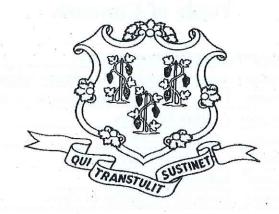
State of Connecticut



Annual Report of Long-Term Care FacilityCost Year 2015

3 4		- V				£ 6	
Name of Facility (as							
Green Lodge of Mar	chester, Inc.						
Address (No. & Stre	et, City, State, 2	Zip Code)					
612 East Middle Tpl	ce. Manchester,	CT					
Type of Facility		-					
Chronic and (Convalescent		Rest Home	with Nursing			
☐ Nursing Hom	e only		~			dential Ca	re Home
(CCNH)			1	1			
Report for Year Beg	inning		Notes	Cleare			
10/1/2014	~	1	v (les	C careo,			
		T					
License Numbers:		CCNF			tial Care Home	- Me	edicare Provider
				_	1702	J IVIC	dicare i rovider
					1702		
	16						
Medicaid Provider N	umbers:	CC	CNH	RI	INS	IC	F-IID
For Department Us	e Only						
Sequence Number	Signed and	Date	Sequence	Number	Cionad and N	ل مانسمه	Data Danaina I
Assigned	Notarized	Received	Assi	gned	Signed and N	otarized	Date Received
	0.7						1 n 2

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Green Lodge of Manchester, Inc.	1702	9/30/2015	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 Green Lodge of Manchester, Inc. [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)	Date		
Printed Name (Administrator)			Printed Name (Owner)			
Subscribed and Sworn State of to before me:		Date	Signed (Notary Public)	Comm. Expires		
Address of Notary Public	.l.			<u> </u>		

(Notary Seal)

State of Connecticut **Department of Social Services**

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	tm	ent		Page 1A	of 37
Name of Facility		Period Cov	ered:	From	То
Green Lodge of Manchester, Inc.				10/1/2014	9/30/2015
Address of Facility 612 East Middle Tpke. Manchester, CT					
Report Prepared By		Phone Num	ber	Date	
Item	1.1	Total	CCNH	RHNS	Residentia 1 Care Home
Dietary wages paid	\$	39,199			39,199
2. Laundry wages paid	\$	16,640			16,640
3. Housekeeping wages paid	\$	26,688			26,688
4. Nursing wages paid	\$				
5. All other wages paid	\$	265,237			265,237
6. Total Wages Paid	\$	347,764			347,764
7. Total salaries paid	\$				
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$	347,764			347,764

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

			ne No. of Fac -649-5985	cility	Report for Y 9/30/2015	'ear Ended	Page 2		of 37
Name of Facility (as shown on license)		1800		o. & S	Street, City, S	tate, Zip)	4		<u> </u>
Green Lodge of Manchester, Inc.			1		Tpke. Manch				
	CCNH	l l	RHNS		dential Care l		Medicare I	rovid	er No.
License Numbers:						1702			
Type of Facility (Check appropriate box(es)))								
Chronic and Convalescent Nursing Home only (CCNH)			t Home with ervision only			l Residenti	al Care Hor	ne	
Type of Ownership (Check appropriate box)									
O Proprietorship O LLC O P	Partnership	•	Profit Corp.	0	Non-Profit Co	orp. O	Government	0	Trust
If this facility opened or closed during report	t year provide	e:		Date	Opened	Date Clos	sed		
Has there been any change in ownership	·					l.			
or operation during this report year?		0	Yes	•	No	If "Yes,"	explain full	у.	
Administrator					·				
Name of Administrator					Nursing H				
Stuart T. Beilman					Administra	I			
Other Organizations/Organization	1	/C . 11		Cil	License	No.:			
Other Operators/Owners who are assistant ac Name	iministrators	(IuII	or part time)	or th	License	N's a			
Ivanic					License	No.:			
			•						
						I			

General Information and Questionnaire Partners/Members

Name of Facility		License No.	Report for Y	ear Ended	Page of
Green Lodge of Manchester, Ir	nc.	1702	9/30/2015		3 37
Legal Name of Part	nership/LLC	Business A	Address		or Town(s) in egistered
Name of Partners/Members	Business Ac	ldress		Γitle	% Owned

General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year Er	nded	Page of
Green Lodge of Manchester, Inc.	1702	9/30/2015		3A 37
If this facility is owned or operated as a corp	oration, provide th	e following informa	tion:	
Legal Name of Corporation	Busines	Business Address		ch Incorporated
Green Lodge of Manchester,	612 East Middle	Tpke. Manchester	СТ	
Inc.	CT 06040			
				i
Name of Directors, Officers	Busines	s Address	Title	No. Shares Held by Each
Stuart T. Beilman	26 Mohawk Circl 06111	e Newington CT	President	
Nancy Beilman	26 Mohawk Circl 06111	e Newington CT	Secretary	100
Names of Stockholders Owning at Least 10% of Shares				
Nancy Beilman	26 Mohawk Circle 06111	e Newington CT		1

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-3B Rev. 10/2005

General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Green Lodge of Manchester, Inc.	1702	9/30/2015	3B	37
If this facility is owned or operated as an indiv	idual proprietorship,	provide the following inform	ation:	
	Owner(s) of Facility			
	•			
				•
	:			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-4 Rev. 10/2005

General Information and Questionnaire Related Parties*

Name of Facility Green Lodge of Manchester, Inc.	ster, Inc.	License No.	No. 1702	Report for Year Ended 9/30/2015		Page 4	of 37
over cloubiniting and	t oft most softon from the	1342	14 10 14 17				
marriage, ability to conti	marriage, ability to control, ownership, family or business association?	ess assoc	ino.	o Yes © No	If "Yes," provide the Name/Address and complete the information on Page 11 of the report.	e Name/Ado nation on Pa	fress and ge 11 of the report.
							1
Are any individuals or c	Are any individuals or companies which provide goods or services,	or servi	ces,				
including the rental of p	including the rental of property or the loaning of funds to this facility,	to this fa	cility,				
association to any of the	association to any of the owners, operators, or officials of this facility?	of this fa	or ousiness icility?	• Yes O No	If "Yes," provide the following information:	e following	information:
	A TABLE SALLS SALL			Half to a second			and a state of the
	_	Also]	Provides		Indicate Where		
		Goods	Goods/Services to		Costs are Included		
Name of Related	Business	Non-R	므	Description of Goods/Services		Cost	Actual Cost to the
Individual or Company	Address	Yes	No %**	Provided	Page # / Line #	Reported	Related Party
Nancy Beilman	26 Mohawk Circle Newington CT 06111	0	•	Owner of land and building	pg 22/9 & 10b	24,000	
		0	0				
		0	0				
		0	0				
		0	0				Acceptance of the second secon
		0	0				
		0	0				
		0	0				A PARTY TO THE PARTY TO
		0	0				
* I Ico odditional about if the	1++						

^{*} Use additional sheets if necessary.

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

General Information and Questionnaire Basis for Allocation of Costs

Name of Facility	License No		Report for Year Ended	Page	of
Green Lodge of Manchester, Inc.	1702		9/30/2015	5	37
If the facility is licensed as CDH and/or RCH o	r provides A	AIDS or TB	services with special Medicai	d rates,	costs
must be allocated to CCNH and RHNS as follo	ws:				
Item			Method of Allocation		
Dietary		Number of	meals served to residents		
Laundry		Number of	pounds processed		***
Housekeeping		Number of	square feet serviced		
		Number of	hours of routine care provided	by EAG	CH
Nursing		employee c	lassification, i.e., Director (or	Charge	Nurse),
		Registered	Nurses, Licensed Practical Nu	rses, Ai	des and
		Attendants			
Direct Resident Care Consultants		Number of	hours of resident care provide	d by EA	.CH
		specialist (See listing page 13)		
Maintenance and operation of plant		Square feet			
Property costs (depreciation)		Square feet			
Employee health and welfare		Gross salar			
Management services			e cost center involved		
All other General Administrative expenses		Total of Di	rect and Allocated Costs		
The preparer of this report must answer the following questions applicable to the cost information provided.					
1. In the preparation of this Report, were all Q Voc O No If "No," explain fully why such allocation was					
costs allocated as required? O Yes O No not made.					
2. Explain the allocation of related company ex	penses and	attach copy	of appropriate supporting data	ι.	
·					
				· · · · ·	
3. Did the Facility appropriately allocate and se	elf-disallow	direct and in	ndirect costs to non-nursing ho	me cost	t centers?
(e.g., Assisted Living, Home Health, Outpati	ent Services	s, Adult Day	Care Services, etc.)		
	0. 17	O N	If "No," explain fully why suc	h alloca	tion was
	• Yes	O NO	not made.		

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CSP-6 Rev. 9/2002

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.

of 37 Amount Claimed Page of Lease Amount Annual Report for Year Ended Term of Lease 9/30/2015 Date of Lease** Description of Items Leased 1702 License No. Related * to No Operators, 0 0 0 0 0 0 0 0 Officers 0 0 Owners, Yes 0 0 0 0 O 0 0 0 0 0 Name and Address of Lessor Green Lodge of Manchester, Inc. Name of Facility

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

Is a Mileage Log Book Maintained for All Leased Vehicles?

Total ***

% O

O Yes

** Attach copies of newly acquired leases.

*** Amount should agree to Page 22, Line 6e.

Annual Report of Long-Term Care Facility

CSP-7 Rev. 6/95

General Information and Questionnaire Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page of
Green Lodge of Manchester, Inc.	1702	9/30/2015	7 37
The records of this facility for the p	period covered by this re	port were maintained on the following basis:	
	Modified Cash		
Is the accounting basis for this		50m t n 11	
E	Yes	If "No," explain.	
previous period?	No		
Independent Accounting Firm			
Name of Accounting Firm	•	Address (No. & Street, City, State, Zip Code)
1 None			
2			
3		·	
4			
Services Provided by This Firm (de	scribe fully)		
1 None			\$
2			\$
3			\$
4			\$
			Charge for Services Provided
			\$
Are Those Charges Patlested in the Evnen	diture Portion of This Repor	t? If Yes, Specify Expense Classification and Line No.	.1*
O Yes O No		t: If 103, openly Expense Chastitedicin and Emo 110.	
Legal Services Information			
Name of Legal Firm or Independen	t Attorney		Telephone Number
	t Attorney		Tolophone Humbol
2			
3			
4			
5 Address (No. & Street, City, State, 1	Zin Coda)		
1	zip Code j		
2			
3			
4			
5			
Services Provided by This Firm (de	scribe fully)		
1 None			\$
2			\$
3			\$
4		1,000	\$
			\$
5		1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	Charge for Services Provided
			_
		O TOTAL OLD TO	\$
Are These Charges Reflected in the Expen	diture Portion of This Repor	t? If Yes, Specify Expense Classification and Line No.	
O Yes O No			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 9/2002

Schedule of Resident Statistics

Name of Facility Green Lodge of Manchester, Inc.			License No. 170	No. 1702			Report for 9/30/2015	Report for Year Ended 9/30/2015	-9		Page 8	of 37
						Period 10/1 Thru 6/30	/1 Thru 6/	30		Period 7/1	E	
	Total Ail	Total	Total	Total				J. 777				
	Levels	Level	Level	Care Home	Total	CCNH	RHINS	Kesidentiai Care Home	Total	CCNH	RHNS	Kesidential
1. Certified Bed Capacity												amore and
A. On last day of PREVIOUS report period	20			20	20			20	20			20
B. On last day of THIS report period	20			20	20			20	20			02
2. Number of Residents												3
A. As of midnight of PREVIOUS report period	19			19	19			61	61			19
B. As of midnight of THIS report period	19			19	19			19	10			10
3. Total Number of Days Care Provided During Period												
A. Medicare												
B. Medicaid (Conn.)	6,728			6,728	4,963			4,963	1.765			1 765
C. Medicaid (other states)			-									
D. Private Pay												
E. State SSI for RCH								The state of the s				
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	6,728			6,728	4.963			4 963	1 765			1 765
Total Number of Days Not Included in Figures in 3G 4. for Which Revenue Was Received for Reserved Beds									3			20141
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	6,728			6,728	4,963			4,963	1,765			1,765

Schedule of Resident Statistics (Cont'd)

Name of Faci	lity			Lice	nse No.				Repor	t for Year	Ended		Page	of .
Green Lodge	of Man	chester,	Inc.		1702					9/30/201	5		9	37
Í	•	_	in the certified b		pacity du	ring tl	he repo	rt yea	r?	0	Yes	0	No	
н тез			· · · · · · · · · · · · · · · · · · ·	uon,	Cl		in Dad			Co	nagity A ft	er Change	<u> </u>	
		Place of	f Change Residential		Cr	nange	in Bed	<u>s</u>		Ca	расну Ане	er Change	ł	
Date of	CCNH	RHNS	Care Home		Lost			Gaine	d					
	COM	Tunto			Loui				•			Residential		
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Care Home	Reason f	or Change
				<u>.\</u>										
											11111111111			
								l						
5 If there y	งละ anv	change	in certified bed	ranaci	ity during	the re	enort ve	ear (as	renori	ed in item	4 above)	provide the nu	nber of	
		_	90 days followir			1110 1	oportje	our (uc	торог	.00 111 11011	1 1 40010)	provide the hai	11001 01	
KESIDI	SNIDA	19101	90 days followii	ig inc	change.					T			<u> </u>	
			Changa in D	::	A Davia						NH	RHNS	 Residential	Care Home
1 st chang	~~		Change in Ro	esider	it Days					CC	INII	KHINS	Kestucituai	Care Home
2nd char														
3rd chan														
4th chan													10.11.00	
		lents an	d Rates on Septe	mber	30 of Co	st Yea	ar			•			•	
			Medicare		Medi	caid				Se	lf-Pay	****	Other Sta	te Assisted
										Residential				
	Item		CCNH	C	CNH	RI	INS	CC	CNH	RF	INS	Care Home	R.C.H.	ICF-MR
No. of R		,	A	Prize Santa		1409287755332577								
Per Dien														
a. One b														
b. Two														
c. Three		e												
bed r	ms.							<u> </u>						
														Residential
7 Total Nu	mber of	Physica	al Therapy Treat	ments	:					TO	TAL	CCNH	RHNS	Care Home
	Medica													
В.	Medica	id (Excl	lusive of Part B)											
			e Treatments											
		torative	Treatments											
	Other		7TI (
			Therapy Treatm											
	mber of Medica		Therapy Treatn	iems										
			lusive of Part B)											
			e Treatments											
			Treatments											
	Other													
			Therapy Treatm							O		GAN CONTRACTOR OF THE CONTRACT	a an ann a bhaile ann an an ann an an an an an an an an a	MAMARIAN MARIAN MAR
			ational Therapy	Treati	nents									
<u>A.</u>	Medica	re - Par	t B								<i>y</i> 24			
В.			lusive of Part B)											
			e Treatments Treatments							-				
C	Other	wative	TICAUNCIUS											
		Occupati	ional Therapy T	reatn	nents					 				
1.		I								1		L		<u> </u>

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Julil	Report for Yea		Page	of
Green Lodge of Manchester, Inc.	1702		9/30/2015	a Liiucu	10	37
Are time records maintained by all individuals receiving or		0	Yes		No No	
and the records maintained by an individuals receiving to	mpensation:		Total Cost		110	***************************************
			Total Cost	and Hours		<u> </u>
		1			Residential	
Item	CCNH	Hours	RHNS	Hours	Care Home	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I						
of Schedule A1)				C 100 Montes Constanting States Con-		
2. Administrator(s) (Complete also Sec. III						
of Schedule A1)					56,757	2,20
3. Assistant Administrator (Complete also Sec. IV						
of Schedule A1) 4. Other Administrative Salaries (telephone			W. Transfer			
operator, clerks, receptionists, etc.)					32,130	1,83
5. Dictary Service					32,130	1,00
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers					39,199	2,44
Housekeeping Service Head Housekeeper						
b. Other Housekeeping Workers					26,688	1,66
7. Repairs & Maintenance Services					20,088	1,00
a. Engineer or Chief of Maintenance				, 201	<u> </u>	
b. Other Maintenance Workers					18,083	1,15
8. Laundry Service						
a. Supervisor					16640	7.01
b. Other Laundry Workers 9. Barber and Beautician Services					16,640	1,04
10. Protective Services						
11. Accounting Services						
a. Head Accountant					38,685	2,08
b. Other Accountants				000000000000000000000000000000000000000		**************************************
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses					SANSARA KANSANSA MENDANGANSA KANSA KAN	
b. RN						
1. Direct Care 2. Administrative**		,47°				
c. LPN						
1. Direct Care				100000000000000000000000000000000000000		VIII.
2. Administrative**			, remaining			
d. Aides and Attendants					110,143	7,069
e. Physical Therapists f. Speech Therapists						····
g. Occupational Therapists						
h. Recreation Workers	 		1		9,438	572
i. Physicians					2,	
Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists	 					
k. Pharmacists						
I. Podiatrists						
m. Social Workers/Case Management						
n. Marketing o. Other (Specify)						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures					347,764	20,070

^{*} 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)

	CC	NH	RF	INS	Residential	Care Home
Position	\$	Hours	\$	Hours	\$	Hours
	\$ 10.000 (\$100)		3.00.6.90.00	Day of Street		G az szerőszáj al
	10 10 10 10 10 10	28 (45) (60) (60) (71) (73		20 000 000 000 000 000 U	9 00 00 00 00 00	
	a complete a part		4 m 4 m 2			
	10.00					
	20 20 20 20 20 20		(0) (0) (0) (0) (0) (0)	ASS (100 100 1 100 100 100 100 100 100 100		Stephen and the con-
		Bacago de la companya				
	Sales and the second	77 (45) (89) (5) (80) (3)	P. 100 (100 (100 (100 (100 (100 (100 (100	F6 (65 (64 (64 (65)	0.760 000 000	
STATE OF THE STATE	of publication and the plant with		1971 - 107 107 107 107 107			
					1 10 10 10 10 10 10 10 10 10 10 10 10 10	
	250 100 100 100 100 100 100	36 N. 10 N.		0.0000000000000000000000000000000000000		ger teatral and the contract
	50,105,050,060,007,052	000 000 000 000 000 000 000 000 000 00	351,552,550,580,553,555	13 (94) (Gurago (62))	physical selection (Sec. 44)	8/03/38/39/20/20
	0.00			0.00		
			Garatanas garas			
			98430.00.00	G (4) (6) (6)		
Total	\$ -	-	\$ -	-	\$ -	

Schedule of Other Fees (Page 13)

	CC	NH	RH	NS	Residential	Care Home
Service	\$	Hours	\$	Hours	\$	Hours
	0.0000000000000000000000000000000000000	Banen alvinor const		30 A 10 A		
					0.000	
		10 (11 (2) (12 (3) (3)	21 32 01 22 0			
Physical Control of Co						
					8 10 C 12 C	C. 100 (6) (6)
		100		in all along allow		
The state of the s		180 (190 (190 (190 (190 (190 (190 (190 (19				
	or de la constant	ar (a) (a) (a) (a) (a)	\$ 12 SE \$5705 SE	20.000.000.000.00	South resource and	SOME SECTION SECTION
				6 80 65 65 81 6		
	99 COLUMN 99 GO			(6. 127. 128.70% (40.116)	10.00	
1 9000						
The state of the s					10 M W W W	
The second secon	100					
		5 0 0 0 0 0	St. 25. (2. 35. 35. 35.		0.00	
		RESPONDENCE OF THE PARTY OF THE	160 160 160 160 160	10 (0) (0)		
The angular participation of the control of the con						
Total	\$ -	5 5 F	\$ -	E.	\$ -	5.0

State of Connecticut

Annual Report of Long-Term Care Facility CSP-11 Rev. 10/2005

Schedule A1 - Salary Information for Operators/Owners; Administrators,

Compensation Received of 37 Worked Hours Total Page Name and Address of All Other Employment** None None None Assistant Administrators and Other Related Parties* Claimed on Line Where Report for Year Ended Page 10 2,080 A 11a 1,008 A 12d 2,200 A 12d Worked Hours Total 9/30/2015 Full Description of Services Rendered Accounting/Clerical Night Manager Aide Fringe Benefits (describe fully) and/or Other Payments License No. Residential Care Home 38,685 14,212 41,883 Salary Paid RHINS CCNH Green Lodge of Manchester, Inc. Nancy Beilman 26 Mohawk Cir. Section I - Operators/Owners Assistant Administrators who Ted Beilman 128 Lakeview Dr. Dawne Beilman 128 Lakeview parties of Operators/Owners facility (EXCEPT those who may be the Administrator or are identified on Page 12). Section II - Other related employed in and paid by Newington CT 06111 Name Dr. Colchester, CT Name of Facility Colchester, CT

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

^{**} Include all employment worked during the cost year.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties*

		7	issistant	Aummsua	Assistant Auminishators and Other Acialcu Falues	Notated	railes				
Name of Facility (as licensed)				License No.		Report for Year Ended	ear Ended		Page	Jo	
Green Lodge of Manchester, Inc.				1702		9/30/2015			12	37	
	٠	Salary Paid	þ								
	-			Fringe Benefits and/or Other		Total	Line Where		Total		
Name	CCNH	RHNS	Residential Care Home	Payments (describe fully)	Full Description of Services Rendered	Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours Worked	Compensation Received	
Section III - Administrators***											
Stuart Beilman 26 Mohawk Cir. Newington, CT 06111			56,757		Administrator	2,200 A2		None			
Section IV - Assistant Administrators											
*No allocation of the constant of the constant of the formation is an additional phosts if warning	to concide	toolan bea	1.11 informatio	of I beding 1 In	odditional chapta if no	Position in the second					

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

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

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

Annual Report of Long-Term Care Facility

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	CS - 1 1 U)			D	- C
Green Lodge of Manchester, Inc.	License No.	രാ	Report for Y 9/30/2015	ear Engeg	Page	of L 27
Green Boage of Manchester, the.	17	UZ.			13	37
			Total Cost	and Hours	<u> </u>	1
					Residential	
Item	CCNH	Hours	RHNS	Hours	Care Home	Hours
*B. Direct care consultants paid on a fee					0.1.0	Hours
for service basis in lieu of salary						
(For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care			·			
b. Other						
6. Social Worker						
7. Recreation Worker			\$2977 000000 0000 1 6		(a) (a) (b) (b) (b) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c	
8. Physicians						
a. Medical Director (entire facility)	ministración de la companya de la c	andrianos proportionis de		***************************************	TO CONTROL OF THE PARTY OF THE	PAGE STREET OF THE STREET OF THE STREET
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**						And the same of th
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						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	The second secon					
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule		- A CONTRACTOR OF THE CONTRACT	The state of the s			
-13 Total Fees Paid in Lieu of Salaries						**

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

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

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

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

Name of Facility		License No.		Report for Y	ear Ended	Page	of
Green Lodge of Manchester, Inc.		1702		9/30/2015		14	37
hande 6 6 6 7 6 7 6 7 6 7 7 7 7 7 7 7 7 7 7			Related**	to Owners,			
Name & Address of Individual	Full Expla	anation of Service	Operator	rs, Officers	Expla	nation of R	elationship
			Yes	No			
Nancy Beilman	Owner of	the land & building	0	0			
			0	0			
			0	0			
			0	0			
-			0	0			
			0	0			
			0	0			
			0	0			
			0	0	•		
			0	0			
			0	0			
			0	0	•		
			0	0			
			0	0			
			0	0			
			0	0			
100-0			0	0			
				0			
			0	0			
2000-2000-00			0	0			
			0	0			
			0	0			

^{*} Use additional sheets if necessary.

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

Annual Report of Long-Term Care Facility CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility License No.				d General	
Green Lodge of Manchester, Inc. 1702		Report for Y 9/30/2015	ear Ended	Page	of
1/02		19/30/2013		15	37
Item		Total	CCNH	DIBIG	Residential
1. Administrative and General	_	Total	CCNH	RHNS	Care Home
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	11,878			11.070
2. Disability Insurance	\$	·			11,878
3. Unemployment Insurance	\$				7.452
4. Social Security (F.I.C.A.)	\$				7,453
5. Health Insurance	\$				26,479
6. Life Insurance (employees only)	······································				105,285
(not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory)	\$				
(not-owners and not-operators)					
8. Uniform Allowance	\$				
9. Other (Specify)	\$				
See Attached Schedule	·		(4)		
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	\$	4,494			4,494
h. Telephone and Cellular Phones					4,494
1. Telephone & Pagers	\$	3,226			3,226
2. Cellular Phones	\$	2,697			2,697
i. Appraisal (Specify purpose and	\$				2,097
attach copy)*					1
j. Corporation Business Taxes (franchise tax)	\$				
k. Other Taxes (Not related to property - See Page 22)					
1. Income*	\$	1,934	Un		1,934
2. Other (Specify)	\$	1,130	/ \ 		1,130
See Attached Schedule			V		1,130
3. Resident Day User Fee	\$				
Subtotal	\$	164,576			164,576

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

*** DO NOT Include Holiday Parties / Awards / Gifts to Staff

Green Lodge of Manchester, Inc. 9/30/2015

Attachment Page 15

Schedule of Other Employee Benefits

	CCNH	RHNS	Residential Care Home
Description	COMI	KIIIAS	Care Home
		SALES AND SHOULD BE A SHOULD	And Silver Silve
	100.00.00.00.00.00		e Gin Richard
	0.000	Actual Court Court	
		and the second	
	-		
	1 10 10 10 10 10 10 10 10 10 10 10 10 10		
	The second second		
			0.0000000000000000000000000000000000000
Total			

Schedule of Other Taxes

Description	CCNH	RHNS	Residential Care Home
Food Service License			\$ 85
CT three year license renewal			\$ 655
CT Boilers and Water Heaters Inspections every two years			\$ 240
Secretaey of State Annual Corp Filing Fee			\$ 150
Total	\$ -	\$ -	\$ 1,130

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

Name of Facility	License No.		Report for Y	Year Ended	Page	of
Green Lodge of Manchester, Inc.	1702		9/30/2015		16	37
					111111111111111111111111111111111111111	
						Residential
Item			Total	CCNH	RHNS	Care Home
	ls Brought Forwa	ırd:	164,576			164,576
Travel and Entertainment						
Resident Travel and Entertainment		\$				
2. Holiday Parties for Staff		\$				
3. Gifts to Staff and Residents		\$				
4. Employee Travel		\$				
Education Expenses Related to Seminars an		\$				
6. Automobile Expense (not purchase or depr	eciation)	\$	5,632			5,632
7. Other (Specify)		\$				
See Attached Schedule						
m. Other Administrative and General Expenses						
 Advertising Help Wanted (all such expense 	es)	\$	213			213
2. Advertising Telephone Directory (all such	expenses)***	\$				
3. Advertising Other (Specify)***		\$				
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		\$	390			390
* 8. Dues and Membership Fees to Professional		\$	1,055			1,055
Associations (Specify)						,
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other Non-A	llowable Org.***	\$				
9. Subscriptions		\$				
10. Contributions***		\$				
See Attached Schedule						
11. Services Provided by Contract (Specify and	Complete	\$	ALIAN CANADA			
Schedule C-2, Page 21 for each firm or ind	•					
12. Administrative Management Services**	/	\$				
13. Other (Specify)		\$				
See Attached Schedule						
C-14 Total Administrative & General Expenditures		\$	171,866			171,866

^{*} 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	CCNII	RHNS	Residential Care Home
	20, 200, 021, 021	100 (100 (100 (100 (100 (100 (100 (100	
		1000 050 500 055 0	
	88 (637) 432 (601) 460	000000000000000000000000000000000000000	
	800×250 000 000 000	39.101190.76610	
	(10.40)		
		40:11.00	33. 33. 33.
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

,			Residential
Description	CCNH	RHNS	Care Home
	(4) (5) (3) (4) (4)	atterior necession	AZZÁRAN M
Total Other Advertising	\$ 4	\$ -	\$

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
Carch		nan saas saas saas	\$ 550
Journal Inquirer Newspaper subscription			\$ 505
	She stored to the	100 miles	
	50 100 100 100 115		360 1650 1650 1650
	80.400.02.000.02	200.000.000.000	
	60.63 (5.65 (5	600	100100000000000000000000000000000000000
	(Special meralisaria)	660,000,000,000	1 (50) (50) (60) (60)
	51 (61 (40 (64 (6	Security (Security)	1650 (file 1950 (gg)
		130 300 01.02	ALC: 450-450-101
		30 100 100 100 I	40.00 20.00
Total Dues	\$ -	\$ -	\$ 1,055

Schedule of Contributions

			Residential
Description	CCNH	RHNS	Care Home
	25 (1000)	en de colonia	
	Marigar all offer in	es de la ciu	700000000000000000000000000000000000000
Total Contributions	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
	(a) (a) (b) (b) (b)		69-76-80-65
		(0) (0) (0) (0) (0)	
		90 St. 65 All 6	(2.06) (10.05)
		15 15 15 16 d	6.00
	8 8 8 8 8 6		
	60.00		10 10 10
			30 (S) (S)
Total Other Administrative and General	\$	\$ -	\$ -



Schedule C-1 - Management Services*

Name of Facility Green Lodge of Manchester, Inc.	License No. 1702	Report for Year Ended 9/30/2015	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)

	A.D. 111.				age 3)	T-5 . C . T	7 1 1 1	T D	~
	ne of Facility		Licens			Report for		Page	of
Gre	en Lodge of Manchester, Inc.			- 1	702	9/30/201	3	18	37
								1	ntial Care
	Item			Negati	Total	CCNH	RHNS	H	lome
2.	Dietary								
	a. In-House Preparation & Service							B 8 8	
	1. Raw Food			\$			ļ		
	2. Non-Food Supplies			\$				_	
	3. Other (Specify)		_ 3	\$	45,201				45,201
	Food and Non-Food								
	b. Purchased Services (by contract other		9	5					
	than through Management Services)								
	(Complete Schedule C-2 att. Page 21)						53650		
	c. Management Services**			B					
	d. Other (Specify)		_	\$[ot 4000000000000000000000000000000000000	503 X-1010 X
						Marie Ma Marie Marie Ma			
2E.	Total Dietary Expenditures $(2a+b+c+d)$		9	5	45,201				45,201
				1				Reside	ntial Care
2F.	Dietary Questionnaire				Total	CCNH	RHNS	1	lome
G.	Resident Meals: Total no. of meals served per	· da	y:*		60				60
Н.	Is cost of employee meals included in 2E?		Yes		•	No			
I.	Did you receive revenue from employees?	0	Yes		•	No	If yes, specify amt.		
J.	Where is the revenue received reported in the	Co	st Repo	rt?	(Page/Line	Item)			
	Is cost of meals provided to persons other						If you amonify		
K.	than employees or residents (i.e., Board	0	Yes		•	No	If yes, specify		
	Members, Guests) included in 2E?						cost.		
L.	Is any revenue collected from these people?	0	Yes		•	No	If yes, specify amt.		
M.	Where is the revenue received reported in the	Co	st Repo	rt?	(Page/Line	Item)		•	
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2F2	0	Yes		. .	No	If yes, specify cost.		
O.	in 2E? Is any revenue collected from employees?	0	Yes		•	No	If yes, specify amt.		
P.	Where is the revenue received reported in the	Co	st Repo	rt?	(Page/Line	Item)			
	-								

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

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

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

Name of Facility			e No.	Report for Year Ended		Page	of
Green Lodge of Manchester, Inc.			1702	9/30/20	15	19	37
Item			Total	CCNH	RHNS	Į.	ential Care Iome
3.	Laundry					 	TOTILC
	a. In-House Processing*	Lbs.					
	1. Bed linens, cubicle curtains, draperies,					-	
	gowns and other resident care items	Amt. \$					
	washed, ironed, and/or processed.*** 2. Employee items including uniforms						
	T-y,	Lbs.					
	gowns, etc. washed, ironed and/or processed.***			<u> </u>			
	processed.	Amt. \$."			
	3. Personal clothing of residents	Lbs.					
	washed, ironed, and/or processed.***						
	,,	Amt. \$		<u> </u>			
	4. Repair and/or purchase of linens.***	Lbs.					
	-						
	b. Purchased Services (by contract other	Amt. \$					
	than through Management Services)	Ψ					
	(Complete Schedule C-2 att. Page 21)						
	c. Management Services**	\$					
	d. Other (Specify)	\$	1,034				1,034
	Linens and Supplies						1,0,5
E.	Total Laundry Expenditures $(3a+b+c+d)$	\$	1,034				1,034
F.	Laundry Questionnaire						
3.	Is cost of employee laundry included in 3E? O	Yes	•	No	If yes, specify cost.		
I.	Did you receive revenue from employees?	Yes	•	No	If yes, specify amt.		
	Where is the revenue received reported in the Cost	Report?		(Page/Lin			
	Is Cost of laundry provided to persons other				If yes,		
•	than employees or residents included in 3E?	Yes	•	No	specify cost.		
,		Yes	•	No	If yes, specify amt.		
	Where is the revenue received reported in the Cost	Report?		(Page/Line			

^{*} 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.

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

^{***} 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.	Rep	ort for Year E	nded	Page	of
Green Lodge of M	Ianchester, Inc.	1702	<u> </u>	9/30/2015		20	37
	Item			Total	CCNH	RHNS	Residential Care Home
4. Housekeepin		Sq. Ft. Serviced					
a. In-House		by Personnel					
1. Supp	lies - Cleaning (<i>Mops</i> , , brooms, etc.)	Amt.	\$				
	Services (by contract other	Sq. Ft. Serviced					
i e	ough Management Services)	by Personnel					
i	e Schedule C-2 att.	Amt.	\$				
	ent Services*	<u> </u>	\$				
d. Other (Sp			\$	5,446			5,446
	s, Toilet paper, Rubbish bags	etc.	*	5,			
	ekeeping Expenditures (4a +		\$	5,446		100000000000000000000000000000000000000	5,446
	e (Supplies)**			_,			
a. Prescripti							
	Pharmacy		\$				
	nased from		\$				
						10.0	
b. Medicine	Cabinet Drugs		\$	376			376
	and Therapeutic Supplies		\$				
	ce/Limousine***		\$				
e. Oxygen							1000000
1. For E	mergency Use		\$				
2. Other	***		\$				
f. X-rays ar	d Related Radiological		\$	***************************************			
Procedure							
g. Dental (λ	lot dentists who should be inc	luded under	\$	220 32 - 316 - 327 - 327 - 327			
salaries o							
h. Laborator			\$				
i. Recreation			\$	596			596
, -	ecify)****		\$	474			474
	Attached Schedule						1.45
5K. Total Reside	nt Care Expenditures (5a - 5) <u>)</u>	\$	1,447			1,447

^{*} 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		dential Home
Misc.		Self-die	\$	474
			2	
Total Other Resident Care	\$ -	\$ -	\$	474

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

Name of Facility				License No.	Report for Year Endec	77			Page	Jo
Green Lodge of Manchester, Inc.	nc.			1702	9/30/2015				-	37
		Related ** t	** to Owners,	:						
		Operators, Officers	Officers			`	Fotal Cost	Total Cost/Page Ref.***	ŀ	T
Name of Individual or Company	Address	Yes	No	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	Residential Care Home	Pg I	Line
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
	·	0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							-
		0	0							
										1

^{*} List all contracted services over \$10,000. Use additional sheets if necessary.

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

^{***} Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Y	ear Ended		Page	of
Green Lodge of Manchester, Inc.	1702	9/30/2015			22	37
Item		Total	CCNH	RHNS	ľ	ntial Care
6. Maintenance & Operation of Plant			OULT	Idito	IN	JIRO
a. Repairs & Maintenance	\$	16,975				16,975
b. Heat	\$	5,676				5,676
c. Light & Power	\$	11,308				11,308
d. Water	\$	4,616		<u></u>		4,616
e. Equipment Lease (Provide detail of				(<u> </u>		4,010
f. Other (itemize)	\$	2,391				2,391
See Attached Schedule	·	4.65				2,391
6g. Total Maint. & Operating Expense (6a - 6f) \$	40,966				40,966
7. Depreciation (complete schedule page						40,200
a. Land Improvements	\$		-			
b. Building & Building Improvement						
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$					
*7e. Total Depreciation Costs (7a + b + c						
8. Amortization (Complete att. Schedule						
a. Organization Expense	\$	ł				
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$	7,277				7,277
d. Other (Specify)	\$, , , , , , , , , , , , , , , , , , ,				1,211
*8e. Total Amortization Costs (8a + b + c -		7,277				7,277
9. Rental payments on leased real propert						1,211
real estate taxes included in item 10b	\$	15,645				15,645
10. Property Taxes		10,0.0				13,043
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	8,355				8,355
c. Personal property taxes	\$	502		· · · · · · · · · · · · · · · · · · ·		502
1. Total Property Expenses (7e + 8e + 9		31,779				31,779

^{*} Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 24.

Green Lodge of Manchester, Inc. 9/30/2015

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS		dential Home
Cox Cable			\$	2,391
An .				
y				
		ni Sili zames zapries	4 60 60	person of
				1, 46 SG SS S
		NELSON CONTROL OF THE CONTROL		
		1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1		
Total Other Repairs and Maintenance	\$ -	\$ -	\$	2,391

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Depreciation Schedule

	Debrec	Depreciation Schedule	arnnan					
Name of Facility	License No.			Report for Year Ended	nded		Page	of
Green Lodge of Manchester, Inc.	1702	77		9/30/2015			23	37
	Historical			Accumulated	,	•		
	Cost	Colmogo	Oct to	Depreciation to	Method of	Tlochi	T. Common of the	
Property Item	Exclusive of	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
- T			-	*				
A. Land Improvements 1 Acquired union to this report negled								
1. Acquired prior to this report period								
Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. Building and Building Improvements					4-			
1. Acquired prior to this report period								
3. Acquired during this report period (attach schedule)								
C. Non-Movable Equipment								
 Acquired during this report period (affach schedule) 								
C-4. Subtotal							,	
4)	i			7				
logbook Date of maintained? Acquisition	Cost	Less		Depreciation to	Method of			***
	Dyoluging of	Colynoge	Cost to Be	Demining of	Compating	Heafil	Denreviation	
Yes No Month Year		Salvage Value	Cost to be Depreciated	Year's Operations		Useiui Life	for This Year	Totals
D. Movable Equipment								
1. Motor Vehicles (Specify name, model								
and year of each vehicle)								
a.								
b.								
d,								
2. Movable Equipment								
a. Acquired prior to this report period								
b. Disposals (attach schedule)								
c. Acquired during this report period								
(attach schedule)	8,173						1,635	
D-3. Subtotal								1,635
E. Total Depreciation								1,635

Green Lodge of Manchester, Inc. 9/30/2015

Schedule of Land Improvements Acquired during this report period

	provemento required during this report period		Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				1
			5 S S S S S S S S S S S S S S S S S S S	60000
	The state of the s			
		0.00		105 St. 108 108 105 105
	C-ST		2011/2012/1906	•
Total additions for L	and Improvements	\$ -		\$ -
Deletions:				
			consilir specific	
				80.00.00.00.00
50 (52 (6) 55 (6) 65 (6)		5000 000 000 000 000	93 (00) (00) (00)	
		288810000 NOGO 2500 NEV	contribution to the contribution of	775A 58 54 055M 410H 50.0
		200		100 00 1850 1980 00 1
Fotal deletions for La	and Improvements	\$ -		\$ -

^{*}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:				
				10 10 10 10 10 10 10 10 10 10 10 10 10 1
			100	
		0.00		65 880 88 69 69
A 10 (10 (10 (10 (10 (10 (10 (10 (10 (10				
Total additions for B	uilding Improvements	\$ -	600000000000000000000000000000000000000	\$ -
Deletions:	74-E01/2022/20150/00001			
	Massar and the second s		10 10 10 10 10 10 10 10 10 10 10 10 10 1	
Complete State of Complete		dia a a a a		0.000
	Company of the compan			0.0000000000000000000000000000000000000
		(0)	0.0000000000000000000000000000000000000	715 701 75 Sept. 80
		100000000000000000000000000000000000000	15 (15)	2502-0300 3522-3557 1030
Total deletions for B	uilding Improvements	\$ -		\$ -

^{*}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:	Description of Item	Cust	Life	Depreciation
2011	The state of the s			2 2 2
		5 10 6 11 50	0.10.00.00	3. 2. 3
		10.00		
(8) (12/10) (9) (13/10)		100		
Total additions for	Non-Movable Equipment	\$ -		\$ -
Deletions:				
		20 000 000 00	16 C C C C C C C C C C C C C C C C C C C	15 APR 10 11 11 11 11 11 11 11 11 11 11 11 11
		100 (8) (6) (6)		6. 8. 6. 6. 6.
		100 100 100 100 100		
Total deletions for	Non-Movable Equipment	\$ -	56. 650. 650. 650. 650.	\$ -

^{*}Ties to Page 23, Line C3

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

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item		Cost	Useful Life	Deni	eciation
Additions:	Description of item			, Jane	T Dept	ceration
11/24/2014	Paved Driveway	\$	5,310	5yrs	\$	1,062
7/10/2015	Dishwasher	\$	2,863	5yrs	\$	573
		M Maria				100 miles
				\$100000		
and the other parties of	2000 A 1000 A	OUR REPORT			0 100000	
	(1975) (1975) (1975) (1975) (1975) (1975) (1975) (1975) (1975) (1975) (1975) (1975) (1975) (1975) (1975) (1975)			31 10e 031 055	7 100 CO	
Total additions for	Movable Equipment	\$	8,173	(e-100 as) (00 (e)	\$	1,635
Deletions:						
	The control of the co			17 (\$2), (2), (3)	0 100050	
		604 (666)		5) Self-Self-Self-Self-Self-Self-Self-Self-		
						(A)
				100		
					200	A 185 183
Fotal deletions for .	Moyable Equipment	S			\$	

Schedule of Leasehold Improvements Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				1
Sit of Section 5		0.000 (0.000 (0.000)	SUMMER SHOWS	100000000000000000000000000000000000000
on the state of			0.0000000000000000000000000000000000000	
		100 00 00 00	Sec. 000 Sec. (1996)	5 5 9 at 40
		0.96 00 00 00	35 65 06 35	60 00 00 00
100000000000000000000000000000000000000		I GOLDAN CONTRACTOR	G-1002960V/108V/108V	Pode odkova zalika
		Burgal against mercura	10.5 (20.00) (20.00)	17700 007 107 92 17
Total additions for	Leaschold Improvement	\$ -		\$ -
Deletions:	T	9 -		Ψ
Detetions:		-		
			gi 450.00.00 St.	
100 Miles (2000 Mi		220 (0.10)	77 27 12 34 34	0.000, 320, 380, 380, 30
Total deletions for	Leaschold Improvement	\$ -	(3) (6) (5) (6) (6)	\$ -

^{*}Ties to Page 24, Line C3

^{*}Ties to Page 23, Line D2c **Ties to Page 23, Line D2b

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

Annual Report of Long-Term Care Facility CSP-24 Rev. 10/2006 State of Connecticut

Amortization Schedule*

Name of	Name of Facility			License No.		Report for Year Ended	r Ended		Page	Jo
Green L	Green Lodge of Manchester, Inc.			1702	22	9/30/2015			24	37
		Date of				Accumulated				
		Acquisition				Beginning of	Basis for			
			Γ	Length of	Cost to Be	Year's	Computing	Rate	Rate Amortization	
	Item	Month Year		Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
A. Or	Organization Expense									
1.										
2.										
3.										
A-4. Subtotal	ıbtotal									
B. M	Mortgage Expense									
1.										
2.										
3.										
B-4. Su	Subtotal									
C. Le	Leasehold Improvements and Other									
ij	1. Acquired prior to this report period				77,577	33,678	ST		7,277	
2.	2. Disposals (attach schedule)									
3.	3. Acquired during this report period									
	(attach schedule)									
C-4. Subtotal	ibtotal									7,277
D. <i>To</i>	Total Amortization									7,277
* St	* Straight-line method must be used.									

* Straight-line method must be used. ** Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.

B. Life of mortgage; OR
C. Remaining Life of Lease; OR
D. Actual Life if owned by Related Party.

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

Name of Facility	License No.	Report for Year E	nded		Page of
Green Lodge of Manchester, Inc.	1702	9/30/2015			25 37
11. Property Questionnaire					
Part A					
Is the property either owned by the	ne Facility	⊙ Yes	0	No	If "Yes," complete Part B.
or leased from a Related Party?*				140	If "No," complete Part C.
*If any owner or operator of this fa					
business association to any person a related party transaction.	or organization from wi	nom buildings are leased, th	nen it is considered		
Description		Total			
Date Land Purchased					
2. Date Structure Completed					Constitution of the Consti
3. If NOT Original Owner, Date	e of Purchase	03/22/74	-		
4. Date of Initial Licensure		03/22/74	-		
5. Total Licensed Bed Capacity6. Square Footage		5,810			
7. Acquisition Cost		3,610			
a. Land					
b. Building					
Part B - Owner and Related Pa	rties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fi	ixed, variable)				
b. Date Mortgage Obtainedc. Interest Rate for the Cost	Voor				*************************************
d. Term of Mortgage (number					
e. Amount of Principal Borr					
f. Principal balance outstand					
Complete if Mortgage was I	Refinanced				
During Current Cost Ye					
g. Type of Financing (e.g., fi	ixed, variable)				
h. Date of Refinancing					
i. New Interest Rate j. Term of Mortgage (number	ar of voord)		•		
k. Amount of Principal Borre			-		
I. Principal Outstanding on I					
Part C - Arms-Length Leas		ty Improvements Onl	y		
Name and Address of Lesso	r]	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
					- · · · · · · · · · · · · · · · · · · ·

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

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

Name of Facility	License No.		Report for Ye	ear Ended		Page of
Green Lodge of Manchester, Inc.	1702		9/30/2015			26 37
						Residential Care
Item			Total	CCNH	RHNS	Home
12. Interest						
A. Building, Land Improve	ment & Non-Movabl	e				
Equipment 1. First Mortgage						
Name of Lender						
Traine of Bender		Rate				
Address of Lender						
2. Second Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
radiess of Lender					0.000	
3. Third Mortgage		\$				
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage		\$				
Name of Lender		Rate				
Address of Lender		•				
B. CHEFA Loan Informati	on					
1. Original Loan Amou	nt	\$				
2. Loan Origination Da	te					
3. Interest Rate %						
4. Term						
5. CHEFA Interest Exp	ense					
12 B7. Total Building Interest Exp		\$				
	(/	4	<u> </u>	v Subtotals f	ompard to n	evt naga)

(Carry Subtotals forward to next page)

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

Name of Facility	License No.		Report for Y	ear Ended		Page	of
Green Lodge of Manchester, Inc.	1702		9/30/2015	cai Lilucu		27	37
						Resid	
Ite	m_		Total	CCNH	RHNS	Care I	
	Subtotals Bro	ught Forward:					
12. C. Movable Equipment							
1. Automotive Equipme		\$					
A. Item	Rate	Amount					
Lender							
Address of Lender	.,,,,						
2. Other (Specify)		\$					
A. Item	Rate	Amount					
Lender							
Address of Lender							
B. Item	Rate	Amount					
Lender							
Address of Lender							
12. C. 3. Total Movable Equipm	nent Interest						
Expense (C1 + 2)	iioiit xiitoi obt	\$					
12. D. Other Interest Expense (S	Specify)	\$					
,	,						
13. Total All Interest Expense (1)	2B7 + 12C3 + 12D) \$					
14. Insurance		, ,					
a. Insurance on Property (bu	nildings only)	\$	10,324			j	10,324
b. Insurance on Automobile		\$,,
c. Insurance other than Prop							
1. Umbrella (Blanket Con		\$					
2. Fire and Extended Cov	/erage	\$					
3. Other (Specify)		\$					
		e manual de la companya de la compan					
141 m . IV		et de la company					
14d. Total Insurance Expenditure. 15. Total All Expenditures (A-13)		\$	10,324				0,324
15. Total All Expenditures (A-13	<i>tnru C-14)</i>	\$	655,827			65	5,827

D. Adjustments to Statement of Expenditures

Name	e of Fa	cility		Lie	cense No.	Report for Ye	ar Ended	Page	of
Greei	n Lodg	ge of I	Manchester, Inc.		1702	9/30/2015		28	37
					Total				
	Page				Amount of				ntial Care
	No.		Item Description		Decrease	CCNH	RHNS	H	ome
Page	10 - S	Salari	es and Wages						
1.		<u> </u>	Outpatient Service Costs	\$					
2.			Salaries not related to Resident Care	\$					
3.			Occupational Therapy	\$					
4.			Other - See attached Schedule	\$	4,796		DHE SHAN SHOWN		4,796
Page	13 - I	rofes	sional Fees						
5.			Resident Care Physicians **	\$					
6.			Occupational Therapy	\$					
7.			Other - See attached Schedule	\$					
Page:	s 15 &	16 -	Administrative and General						
8.			Discriminatory Benefits	\$					
9.			Bad Debts	\$					
10.			Accounting & Legal	\$					
11.			Telephone	\$					
12.	15	h2	Cellular Telephone	\$	2,697				2,697
13.			Life insurance premiums on the life						
			of Owners, Partners, Operators	\$					
14.			Gifts, flowers and coffee shops	\$					
15.			Education expenditures to colleges or						
			universities for tuition and related costs						
			for owners and employees	\$					
16.			Travel for purposes of attending		W. W. W. W. W.				
			conferences or seminars outside the						
			continental U.S. Other out-of-state						
			travel in excess of one representative	\$					
17.	16	6	Automobile Expense (e.g. personal use)	\$	5,632				5,632
18.			Unallowable Advertising *	\$					
19.	15	k1	Income Tax / Corporate Business Tax	\$	1,684				1,684
20.			Fund Raising / Contributions	\$					
21.			Unallowable Management Fees	\$					
22.			Barber and Beauty	\$					
23.		<u> </u>	Other - See attached Schedule	\$					474
	18 - 1)ietar	y Expenditures						
24.		· · · · · ·	Meals to employees, guests and others						
			who are not residents	\$				Secretary Constitution	
Page	19 - I	auna	lry Expenditures	*					
25.		<u></u>	Laundry services to employees, guests						
25.			and others who are not residents	\$				- August Macanilles	
Page	20 - 1	401100	keeping Expenditures						
26.	20-1	Louise	Housekeeping services to employees, guests						
۷٠.			and others who are not residents	\$				p	
	L	L	Subtotal (Items 1 - 26)					<u> </u>	15,283
<u> </u>			Subtotal (10,118 1 - 20)	, ψ	<u> </u>	larry Subtotal f	<u> </u>		10,000

^{*} 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 o	of Other Sa	laries Adjustment	a Give ba	Ne			
Page Ref	Line Ref	Description	1011	CCNH	RHNS		idential e Home
10 & 12	A2	Administrator Salary				\$	4,080
10	12 d					\$	716
T-4-1 04b	6-1	Adjustment		\$ -	\$ -	Φ.	4,796

Schedule of Fees Adjustments

Page Ref	Line Ref Description	CCNH	RHNS	Residential Care Home
Total Othe	r Fees Adjustments	\$ -	\$ -	\$ -

Schedule of Other A&G Adjustments

age Ref	Line Ref	Description	CCNH	RHNS	Residentia Care Hom
20	5b	Misc.			\$. 47
100					
otal Othe	r A&G Ad	ustments	\$ -	\$ -	\$ 47

		To the state of th

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

N.T.	Name of Facility License No. Report for Year Ended Page Of								
1		•		Lie	cense No.	Report for Y	Year Ended	Page	of
Gree	n Lodg	ge of J	Manchester, Inc.		1702	9/30/2015		29	37
L					Total				
1	Page				Amount of			Reside	ential Care
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	I	Iome
			Subtotals Brought Forward	\$	15,283				15,283
	20 - I	Reside	nt Care Supplies***						
27.			Prescription Drugs	\$					
28.			Ambulance/Limousine	\$					
29.			X-rays, etc	\$					
30.			Laboratory	\$	*				***************************************
31.			Medical Supplies	\$					
32.			Oxygen (non emergency)	\$					
33.			Occupational Therapy	\$					
34.			Other - See Attached Schedule	\$					
Page	22 - N	Lainte	enance and Property						
35.			Excess Movable Equipment Depreciation						
			See Attached Schedule	\$					
36.			Depreciation on Unallowable						
	ĺ		Motor Vehicles	\$					
37.			Unallowable Property and Real	1					
			Estate Taxes	\$				0 30 30 30 30 30 30 30 30 30 30 30 30 30	
38.			Rental of Building Space or Rooms	\$					
39.			Other - See Attached Schedule	\$			-		
Page	27 - II			<u> </u>					
40.			Mortgage Insurance	\$					
41.			Property Insurance	\$					
Other	- Mis								
42.			Research or Experimental Activities	\$					
43.			Radio and Television Revenue	\$					
44.			Vending Machine Revenue	\$					
45.			Purchase Discounts and Allowances	\$					
46.			Duplications of functions or services	\$					
47.			Expenditures made for the protection,	-					
			enhancement or promotion of the						
			providers interest	\$					
48.			Interest Income on Accounts Rec	\$					
49.			Other (include personnel and other	*					
			costs unrelated to resident care) - See						
			Attached Schedule	\$					
Not F	or Pro		oviders Only	T I					
50.	T		Building/Non Movable Eq. Depreciation						
			Unallowable Building Interest -						
	l		See Attached Schedule	\$					
51.	Total 2		nt of Decrease (Items 1 - 50)	\$	15,283	<u> </u>			15 202
- ^ 1			of ~ coredo (Alemo I - 50)	<u>Ψ</u> [13,263				15,283

^{***} 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.

Green Lodge of Manchester, Inc. 9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
(5) (5) (6) (6) (6) (6) (6) (6) (6) (6) (6) (6	400 A201 (840 A8)		0.00		10 (20 (20 (20 (20 (20 (20 (20 (20 (20 (2
			35 44, 381 36 3		2011/06/05/2011/06/2011
44 (50 (50 (5)			(50.60 60.60 60.00		
			W 100 CO		10,000,000,000
	123 (623 (520 (62)) 56 (62) (62) (62)				
8 8 8 8	an (8) (8) (8)				
					0.000.000.000.000
	(C) (SO SO SO)				
Total Othe	r Ancillary	Costs	\$ -	s -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
	(4) (6) (6)				
10.00			10. Pr. 90. St. 10. L	r veznom der ses ein ni	
					0.0000000000000000000000000000000000000
					90.00
				21 00 10 00	
	10.000000000000000000000000000000000000			100 (000)	3 20 15 15 15 15 15 15
Total Exce	ss Movable	Equipment Depreciation	\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

Daga Daf	Lina Daf	Description	COMI	DIDIO	Residential
Page Ref	Tille Wel	Description	CCNH	RHNS	Care Home
	(48, 75, 50, 50)				
					2017/06/2017 03:00
	(0) (0) (2) (0)				
16 6 66					620,007,000,000,000
	(2) (3) (3) (3)				
			takin desambanan dan m	100	
Total Othe	r Property	Adjustments	s -	s -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
			13 (21 (2) (3) (4) (5)	0.00.00.00.00	1 150 00 00 00 00 00 00 00 00 00 00 00 00 0
90.000.000.000					
Value of the second			M. C. M. C. C. C.		
			F 40 0 0 00 00 00		16 6 6 6
	0.000 05 05 00		profit to the second		100000000000000000000000000000000000000
0.00					9 (00 (00 (00 (00 (00 (00 (00 (00 (00 (0
			sis (32) (37) (32) (33) (31)	00/110/01/01/05/01/05	
Total Othe	r Adjustm	ents	\$ -	\$ -	\$

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
	1.34 (0.46)			BLOS CONTRACTOR	
			01.79.7		
		A CONTRACTOR OF THE CONTRACTOR	60 8 B 68 8 6 6	5,730,000,000,000	
	5 (5 (5 (1)))		No. 100 (160) / 150 (100)	9	
57 (62 / 65 55)			0.00	6 6 6 6 6 6	1.05.26 (8.9) (0.1)
	5 (42 03 05 0	Talan 2		Common de la composition del	
				\$1.50 to 10.10 ft 10.00	
0.01.05					
	a de la				
Total Unal	lowable Bu	iilding Interest	\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility License No.		Report for Y	ear Ended		Page of
Green Lodge of Manchester, Inc. 1702		9/30/2015		30 37	
					Residential Care
Item		Total	CCNH	RHNS	Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (CT only)	\$	654,869			654,869
b. Medicaid Room and Board Contractual Allowance **	\$				
2. a. Medicaid (All other states)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (all inclusive)	\$				
b. Medicare Room and Board Contractual Allowance **	\$				
4. a. Private-Pay Residents and Other	\$				
b. Private-Pay Room and Board Contractual Allowance **	\$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$				
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$		***		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
2. a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$				
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$				
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$			*****	
5. a. Occupational Therapy - Medicare	\$				
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$			Ī	
6. a. Other (Specify) - Medicare	\$				
b. Other (Specify) - Non-Medicare	\$				
III. Total Resident Revenue (Section I. thru Section II.)	\$	654,869			654,869
IV. Other Revenue*					
Meals sold to guests, employees & others	\$		<u> angulannoistannistannistannis</u>		
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
Rental of Television and Cable Services	\$				
5. Interest Income (Specify)	\$				
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (Specify)	 \$				
V. Total Other Revenue (1 thru 8)	\$				
VI. Total All Revenue (III+V)	\$				
ri. Ioiai An Revenue (III TV)		654,869	L	<u> </u>	654,869

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
			310 65 (38 (30) 50	400 44 62 60 50
(5) (1)11 (65) (6			10 10 10 10 10 100	32 (81) (82) (43)
			100	
- 1 (S. 1/4) 15		65 12 15 19 19	40,000,000,000,000,00	350, 450 Ale Vet 535
10 (St. 1881)		7 (0.40 (0.40 (0.40		3 3 3 6 5
Total Oth	er Resident Revenue - Medicare	\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

				Residential
Page Ref	Description	CCNH	RHNS	Care Home
100 100 100 100				
ACCUPATION OF		1 65 AS 52 AS 55	or all the second	algunelin eller och med
		policies de la composición	Gorge West allen	10 00 00 00
Total Othe	er Resident Revenue	\$ -	\$ -	\$ -

Interest Income

Account

					Residential
Page Ref	Account	Balance	CCNH	RHNS	Care Home
20.0015213		5 5 3 8 9 6		2 (A) (II) (A) (C)	
					33 July 10 10 W
				district the feet as	
Total Inter	rest Income	60 (80 (60 opt 10) 70.	\$ -	\$ -	\$ -

Schedule of Other Revenue

				Residential
Page Ref	Description	CCNH	RHNS	Care Home
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			Side of the same o	
Total Oth	er Revenue	\$ -	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ende		of
Green Lodge of Manchester, I		9/30/2015	31	37
	Account			Amount
Assets				
A. Current Assets	n hanka)		\$	2,811
1. Cash (on hand and is	Receivable (Less Allowance	for Rad Debts)	\$	2,011
	eivable (Excluding Owners		\$	
4 Inventories	ervable (Excluding Owners	Of Related Lattices)	\$	450
5. Prepaid Expenses			\$	150
			Ψ	
a				
c. d.				
6. Interest Receivable			s	<u> </u>
7. Medicare Final Settle	ement Receivable		\$	
8. Other Current Assets			\$	
g. Office Carrent 1 1000	, (1001111110)			
A-9. Total Current Assets (L	ines A1 thru 8)		\$	3,261
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost		\$	
*	Accum, Deprecia	ation Net		
3. Buildings	*Historical Cost		\$	
Ü	Accum, Deprecia	ation Net		
4. Leasehold Improven	nents *Historical Cost	77,577	\$	43,899
•	Accum. Deprecia	ation 33,678 Net		
5. Non-Movable Equip			\$	
• •	Accum. Deprecia	ation Net		
6. Movable Equipment	*Historical Cost		\$	
	Accum. Deprecia	ation Net		
7. Motor Vehicles	*Historical Cost		\$	
	Accum, Deprecia	ation Net		
8. Minor Equipment-N	ot Depreciable		\$	
9. Other Fixed Assets (itemize)		\$	
B-10. Total Fixed Assets	(Lines B1 thru 9)		\$	43,899

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

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended		Page		of
Green	Lodge of Manchester, Inc.	1702	9/30/2015		32		37
		Account			A 1	moun	t
			Total Brought Forward:	\$			47,160
C.	Leasehold or like property record	ed for Equity Purposes	S.				
	1. Land			\$			
	2. Land Improvements	*Historical Cost					
		Accum. Depreciation	Net	\$			
	3. Buildings	*Historical Cost					
		Accum. Depreciation	Net	\$			
	4. Non-Movable Equipment	*Historical Cost					
		Accum. Depreciation	Net	\$			
	5. Movable Equipment	*Historical Cost					
		Accum. Depreciation	Net	\$			
	6. Motor Vehicles	*Historical Cost					
		Accum. Depreciation	Net	\$			
	7. Minor Equipment-Not Deprec	iable		\$			
C-8	Total Leasehold or Like Properti	ies (C1 thru 7)		\$			
D.	Investment and Other Assets						
	1. Deferred Deposits			\$			
	2. Escrow Deposits			\$			
	3. Organization Expense	*Historical Cost					
		Accum. Depreciation	Net	\$			
	4. Goodwill (Purchased Only)			\$			
	Investments Related to Reside	ent Care (<i>itemize</i>)		\$		*****************	
	Loans to Owners or Related P	arties (itemize)		\$			
	Name and Address	Amount	Loan Date				
	7. Other Assets (itemize)			\$			
D 0		, /y t		4			
	Total Investments and Other Ass			\$			45 1 40
ル-9.	Total All Assets (Lines A9 + B10	1 + C8 + D8)		\$			47,160

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

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year E	inded	Page	of	
Green Lodge	of N	Manchester, Inc.	1702	9/30/2015		33	37
			Account			Amo	unt
Liabilities							
A.	Cu	rrent Liabilities					
	1.	Trade Accounts Payable			\$		1,537
	2.	Notes Payable (itemize)			\$		
		Υ		\			
	3.	Loans Payable for Equipme		- 	\$		
		Name of Lender	Purpose	Amount	Date Due		
	4.	Accrued Payroll (Exclusive	of Owners and/or L	Stockholders only)	\$		
	5.	Accrued Payroll (Owners a			\$		
	6.	Accrued Payroll Taxes Pay			\$		646
	7.	Medicare Final Settlement			\$		
	8.	Medicare Current Financin			\$		
	9.	Mortgage Payable (Current	(Portion)		\$		
	10.	Interest Payable (Exclusive	of Owner and/or Re	elated Parties)	\$		
		Accrued Income Taxes*			\$	***	
	12.	Other Current Liabilities (in	temize)		\$		
	-						
A-13.	To	tal Current Liabilities (Line	es A1 thru 12)		\$		2,183

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year	Ended	Page	of
Green Lodge of Manchester, Inc.	1702	9/30/2015		34	37
P	Account			Aı	mount
		Total Brough	nt Forward:		2,183
Liabilities (cont'd)					
B. Long-Term Liabilities					
Loans Payable-Equipment (1			\$	
Name of Lender	Purpose	Amount	Date Due		
		1			
		!			
	ĺ				
		!			
2. Mortgages Payable			1	\$	
3. Loans from Owners or Rela	ated Parties (itemize)			\$	
Name and Address of Lender	Amount	Loan Da		Ψ	
Ivalite and Address of Lender	Amount	LOUIL DE	110		
	<u> </u>				
4. Other Long-Term Liabilitie	s (itemize)		₽ V	\$	
· · · · · · · · · · · · · · · · · · ·					
B-5. Total Long-Term Liabilities (I				\$	0.102
C. Total All Liabilities (Lines A-1	13 + B-5)		17	\$	2,183

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

Name of Facility		License No.	Report for Year End	ded	Page	of
Gre	en Lodge of Manchester, Inc.	1702	9/30/2015		35	37
	Account				Amo	ount
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 val	ue of leased perso	nal property (Equity)	\$		
	4. Reserve for leasehold real properties on which fair rental value is based					
	5. Reserve for funds set aside a	s donor restricted		\$		
	6. Total Reserves			\$		
B.	Net Worth					
	1. Owner's Capital			\$		
	2. Capital Stock			\$		1,000
	3. Paid-in Surplus			\$		
	4. Treasury Stock			\$		
	5. Cumulated Earnings			\$		44,935
	6. Gain or Loss for Period	10/1/20	14 thru 9/30	\$ \$		(958)
	7. Total Net Worth			\$		44,978
C.	Total Reserves and Net Worth			\$		44,978
D.	Total Liabilities, Reserves, and	Net Worth		\$		47,160

H. Changes in Total Net Worth

Name of Facility		License No.	Report for Year	r Ended	Page	of	
Green Lodge of Manchester, Inc.		1702	9/30/2015		36] 37	
Account						Amount	
A.	Balance at End of Prior Period as a	shown on Report of	09/30/2014		\$	61,902	
B.	Total Revenue (From Statement of				\$	654,869	
C.						655,827	
D.	Net Income or Deficit				\$	(958)	
Ε.	Balance				\$	60,944	
F.	Additions 1. Additional Capital Contributed 2. Other (itemize)	l (itemize)					
F-3. G.	Deductions				\$		
	1. Drawings of Owners/Operators				\$		
	Name and Address (No., City,	state, Lip)	Title	Amount	\$		
	2. Other Withdrawings (Specify)						
	Purpose		Amo	ount			
	3. Total Deductions				\$		
H.	Balance at End of Period	09/30/	15		\$	60,944	

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of		
Green Lodge of Manchester, Inc.	1702	9/30/2015	37	37		
Check appropriate category						
Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)	☑ Residential Care Home				
	Preparer/Reviewer Certific	ation				
I have read the most recent Federal ar appropriate personnel as to the possib applicable regulations. All non-reimb automatically removed in the State rat performed by me are properly reporte	report and am familiar with the applicand State issued field audit reports for the le inclusion in this report of expenses voursable expenses of which I am aware the computation system) as a result of red as such in this report on Pages 28 and ined in this report is in agreement with	e Facility and have inquired of which are not reimbursable under to the center those expenses known to ading reports, inquiry or other services and the contract of the contra	he be vices			
Signature of Preparer	Title	Date Signed				
Printed Name of Preparer						
Nancy Beilman						
Addres Address		Phone Number				
26 Mohawk Circle Newington, CT 06111	860-666-2026					