
Н.	Is cost of employee meals included in 2E?	O Yes	•	No			
I.	Did you receive revenue from employees?	O Yes	•	No	If yes, specify amt.		
J.	Where is the revenue received reported in the	Cost Repor	t? (Page/Line	Item)			
	Is cost of meals provided to persons other				If yes, specify		
K.	than employees or residents (i.e., Board	O Yes	•	No	cost.		
	Members, Guests) included in 2E?				cost.		
L.	Is any revenue collected from these people?	O Vec	•	No	If yes, specify		
L.	is any revenue concered from these people:	O 163		110	amt.		
M.	Where is the revenue received reported in the	Cost Repor	t? (Page/Line	Item)			
	Is cost of food (other than meals, e.g.,						
NI	snacks at monthly staff meetings, board	O Vac	0	No	If yes, specify		
N.	meetings) provided to employees included	O Yes	•	INO	cost.		
	in 2E?						
	In any mayana called A. F	O V		Ma	If yes, specify		<u> </u>
O.	Is any revenue collected from employees?	O Yes	•	No	amt.		
P.	Where is the revenue received reported in the	Cost Repor	t? (Page/Line	Item)			
	1	1	` 5				

^{*} 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			No.	Report for Y		Page of
Mar	nchester Manor Health Care Center	2	237-C	9/30/2020	1	19 37
	Item		Total	CCNH	RHNS	(Specify)
3.	Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items	Lbs.	12,011	12,011		
	washed, ironed, and/or processed.*** 2. Employee items including uniforms,	Lbs.	12,011	12,011		
	gowns, etc. washed, ironed and/or processed.***	Amt. \$				
	3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs. Amt. \$				
	4. Repair and/or purchase of linens.***	Lbs.				
	b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	Amt. \$	788	788		
	c. Other (Specify) Supplies	\$	9,457			
3D.	Total Laundry Expenditures (3a + b + c)	\$	22,256	22,256		
3F. G.	Laundry Questionnaire Is cost of employee laundry included in 3E? O	Yes	•	No	If yes, specify cost.	
Н.	J J	Yes	•	No	If yes, specify amt.	
I.	Where is the revenue received reported in the Cost	Report?		(Page/Line		
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	Yes	•	No	If yes, specify cost.	
K.	J 1 1	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.

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.	Repo	ort for Year E	nded	Page	of
Manchester Manor Health Care Center	2237-C 9/30/2020			20	37	
Itam			Total	CCNH	RHNS	(Specify)
Item	G F: G : 1		Total	CCNII	KIINS	(Specify)
4. Housekeeping a. In-House Care	Sq. Ft. Serviced					
	by Personnel	¢.	(2.240	(2.240		
1. Supplies - Cleaning (Mops,	Amt.	\$	63,349	63,349		
pails, brooms, etc.)	G F: G : 1					
b. Purchased Services (by contract other	-					
than through Management Services)	by Personnel	Φ.				
(Complete Schedule C-2 att.	Amt.	\$				
Page 21)		¢.				
C. Other (<i>Specify</i>)		\$			_	
4D. Total Housekeeping Expenditures (4a -	+ b + c)	\$	63,349	63,349		
5. Resident Care (Supplies)**			,	,		
a. Prescription Drugs***		- 1				
1. Own Pharmacy		\$				
2. Purchased from		\$	247,407	247,407		
		- I		.,		
b. Medicine Cabinet Drugs		\$	84,836	84,836		
c. Medical and Therapeutic Supplies		\$	254,009	254,009		
d. Ambulance/Limousine***		\$	Í	ĺ		
e. Oxygen						
1. For Emergency Use		\$				
2. Other***		\$	63,873	63,873		
f. X-rays and Related Radiological		\$				
Procedures***						
g. Dental (Not dentists who should be in-	cluded under	\$				
salaries or fees)						
h. Laboratory***		\$	44,380	44,380		
i. Recreation		\$	8,115	8,115		
j. Direct Management Services*		\$				
k. Indirect Management Services*		\$	İ			
l. Other (Specify)****		\$	287,614	287,614		
See Attached Schedule						
5M. Total Resident Care Expenditures (5a -	5j)	\$	990,233	990,233		

^{*} 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	\$ 9,604		
COVID Related Expenses	\$ 278,010		
Total Other Resident Care	\$ 287,614	\$ -	\$ -

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					Page 21	of 37
		Related ** Operators		,			/Page Ref.**	*		
Name of Individual or Company	Address	Yes	No	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	(Specify)	Pg	Line
ADP	100 Corporate Dr, Windsor, CT 06095	0	•	•	Payroll Services	46,123				m11
Wescom Solutions	3500 American Blvd W. Suite 155, Bloomington	0	•		Point Click Care	39,474			16	m11
KIT Consulting	285 Old Enfield Rd, Belchertown MA 507 E Main St #308,	0	•		IT Consulting	89,772			16	m11
Celtic Consulting	Torrington, CT	0	•		Clinical Consulting	12,849			16	m11
		0	•							
		0	•							
		0	•							
		0	•							
		0	•							
	<u> </u>	0	•							
		0	•							
		0	•							
		0	• •							

^{*} 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 Li	cense No.	Report for Y	ear Ended		Page	of
Manchester Manor Health Care Center	2237-C	9/30/2020			22	37
Item		Total	CCNH	RHNS	(Spec	ify)
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	167,976	167,976			
b. Heat	\$	25,275	25,275			
c. Light & Power	\$	103,394	103,394			
d. Water	\$	35,557	35,557			
e. Equipment Lease (Provide detail on page	e 6) \$	2,057	2,057			
f. Other (itemize)	\$	46,754	46,754			
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f	s	381,013	381,013			
7. Depreciation (complete schedule page 23*)						
a. Land Improvements	\$	7,917	7,917			
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$	42,299	42,299			
d. Movable Equipment	\$	81,885	81,885			
*7e. Total Depreciation Costs $(7a + b + c + d)$	\$	132,100	132,100			
8. Amortization (Complete att. Schedule Page	24*)					
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$	178,836	178,836			
d. Other (Specify)	\$					
*8e. Total Amortization Costs $(8a + b + c + d)$	\$	178,836	178,836			
9. Rental payments on leased real property less	3					
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	\$	140,795	140,795			
c. Personal property taxes	\$	20,110	20,110			
11. Total Property Expenses $(7e + 8e + 9 + 10)$	\$	1,015,601	1,015,601			

^{*} 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	\$ 37,218		
Snow Removal	\$ 9,536		
Total Other Repairs and Maintenance	\$ 46,754	\$ -	\$ -

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Depreciation Schedule

Name of Facility					License No.	iution St		Report for Year E	nded		Page	of
Manchester Manor Health Care Center			2237	-C		9/30/2020			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												
Acquired prior to this report period					397,907		397,907	302,486			7,917	
2. Disposals (attach schedule)												
3. Acquired during this report period (atta	ch sch	edule)			2,047							
A-4. Subtotal												7,917
B. Building and Building Improvements												
Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (atta	ch sch	edule)										
B-4. Subtotal												
C. Non-Movable Equipment												
Acquired prior to this report period					723,706		723,706	289,491			42,299	
Disposals (attach schedule)												
3. Acquired during this report period (atta	ch sch	edule)			48,871							
C-4. Subtotal												42,299
	logł maint		Date Acqui	sition	Historical Cost Exclusive of	Less Salvage	Cost to Be	Accumulated Depreciation to Beginning of	Method of Computing	Useful	Depreciation	
	Yes	No	Month	Year	Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
D. Movable Equipment 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					960,204		960,204	884,022			81,885	
b. Disposals (attach schedule)					(12,800)		,	(12,649)			- ,	
c. Acquired during this report period					,,,,,,			()= 12)				
(attach schedule)					28,200							
D-3. Subtotal												81,885
E. Total Depreciation												132,100

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item		Cost	Useful Life	Depreciation
Additions:					
8/19/2020 Repave Parki	ng Lot	\$	2,047	10	
Total additions for Land Improv	vements	s	2,047		\$ -
Deletions:		<u> </u>	_,		7
Total deletions for Land Improv	ements	\$	-		\$ -

^{*}Ties to Page 23, Line A3

Schedule of Building Improvements Acquired during this report period

		Useful					
Acquisition Date	Description of Item	Cost	Life	Depreciation			
Additions:							
Total additions for Building In	nprovements	\$ -		\$ -			
Deletions:							
Total deletions for Building In	provements	\$ -		\$ -			

^{*}Ties to Page 23, Line B3

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/25/2019	Intercom	\$ 3,930	10	
9/2/2020	Phone System Addition	\$ 1,216	10	
8/14/2020	Portable Heat Pumps	\$ 6,106	15	
1/15/2020	Fire Proection System Replacements	\$ 13,811	10	
2/18/2020	Heat Pump	\$ 3,015	10	
3/20/2020	IAQ Device HVAC - COVID	\$ 6,418	15	
3/31/2020	Split System 5 Ton HVAC	\$ 9,412	15	
4/30/2020	HVAC UV Lites Wiring	\$ 1,153	15	
4/27/2020	IAQ Units	\$ 1,176	15	
4/21/2020	IAQ Units	\$ 2,634	15	
Total additions for	Non-Movable Equipment	\$ 48,871		\$ -
Deletions:				

^{**}Ties to Page 23, Line A2

^{**}Ties to Page 23, Line B2

			Attachment Pages 23 24
Total deletions for Non-Movable Equipment	S -	\$ -	**

^{*}Ties to Page 23, Line C3

^{**}Ties to Page 23, Line C2

Acquisition Data	Description of Item	Cost	Useful Life	Danwasiation
Acquisition Date Additions:	Description of Item	Cost	Liie	Depreciation
	Windows 10 Computers	\$ 5,835	5	
11/8/2019	Ultrasound	\$ 3,616	7	
11/8/2019	Shortwave Diathermy Unit	\$ 6,966	10	
11/11/2019	Kenevia Duo Whole Body Trainer	\$ 8,087	7	
1/10/2020	Bariatric Mattresses	\$ 1,176	5	
1/8/2020	Mattress	\$ 354	5	
1/22/2020	Ice Machine	\$ 2,166	10	
Total additions for	Movable Equipment	\$ 28,200		\$ -
Deletions:				
12/31/2019	Computers	\$ (12,800)		
Total deletions for	Movable Equipment	\$ (12,800)		\$ -

^{*}Ties to Page 23, Line D2c

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
11/30/2019	Sprinkler Heads	\$ 6,177	25	
12/11/2019	Vinyl Flooring	\$ 6,825	10	
11/24/2019	Backsplash	\$ 4,687	10	
	Roof Repair	\$ 3,244	10	
1/21/2020	Vinyl Tile	\$ 41,320	10	
1/1/2010	Gutters	\$ 1,016	17	
Total additions for	Leasehold Improvement	\$ 63,269		\$ - *
Deletions:				
Total deletions for	Leasehold Improvement	\$ -		\$ - *

^{*}Ties to Page 24, Line C3

^{**}Ties to Page 23, Line D2b

^{**}Ties to Page 24, Line C2

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Amortization Schedule*

Name of Facility	Name of Facility					Report for Yea	r Ended		Page	of
Manchester Manor Healt	th Care Center			2237-C		9/30/2020			24	37
						Accumulated				
						Amort. to				
		Acqui	sition			Beginning of	Basis for			
				Length of	Cost to Be	Year's	Computing	Rate	Amortization	
Iten	1	Month	Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
A. Organization Exp	ense									
1.										
2.										
3.										
A-4. Subtotal										
B. Mortgage Expens	e									
1.										
2.										
3.										
B-4. Subtotal										
C. Leasehold Improv	vements and Other									
1. Acquired prior	to this report period	Var	Var	Var	6,277,929	2,891,731			178,836	
2. Disposals (attac	,	Var	Var	Var						
3. Acquired during	g this report period									
(attach schedule	e)				63,269					
C-4. Subtotal										178,836
D. Total Amortization	ı									178,836

^{*} Straight-line method must be 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.

^{**} Specify which of the following bases were used:

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

Name of Facility Manchester Manor Health Care Center 223	o. 37-C	Report for Year En 9/30/2020	ded		Page of 25 37
-		3.00.2020			20 07
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 relate business association to any person or organization a related party transaction.					
Description		Total			
Date Land Purchased		01/01/70			
2. Date Structure Completed		01/01/70			
3. If NOT Original Owner, Date of Purchas	se				
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity		126			
6. Square Footage		42,099			
7. Acquisition Cost		42.000			
a. Land b. Building		42,000 424,160			
		,		21 M	441- Mantagas
Part B - Owner and Related Parties 1. Financing		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
a. Type of Financing (e.g., fixed, variate	de)	Variable			
b. Date Mortgage Obtained	лс)	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		, ,			
Complete if Mortgage was Refinanced					
During Current Cost Year					
g. Type of Financing (e.g., fixed, variab	ole)				
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed	0.00				
Principal Outstanding on Note Paid-					
Part C - Arms-Length Leases for Real	_ · · · ·	<u> </u>	·	lm or	
Name and Address of Lessor	Proj	perty 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 Ye	ar Ended		Page of	
Manchester Manor Health Care Cent 2237-C	9/30/2020			26 37	
Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable	e				
Equipment	¢.		l		
1. First Mortgage Name of Lender	Rate				
Ivalle of Lender	Rate				
Address of Lender					
2. Second Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
Address of Lender					
3. Third Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
D. CHEDA I. I.C. di					
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)	\$				
<u> </u>			v Subtotals f	. 1,	

(Carry Subtotals forward to next page)

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

Rem	Name of Facility License 1 Manchester Manor Health Care Ce 223	Report for Y 9/30/2020	ear Ended		Page 27	of 37		
Subtotals Brought Forward: 1. Automotive Equipment 1. Automotive Equipment A. Item Rate Amount Lender A. Item Rate Amount 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) S 12. D. Other Interest Expense (Specify) Vendor Interest 13. Total All Interest Expense (12B7 + 12C3 + 12D) S 14. Insurance a. Insurance on Property (buildings only) b. Insurance on Automobiles c. Insurance other than Property (as specified above) 1. Umbrella Blanket Coverage S 3. Other (Specify) \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$								
12. C. Movable Equipment 1. Automotive Equipment 2. Other (Specify) 3. A. Item Rate Amount Lender Address of Lender 2. Other (Specify) 5. 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) Vendor Interest 13. Total All Interest Expense (12B7 + 12C3 + 12D) 14. Insurance a. Insurance on Property (buildings only) 5. Insurance on Property (buildings only) 5. Insurance on Automobiles 5. Insurance on Automobiles 6. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) 3. Other (Specify) \$ 3. Other (Specify) \$ 3. Other (Specify) \$ 4. Insurance on Automobiles \$ 5. Insurance Description of the Specified above) 1. Umbrella (Blanket Coverage) 3. Other (Specify) \$ 5. Oth	Item			Total	CCNH	RHNS	(Spec	ify)
1. Automotive Equipment A. Item Rate Amount Lender Address of Lender 2. Other (Specify) S 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) S 12. D. Other Interest Expense (Specify) Vendor Interest 13. Total All Interest Expense (12B7 + 12C3 + 12D) S 14. Insurance a. Insurance on Property (buildings only) S b. Insurance on Automobiles C. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) S 2. Fire and Extended Coverage S 3. Other (Specify) S	Sub	totals Brou	ught Forward:					
A. Item Rate Amount Lender Address of Lender 2. Other (Specify) S 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) S 12. D. Other Interest Expense (Specify) S 914 914 914 914 914 914 914 914 914 914								
Lender Address of Lender 2. Other (Specify) \$ \$ A. Item Rate Amount			\$					
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) \$ 914 914 914 914 914 914 914 914 914 914	A. Item	Rate	Amount					
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) Vendor Interest 13. Total All Interest Expense (12B7 + 12C3 + 12D) 14. Insurance a. Insurance on Property (buildings only) b. Insurance on Automobiles c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) 2. Fire and Extended Coverage § 3. Other (Specify) §	Lender							
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) 13. Total All Interest Expense (Specify) Vendor Interest 14. Insurance 15. Insurance on Property (buildings only) 16. Insurance on Automobiles 17. Insurance other than Property (as specified above) 18. Insurance other than Property (as specified above) 19. Umbrella (Blanket Coverage) 10. Time All Interest Expense (Specify) 11. Umbrella (Blanket Coverage) 12. Fire and Extended Coverage 13. Other (Specify) 15. Specify 16. Specify 17. Specify 18. Specified above) 19. Specified above) 19. Specified above) 10. Specify 10. Specified above 11. Specified above 12. Specified above 13. Specified above 14. Specified above 15. Specified above 16. Specified above 17. Specified above 18. Specified above 19. S	Address of Lender							
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) 13. Total All Interest Expense (Specify) Vendor Interest 14. Insurance 15. Insurance on Property (buildings only) 16. Insurance on Automobiles 17. Insurance other than Property (as specified above) 18. Insurance other than Property (as specified above) 19. Umbrella (Blanket Coverage) 10. Time All Interest Expense (Specify) 11. Umbrella (Blanket Coverage) 12. Fire and Extended Coverage 13. Other (Specify) 15. Specify 16. Specify 17. Specify 18. Specified above) 19. Specified above) 19. Specified above) 10. Specify 10. Specified above 11. Specified above 12. Specified above 13. Specified above 14. Specified above 15. Specified above 16. Specified above 17. Specified above 18. Specified above 19. S	2. Other (Specify)		\$					
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) Vendor Interest 13. Total All Interest Expense (12B7 + 12C3 + 12D) 14. Insurance a. Insurance on Property (buildings only) b. Insurance on Automobiles c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) 2. Fire and Extended Coverage \$ 3. Other (Specify) \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$		Rate						
B. Item Rate Amount Lender Address of Lender 12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) \$ 12. D. Other Interest Expense (Specify) \$ 914 914 914 914 914 914 914 914 914 914	Lender							
Lender Address of Lender 12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) 12. D. Other Interest Expense (Specify) Vendor Interest 13. Total All Interest Expense (12B7 + 12C3 + 12D) 14. Insurance a. Insurance on Property (buildings only) b. Insurance on Automobiles c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) 2. Fire and Extended Coverage 3. Other (Specify) \$ 12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) \$ 914 914 914 915 916 917 918 918 919 919 919 919 919	Address of Lender							
Lender Address of Lender 12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) 12. D. Other Interest Expense (Specify) Vendor Interest 13. Total All Interest Expense (12B7 + 12C3 + 12D) 14. Insurance a. Insurance on Property (buildings only) b. Insurance on Automobiles c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) 2. Fire and Extended Coverage 3. Other (Specify) \$ 12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) \$ 914 914 914 915 916 917 918 918 919 919 919 919 919	D. I.	D (<u> </u>					
Address of Lender 12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) \$ 12. D. Other Interest Expense (Specify) \$ Vendor Interest 13. Total All Interest Expense (12B7 + 12C3 + 12D) \$ 14. Insurance a. Insurance on Property (buildings only) \$ b. Insurance on Automobiles \$ c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) \$ 2. Fire and Extended Coverage \$ 3. Other (Specify) \$	B. Item	Kate	Amount					
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) \$ 12. D. Other Interest Expense (Specify) \$ 914 914 Vendor Interest 13. Total All Interest Expense (12B7 + 12C3 + 12D) \$ 914 914 14. Insurance a. Insurance on Property (buildings only) \$ 68,696 68,696 b. Insurance on Automobiles \$ \$ c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) \$ 2. Fire and Extended Coverage \$ 3. Other (Specify) \$	Lender							
Expense (C1 + 2) \$ 914 914 12. D. Other Interest Expense (Specify) \$ 914 914 Vendor Interest 13. Total All Interest Expense (12B7 + 12C3 + 12D) \$ 914 914 14. Insurance a. Insurance on Property (buildings only) \$ 68,696 68,696 b. Insurance on Automobiles \$ c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) \$ 92. Fire and Extended Coverage \$ 93. Other (Specify) \$ 94	Address of Lender							
12. D. Other Interest Expense (Specify) Vendor Interest 13. Total All Interest Expense (12B7 + 12C3 + 12D) 14. Insurance a. Insurance on Property (buildings only) b. Insurance on Automobiles c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) 2. Fire and Extended Coverage 3. Other (Specify) \$ 914 914 68,696 68,696 68,696 5 2 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	12. C. 3. Total Movable Equipment Inte	rest						
Vendor Interest 13. Total All Interest Expense (12B7 + 12C3 + 12D) \$ 914 914 14. Insurance a. Insurance on Property (buildings only) \$ 68,696 68,696 b. Insurance on Automobiles \$ c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) \$ 2. Fire and Extended Coverage \$ 3. Other (Specify)			\$					
13. Total All Interest Expense (12B7 + 12C3 + 12D) \$ 914 914 14. Insurance a. Insurance on Property (buildings only) \$ 68,696 68,696 b. Insurance on Automobiles \$ 0. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) \$ 0. Fire and Extended Coverage \$ 0. Other (Specify) \$ 0. Other (Specify)	12. D. Other Interest Expense (Specify)		\$	914	914			
14. Insurance a. Insurance on Property (buildings only) \$ 68,696 b. Insurance on Automobiles \$ c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) \$ 2. Fire and Extended Coverage \$ 3. Other (Specify) \$	Vendor Interest							
a. Insurance on Property (buildings only) \$ 68,696 68,696 b. Insurance on Automobiles \$ c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) \$ 2. Fire and Extended Coverage \$ 3. Other (Specify) \$	13. Total All Interest Expense (12B7 + 12	2C3 + 12D	9) \$	914	914			
b. Insurance on Automobiles c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) 2. Fire and Extended Coverage 3. Other (Specify) \$								
c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) \$ 2. Fire and Extended Coverage \$ 3. Other (Specify) \$		only)			68,696			
1. Umbrella (Blanket Coverage) \$ 2. Fire and Extended Coverage \$ 3. Other (Specify) \$								
2. Fire and Extended Coverage \$ 3. Other (Specify) \$	_ ,							
3. Other (Specify)								
14d Total Insurance Expenditures (14a + b + c) \$ 68 606 68 606	3. Other (<i>Specify</i>)		\$					
14d Total Insurance Expenditures (14a + h + c) \$ 68 606 68 606								
14d Total Insurance Expenditures $(14a + b + c)$ \$ 68 606 68 606								
	14d Total Insurance Expenditures (14a +	68,696	68,696					
15. Total All Expenditures (A-13 thru C-14) \$ 12,771,827 12,771,827					-			

D. Adjustments to Statement of Expenditures

Name	of Fa	cility		Lic	ense No.	Report for Year	r Ended	Page of
Manc	hester	Man	or Health Care Center		2237-C	9/30/2020		28 37
					Total			
Item	Page	Line			Amount of			
No.			Item Description		Decrease	CCNH	RHNS	(Specify)
Page	10 - S	alarie	es and Wages					
1.			Outpatient Service Costs	\$				
2.			Salaries not related to Resident Care	\$				
3.			Occupational Therapy	\$				
4.			Other - See attached Schedule	\$				
Page	13 - P	rofess	sional Fees					
5.			Resident Care Physicians **	\$				
6.	13		Occupational Therapy	\$	382,946	382,946		
7.			Other - See attached Schedule	\$				
Pages	s 15 &	16 -	Administrative and General					
8.			Discriminatory Benefits	\$				
9.	15	1c	Bad Debts	\$	153,268	153,268		
10.	15	1d	Accounting	\$,		
10a.			Legal	\$				
11.	30	IV3	Telephone	\$	486	486		
12.			Cellular Telephone	\$	4,688	4,688		
13.			Life insurance premiums on the life					
			of Owners, Partners, Operators	\$				
14.	16	L3	Gifts, flowers and coffee shops	\$	42,272	42,272		
15.	16	15	Education expenditures to colleges or					
			universities for tuition and related costs					
			for owners and employees	\$	3,450	3,450		
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)	\$	1,755	1,755		
18.		m3	Unallowable Advertising *	\$	21,529	21,529		
19.	15	k2	Income Tax / Corporate Business Tax	\$				
20.	16	m10	Fund Raising / Contributions	\$	5,943	5,943		
21.			Unallowable Management Fees	\$				
22.			Barber and Beauty	\$				
23.			Other - See attached Schedule	\$	2,014	2,014		
Page			y Expenditures					
24.	30	IV8	Meals to employees, guests and others					
			who are not residents	\$	3,297	3,297		
	19 - L	aund	ry Expenditures					
25.			Laundry services to employees, guests					
			and others who are not residents	\$				
Page	20 - H		keeping Expenditures					
26.	-	-	Housekeeping services to employees, guests					
			and others who are not residents	\$				
			Subtotal (Items 1 - 26)	\$	621,649	621,649		

^{*} 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)
_					
Total Othe	r Salaries A	Adjustment	\$ -	\$ -	\$ -

.....

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNE	I	RH	NS	(Specify	')
Total Othe	otal Other Fees Adjustments		\$	-	\$	-	\$	-

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	\$	697		
30	IV4	Rental of TV Income	\$	1,084		
Total Othe	Total Other A&G Adjustments				\$ -	\$ -

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

	D. Adjustments to Statement of Expenditures (cont'd)									
Nam	e of Fa	acility		Lic	ense No.	Report for Y	ear Ended	Page	of	
Mano	chester	Man	or Health Care Center		2237-C	9/30/2020		29	37	
					Total					
Item	Page	Line			Amount of					
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	(Sp	ecify)	
			Subtotals Brought Forward	\$	621,649	621,649				
Page	20 - K	Reside	nt Care Supplies***							
27.	20	5a2	Prescription Drugs	\$	247,407	247,407				
28.			Ambulance/Limousine	\$						
29.	20	5f	X-rays, etc	\$						
30.	20	5h	Laboratory	\$	44,380	44,380				
31.	20	5c	Medical Supplies	\$	83,918	83,918				
32.	20	5e2	Oxygen (non emergency)	\$	63,873	63,873				
33.			Occupational Therapy	\$						
34.			Other - See Attached Schedule	\$	9,604	9,604				
Page	22 - N	<i>Iainte</i>	enance 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 - I	nsura	nce							
40.			Mortgage Insurance	\$						
41.			Property Insurance	\$						
Othe	r - Mis	scella	neous							
42.			Other - Indirect	\$						
43.	30	IV5	Interest Income on Account Rec.	\$	215	215				
44.			Other - Miscellaneous Administrative	\$						
45.			Management Fees Direct	\$						
46.			Management Fees Indirect	\$						
47.			Other - Direct	\$						
Not 1	For Pr	ofit P	roviders Only							
48.			Building/Non Movable Eq. Depreciation							
			Unallowable Building Interest -							
			See Attached Schedule	\$						
49.	Total	Amoi	unt of Decrease (Items 1 - 48)	\$	1,071,046	1,071,046				

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

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH		RHNS	(Specify)
20	5j	Supplies - Rehabilitative	\$	9,604		
Total Othe	r Ancillary	Costs	\$	9,604	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Exce	ss Movable	Equipment Depreciation	\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Othe	r Property	Adjustments	\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Othe	r Adjustme	ents	\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unal	lowable Bui	ilding Interest	\$ -	\$ -	\$ -

CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility Manchester Manor Health Care Center License No. 2237-C		Report for Year Ended 9/30/2020				of
Manchester Manor Health Care Center 2237-C		9/30/2020			30	37
Item		Total	CCNH	RHNS	(Spec	rify)
I. Resident Room, Board & Routine Care Revenue		Total	CCIVII	KIIIVB	(Spec	Jiry)
1. a. Medicaid Residents (CT only)	\$	9,123,752	9,123,752			
b. Medicaid Room and Board Contractual Allowance **	\$	(4,267,212)	(4,267,212)			
2. a. Medicaid (All other states)	\$	(4,207,212)	(4,207,212)			
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (all inclusive)		2 495 205	2 495 205			
	\$	2,485,295	2,485,295			
b. Medicare Room and Board Contractual Allowance **	\$	(2,010,354)	(2,010,354)			
4. a. Private-Pay Residents and Other	\$	5,003,578	5,003,578			
b. Private-Pay Room and Board Contractual Allowance **	\$	(355,588)	(355,588)			
II. Other Resident Revenue						
a. Prescription Drugs - Medicare	\$	163,547	163,547			
b. Prescription Drugs - Medicare Contractual Allowance **	\$	889,575	889,575			
c. Prescription Drugs - Non-Medicare	\$	166,262	166,262			
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	\$	987,520	987,520			
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$	340,514	340,514			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$	284,005	284,005			
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$	54,002	54,002			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$	- ,	-)			
5. a. Occupational Therapy - Medicare	\$	956,705	956,705			
b. Occupational Therapy - Medicare Contractual Allowance **	\$,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,,,			
c. Occupational Therapy - Non-Medicare	\$	326,456	326,456			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$	320,130	320,130			
6. a. Other (Specify) - Medicare	\$	383,017	383,017			
b. Other (Specify) - Non-Medicare	\$	(709,323)	(709,323)			
III. Total Resident Revenue (Section I. thru Section II.)	\$					
IV. Other Revenue*	ψ	13,821,751	13,821,751			
	.					
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$	486	486			
4. Rental of Television and Cable Services	\$	1,084	1,084			
5. Interest Income (Specify)	\$	261	261			
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (Specify)	\$	31,623	31,623			
V. Total Other Revenue (1 thru 8)	\$	33,454	33,454			
VI. Total All Revenue (III +V)	\$	13,855,205	13,855,205			

 $^{* \ \}textit{Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.}$

^{**} 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	\$ 775,771		
	Med A & Med B Contractual Allowances	\$ (1,237,298)		
	Medicare HHS Stimulus Payments	\$ 844,544		
Total Oth	er Resident Revenue - Medicare	\$ 383,017	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	(CCNH	RHNS	(Specify)
	Managed Care Ancillaries	\$	146,202		
	Managed Care Contractual Allowances	\$	(855,525)		
	Medicaid Ancillary Contractual Allowance				
Total Oth	er Resident Revenue	\$	(709,323)	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	C	CNH	RHNS	(Specify)
30 A1	Interest Income - Reserves		\$	46		
30 A2	Interest Income - AR		\$	215		
Total Inte	rest Income		\$	261	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	C	CNH	RHNS	(Specify)
18 2 d	Vending Income	\$	3,297		
	Dividend Income	\$	5,985		
	Miscellaneous Income	\$	1,140		
	Gain/Loss on Sale of Fixed Assets	\$	(151)		
	Gain/Loss on Investments	\$	(4,124)		
	Program Fees - Alt. Payments	\$	25,476		
Total Othe	er Revenue	\$	31,623	\$ -	\$ -

G. Balance Sheet

Account Amount		Facility	License No.	Report for Year Ended	Page	of
According Second Manches	ster Manor Health Care Cente		9/30/2020	31	37	
Current Assets 1. Cash (on hand and in banks) \$ 2,297,49			Account			Amount
1. Cash (on hand and in banks) \$ 2,297,49						
2. Resident Accounts Receivable (Less Allowance for Bad Debts) \$ 703,41 3. Other Accounts Receivable (Excluding Owners or Related Parties) \$ 4. Inventories \$ 5. Prepaid Expenses \$ 19,80 a. b.	A. Cu		`			2 207 404
3. Other Accounts Receivable (Excluding Owners or Related Parties) 5	1.			P 1 1 1 1 1 1		
1				,		703,416
5. Prepaid Expenses \$ 19,80 a. b			(Excluding Owners of	r Related Parties)		
a. b. c. d. See Schedule 19,806 6. Interest Receivable \$ 7. Medicare Final Settlement Receivable \$ 8. Other Current Assets (itemize) \$ See Schedule 7,226 See Schedule 7,226 3. Fixed Assets 1. Land \$ 2. Land Improvements *Historical Cost Accum. Depreciation 3,070,567 Net 5. Non-Movable Equipment *Historical Cost Accum. Depreciation Accum. Depreciation 3131,789 Net 6. Movable Equipment *Historical Cost Accum. Depreciation Accum. Depreciation 3131,789 Net 7. Motor Vehicles *Historical Cost Accum. Depreciation Accum. Depreciation Accum. Depreciation Accum. Depreciation S13,789 Net 7. Motor Vehicles *Historical Cost Accum. Depreciation Accum. Depreciation S23,258 Net 7. Motor Vehicles *Historical Cost Accum. Depreciation S23,258 Net 8. Minor Equipment-Not Depreciable \$ 9. Other Fixed Assets (itemize) \$ See Schedule						10.00
C. C. C. C. C. C. C. C.	5.				\$	19,806
C. C. C. C. C. C. C. C.		a			_	
d. See Schedule		b			_	
6. Interest Receivable 7. Medicare Final Settlement Receivable 8. Other Current Assets (itemize) See Schedule 7, 226 See Schedule 7, 226 See Schedule 7, 226 See Schedule 7, 226 See Schedule 8. Fixed Assets (Lines AI thru 8) 8. Fixed Assets 1. Land 2. Land Improvements 8 Historical Cost Accum. Depreciation 9. Accum. Depreciation Accum. Depreciation 4. Leasehold Improvements 8 Historical Cost Accum. Depreciation 9. Net 9. Non-Movable Equipment 9. Non-Movable Equipment 1. Historical Cost Accum. Depreciation 9. Net 9. Movable Equipment 1. Historical Cost Accum. Depreciation 9. Net 9. Movable Equipment 1. Historical Cost Accum. Depreciation 9. See Schedule 9. Other Fixed Assets (itemize) See Schedule See Schedule See Schedule		c				
7. Medicare Final Settlement Receivable \$ 8. Other Current Assets (itemize) \$ See Schedule 7,226 A-9. Total Current Assets (Lines A1 thru 8) \$ 3. Fixed Assets \$ 1. Land \$ 2. Land Improvements *Historical Cost Accum. Depreciation \$ 3. Buildings *Historical Cost Accum. Depreciation \$ 4. Leasehold Improvements *Historical Cost Accum. Depreciation \$ 5. Non-Movable Equipment *Historical Cost Accum. Depreciation \$ 6. Movable Equipment *Historical Cost Accum. Depreciation \$ 7. Motor Vehicles *Historical Cost Accum. Depreciation \$ 8. Minor Equipment-Not Depreciable \$ 9. Other Fixed Assets (itemize) \$ See Schedule \$				19,806		
See Schedule 7,226						
See Schedule 7,226						
Society	8.	Other Current Assets (itemiz	ce)		\$	7,226
Society						
Society					_	
See Schedule Signs		See Schedule		7,226	_	
Sample S	4-9. <i>To</i>	tal Current Assets (Lines A1	thru 8)		\$	3,027,944
2. Land Improvements *Historical Cost Accum. Depreciation 399,954 Se Schedule \$ 89,55 3. Buildings *Historical Cost Accum. Depreciation Net \$ 89,55 4. Leasehold Improvements *Historical Cost Accum. Depreciation 6,341,198 Sa,270,63 \$ 3,270,63 5. Non-Movable Equipment *Historical Cost Accum. Depreciation 772,577 Sa,277 Sa,273,604 Sa,258 \$ 22,34 6. Movable Equipment *Historical Cost Accum. Depreciation 975,604 Sa,258 Net \$ 22,34 7. Motor Vehicles *Historical Cost Accum. Depreciation Net \$ 3,270,63 8. Minor Equipment-Not Depreciable \$ 331,789 Net \$ 32,34 9. Other Fixed Assets (itemize) \$ 36,341,198 Sa,270,63 \$ 32,270,63	B. Fix	xed Assets				
Accum. Depreciation 310,403 Net	1.	Land			\$	
Accum. Depreciation 310,403 Net			*Historical Cost	399,954	\$	89,551
3. Buildings		1	Accum. Depreciati			,
Accum. Depreciation	3.	Buildings		,	\$	
4. Leasehold Improvements *Historical Cost Accum. Depreciation 6,341,198 3,270,63 5. Non-Movable Equipment *Historical Cost Accum. Depreciation 772,577 7 331,789 \$ 440,78 6. Movable Equipment *Historical Cost Accum. Depreciation 975,604 975,604 975,604 \$ 22,34 7. Motor Vehicles *Historical Cost Accum. Depreciation Net \$ 8. Minor Equipment-Not Depreciable \$ 8. Minor Equipment-Not Depreciable \$ 8. Minor Equipment-Not Depreciable \$ 8. See Schedule		8		ion Net		
Accum. Depreciation 3,070,567 Net	4.	Leasehold Improvements			S	3,270,631
5. Non-Movable Equipment *Historical Cost 772,577 Accum. Depreciation 331,789 Net 6. Movable Equipment *Historical Cost 975,604 \$ 22,34 Accum. Depreciation 953,258 Net 7. Motor Vehicles *Historical Cost Accum. Depreciation Net 8. Minor Equipment-Not Depreciable \$ 9. Other Fixed Assets (itemize) \$ \$ See Schedule			Accum. Depreciati			-,-,-,
Accum. Depreciation 6. Movable Equipment *Historical Cost Accum. Depreciation 7. Motor Vehicles *Historical Cost Accum. Depreciation *Historical Cost Accum. Depreciation Net 8. Minor Equipment-Not Depreciable 9. Other Fixed Assets (itemize) See Schedule	5.	Non-Movable Equipment			S	440.788
6. Movable Equipment *Historical Cost 975,604 \$ 22,34 Accum. Depreciation 953,258 Net 7. Motor Vehicles *Historical Cost Accum. Depreciation Net 8. Minor Equipment-Not Depreciable \$ 9. Other Fixed Assets (itemize) \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	٠.					, , , , ,
Accum. Depreciation 953,258 Net 7. Motor Vehicles *Historical Cost	6	Movable Equipment			\$	22 346
7. Motor Vehicles *Historical Cost \$ Accum. Depreciation Net 8. Minor Equipment-Not Depreciable \$ 9. Other Fixed Assets (itemize) \$ See Schedule	0.	THE VACIO Equipment			Ψ	22,540
Accum. Depreciation Net 8. Minor Equipment-Not Depreciable \$ 9. Other Fixed Assets (itemize) \$ See Schedule	7	Motor Vehicles		755,256 1101	•	
8. Minor Equipment-Not Depreciable 9. Other Fixed Assets (itemize) See Schedule \$	7.	Wiotor Venicles		Not	Φ	
9. Other Fixed Assets (itemize) See Schedule	0	Minor Equipment Not Done		loli Net	©	
See Schedule	٥.	Millor Equipment-Not Depre	ECIADIC		Φ	
	9.	Other Fixed Assets (itemize))		\$	
		See Schedule			_	
5,825,51	2 10		R1 thru 9)		•	2 002 214
	B-10.	Ioiai Fixea Assets (Lines B	or inru 9)		\$	3,823,3

^{*} 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 Fac	cility	License No.	Report for Year Ended		Page		of
Manchester	Manor Health Care Center	2237-C	9/30/2020		32		37
		Account			Amo	unt	
			Total Brought Forward:	\$		6,851,2	259
C. Leasel	hold or like property records	ed for Equity Purpose	S.				
1. La:				\$			
2. La	and Improvements	*Historical Cost					
		Accum. Depreciation	Net Net	\$			
3. Bu	ıildings	*Historical Cost					
		Accum. Depreciation	Net Net	\$			
4. No	on-Movable Equipment	*Historical Cost					
		Accum. Depreciation	Net Net	\$			
5. Mo	ovable Equipment	*Historical Cost					
		Accum. Depreciation	Net Net	\$			
6. Mo	otor Vehicles	*Historical Cost					
		Accum. Depreciation	Net Net	\$			
	inor Equipment-Not Deprec			\$			
	Leasehold or Like Propertion	es (C1 thru 7)		\$			
	ment and Other Assets						
	eferred Deposits			\$			
	crow Deposits			\$			
3. Or	ganization Expense	*Historical Cost					
		Accum. Depreciation	Net Net	\$			
	oodwill (Purchased Only)			\$			
5. Inv	vestments Related to Reside	ent Care (itemize)		\$			
			T				
6. Lo	oans to Owners or Related Pa			\$			_
	Name and Address	Amount	Loan Date				
7. 0.1	1			Φ			
/. Ot	ther Assets (itemize)			\$			
	C C -1 - 11 -						
	See Schedule	ata (Linas D1 thm: 7)		¢			
	Investments and Other Asso All Assets (Lines A9 + B10			\$		(0.51 /	250
D-9. Total I	Au Asseis (Lilles A5 + D10	7 · Co · Do)		\$		6,851,2	239

^{*} 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 Fac	cility		License No.	Report for Year	Ended	Page	of
Manchester	Mano	or Health Care Center	2237-C	9/30/2020		33	37
			Account			1	Amount
Liabilities							
A.	Cu	rrent Liabilities					
	1.	Trade Accounts Payable				\$	445,368
	2.	Notes Payable (itemize)				\$	
						4	
						1	
		See Schedule				1	
	3.	Loans Payable for Equip	nent (Current portion	n) (itemize)		\$	
	<u> </u>	Name of Lender	Purpose	Amount	Date Due	Ψ	
		1,00000	1 p 0.00	1 11110 01110			
		1 1 1 1 /F 1 1	6.0			Ф	252 500
	4.	Accrued Payroll (Exclusion 1971)	•			\$	372,780
	5.	Accrued Payroll (Owners		only)		\$	
	6.	Accrued Payroll Taxes Pa				\$	
	7.	Medicare Final Settlemen				\$	
	8.	Medicare Current Financ Mortgage Payable (<i>Curre</i>				\$ \$	
	9.	<u> </u>	· · · · · · · · · · · · · · · · · · ·	Polato d Dantina)			
		. Interest Payable (<i>Exclusi</i> . Accrued Income Taxes*	e oj Owner ana/or K	telalea Pariles)		\$ \$	
		Other Current Liabilities	(itamiza)			\$	2,515,928
	12	. Other Current Liabilities	(tiemize)			J	2,313,928
				See Schedule	2,515,928		
A-13	. To	tal Current Liabilities (Li	nes A1 thru 12)	See Selledaio	2,515,520	\$	3,334,076
							, - ,- ,-

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

Annual Report of Long-Term Care Facility

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G. Balance Sheet (cont'd)

Manchester Manor Health Care Center 2237-C 9/30/2020 34 37	Name of Facility	License No.	Report for Year	Ended	Page	of
Total Brought Forward: 3,334,076	Manchester Manor Health Care Center	2237-C	9/30/2020		34	37
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) Name and Address of Lender Amount Loan Date 4. Other Long-Term Liabilities (itemize) See Schedule B-5. Total Long-Term Liabilities (Lines B1 thru 4)		Account			Am	
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) Name and Address of Lender Amount Loan Date 4. Other Long-Term Liabilities (itemize) See Schedule B-5. Total Long-Term Liabilities (Lines B1 thru 4) §			Total Broug	ht Forward:		3,334,076
1. Loans Payable-Equipment (itemize) Name of Lender Purpose Amount Date Due 2. Mortgages Payable 3. Loans from Owners or Related Parties (itemize) Name and Address of Lender Amount Loan Date 4. Other Long-Term Liabilities (itemize) See Schedule B-5. Total Long-Term Liabilities (Lines B1 thru 4) S	` '					
Name of Lender		<i>(</i>				
2. Mortgages Payable 3. Loans from Owners or Related Parties (itemize) Name and Address of Lender 4. Other Long-Term Liabilities (itemize) See Schedule B-5. Total Long-Term Liabilities (Lines B1 thru 4) S			T			
3. Loans from Owners or Related Parties (itemize) Name and Address of Lender Amount Loan Date 4. Other Long-Term Liabilities (itemize) See Schedule B-5. Total Long-Term Liabilities (Lines B1 thru 4) \$	Name of Lender	Purpose	Amount	Date Due		
3. Loans from Owners or Related Parties (itemize) Name and Address of Lender Amount Loan Date 4. Other Long-Term Liabilities (itemize) See Schedule B-5. Total Long-Term Liabilities (Lines B1 thru 4) \$						
3. Loans from Owners or Related Parties (itemize) Name and Address of Lender Amount Loan Date 4. Other Long-Term Liabilities (itemize) See Schedule B-5. Total Long-Term Liabilities (Lines B1 thru 4) \$						
3. Loans from Owners or Related Parties (itemize) Name and Address of Lender Amount Loan Date 4. Other Long-Term Liabilities (itemize) See Schedule B-5. Total Long-Term Liabilities (Lines B1 thru 4) \$						
3. Loans from Owners or Related Parties (itemize) Name and Address of Lender Amount Loan Date 4. Other Long-Term Liabilities (itemize) See Schedule B-5. Total Long-Term Liabilities (Lines B1 thru 4) \$						
3. Loans from Owners or Related Parties (itemize) Name and Address of Lender Amount Loan Date 4. Other Long-Term Liabilities (itemize) See Schedule B-5. Total Long-Term Liabilities (Lines B1 thru 4) \$						
3. Loans from Owners or Related Parties (itemize) Name and Address of Lender Amount Loan Date 4. Other Long-Term Liabilities (itemize) See Schedule B-5. Total Long-Term Liabilities (Lines B1 thru 4) \$						
3. Loans from Owners or Related Parties (itemize) Name and Address of Lender Amount Loan Date 4. Other Long-Term Liabilities (itemize) See Schedule B-5. Total Long-Term Liabilities (Lines B1 thru 4) \$						
3. Loans from Owners or Related Parties (itemize) Name and Address of Lender Amount Loan Date 4. Other Long-Term Liabilities (itemize) See Schedule B-5. Total Long-Term Liabilities (Lines B1 thru 4) \$						
3. Loans from Owners or Related Parties (itemize) Name and Address of Lender Amount Loan Date 4. Other Long-Term Liabilities (itemize) See Schedule B-5. Total Long-Term Liabilities (Lines B1 thru 4) \$						
3. Loans from Owners or Related Parties (itemize) Name and Address of Lender Amount Loan Date 4. Other Long-Term Liabilities (itemize) See Schedule B-5. Total Long-Term Liabilities (Lines B1 thru 4) \$	2. Mortgages Pavable			\$		
Amount Loan Date 4. Other Long-Term Liabilities (itemize) See Schedule B-5. Total Long-Term Liabilities (Lines B1 thru 4) \$ \$		lated Parties (itemize)			
4. Other Long-Term Liabilities (itemize) See Schedule B-5. Total Long-Term Liabilities (Lines B1 thru 4) \$ \$		1				
See Schedule B-5. <i>Total Long-Term Liabilities</i> (Lines B1 thru 4) \$						
See Schedule B-5. <i>Total Long-Term Liabilities</i> (Lines B1 thru 4) \$				_		
See Schedule B-5. <i>Total Long-Term Liabilities</i> (Lines B1 thru 4) \$				_		
See Schedule B-5. <i>Total Long-Term Liabilities</i> (Lines B1 thru 4) \$				_		
See Schedule B-5. <i>Total Long-Term Liabilities</i> (Lines B1 thru 4) \$				_		
See Schedule B-5. <i>Total Long-Term Liabilities</i> (Lines B1 thru 4) \$				_		
See Schedule B-5. <i>Total Long-Term Liabilities</i> (Lines B1 thru 4) \$				_		
See Schedule B-5. <i>Total Long-Term Liabilities</i> (Lines B1 thru 4) \$				_		
See Schedule B-5. <i>Total Long-Term Liabilities</i> (Lines B1 thru 4) \$				_		
See Schedule B-5. <i>Total Long-Term Liabilities</i> (Lines B1 thru 4) \$				_		
See Schedule B-5. <i>Total Long-Term Liabilities</i> (Lines B1 thru 4) \$	4 Other Long Town Lightlit	iga (itamiza)		¢		
B-5. Total Long-Term Liabilities (Lines B1 thru 4)	4. Other Long-Term Liability	les (tiemize)		\$		
B-5. Total Long-Term Liabilities (Lines B1 thru 4)						
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				_		
B-5. Total Long-Term Liabilities (Lines B1 thru 4)	See Schedule					
		(Lines B1 thru 4)		¢		
				\$		3,334,076

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

	ne of Facility License No. Report for Year Ended		Page	of
Mar	nchester Manor Health Care Cente 2237-C 9/30/2020		35	37
_	Account		An	nount
A.	Reserves			
	1. Reserve for value of leased land	\$		
	2. Reserve for depreciation value of leased buildings and appurtenances			
	to be amortized	\$		
	3. Reserve for depreciation value of leased personal property (<i>Equity</i>)	\$		
	4. Reserve for leasehold real properties on which fair rental value is based	\$		
	5. Reserve for funds set aside as donor restricted	\$		
	6. Total Reserves	\$		
B.	Net Worth			
	1. Owner's Capital	\$		2,433,805
	2. Capital Stock	\$		
	3. Paid-in Surplus	\$		
	4. Treasury Stock	\$		
	5. Cumulated Earnings	\$		
	6. Gain or Loss for Period 10/1/2019 thru 9/30/20	20 \$		1,083,378
	7. Total Net Worth	\$		3,517,183
C.	Total Reserves and Net Worth	\$		3,517,183
D.	Total Liabilities, Reserves, and Net Worth	\$		6,851,259

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year	Ended	Page	of
Manchester Manor Health Care Cente	er 2237-C	9/30/2020		36	37
	Account			A	mount
A. Balance at End of Prior Period as shown on Report of 09/30/2019					7,834,218
B. Total Revenue (From Statement of Revenue Page 30)					13,855,205
C. Total Expenditures (From Statement of Expenditures Page 27)					12,771,827
D. Net Income or Deficit					1,083,378
E. Balance				\$	8,917,596
F. Additions 1. Additional Capital Contribut 2. Other (itemize)	ted (itemize)				
F-3. Total Additions				\$	
G. Deductions					
1. Drawings of Owners/Operat	1. Drawings of Owners/Operators/Partners (Specify)			\$	
Name and Address (No., Ci	ty, State, Zip)	Title	Amount		
2. Other Withdrawings (Specify	y)			\$	
Purpose Amount		ount			
2 Tatal Dadwatiana				0	
3. Total Deductions Balance at End of Period 09/30/20				\$	0.017.507
H. Balance at End of Period	Balance at End of Period 09/30/20			\$	8,917,596

I. Preparer's/Reviewer's Certification

		License No.	Report for Year Ended Page of				
Manche	ester Manor Health Care Center	2237-C	9/30/2020 37 37				
Check appropriate category							
	Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)	□ (Specify)				
Preparer/Reviewer Certification							
I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.							
Signatu	re 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							