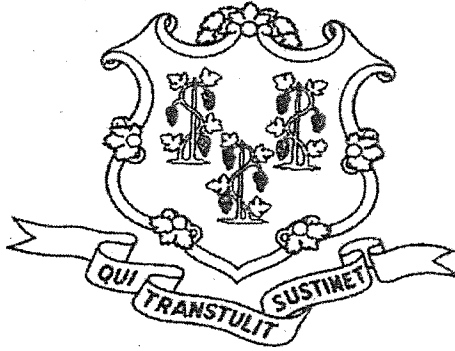


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2017

Name of Facility (as licensed) Greentree Manor & Nursing Rehabilitation Center	
Address (No. & Street, City, State, Zip Code) 4 Greentree Drive, Waterford, CT 06385	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)
<input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH 842C	RHNS	(Specify)	Medicare Provider 07-5113A
------------------	--------------	------	-----------	-------------------------------

Medicaid Provider Numbers:	CCNH 8425	RHNS	ICF-IID
----------------------------	--------------	------	---------

For Department Use Only

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

Table of Contents

General Information - Administrator's/Owner's Certification	1
General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
General Information and Questionnaire - Type of Facility - Organization Structure	2
General Information and Questionnaire - Partners/Members	3
General Information and Questionnaire - Corporate Owners	3A
General Information and Questionnaire - Individual Proprietorship	3B
General Information and Questionnaire - Related Parties	4
General Information and Questionnaire - Basis for Allocation of Costs	5
General Information and Questionnaire - Leases	6
General Information and Questionnaire - Accounting Basis	7
Schedule of Resident Statistics	8
Schedule of Resident Statistics (Cont'd)	9
A. Report of Expenditures - Salaries & Wages	10
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B. Report of Expenditures - Professional Fees	13
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C. Expenditures Other than Salaries - Administrative and General	15
C. Expenditures Other than Salaries (Cont'd) - Administrative and General	16
Schedule C-1 - Management Services	17
C. Expenditures Other than Salaries (Cont'd) - Dietary	18
C. Expenditures Other than Salaries (Cont'd) - Laundry	19
C. Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
Depreciation Schedule	23
Amortization Schedule	24
C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C. Expenditures Other than Salaries (Cont'd) - Interest	26
C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D. Adjustments to Statement of Expenditures	28
D. Adjustments to Statement of Expenditures (Cont'd)	29
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)	34
G. Balance Sheet (Cont'd) - Reserves and Net Worth	35
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
Greentree Manor & Nursing Rehabilitation Center	842C	9/30/2017	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 IMPRISONMENT UNDER STATE OR FEDERAL LAW.

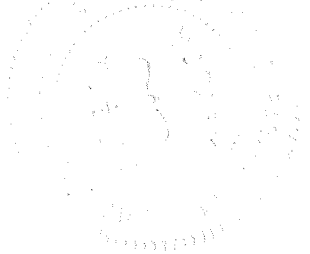
I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Greentree Manor & Nursing Rehabilitation Center [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, and that 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
<i>Alan Bates</i>		2/13/18	<i>Martin Sbriglio</i>		2/13/18
Printed Name (Administrator)			Printed Name (Owner)		
Alan Bates			Martin Sbriglio		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)		MICHELLE A. SNEAD-JOYNER NOTARY PUBLIC State of Connecticut My Commission Expires 12/31/2022
<i>Michelle A. S. Joyner</i>	CT	2/13/18	<i>Michelle A. S. Joyner</i>		
Address of Notary Public					
<i>187 Orange St. Stratford, CT 06461</i>					

(Notary Seal)



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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Greentree Manor & Nursing Rehabilitation Center		Period Covered:	From 10/1/2016	To 9/30/2017
Address of Facility 4 Greentree Drive, Waterford, CT 06385				
Report Prepared By Elizabeth Maglio		Phone Number 203-381-1327	Date 1/28/2018	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-381-1327	Report for Year Ended 9/30/2017	Page 2	of 37
---------------------------------------	------------------------------------	-----------	----------

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

License Numbers: 842C	CCNH	RHNS	(Specify)	Medicare Provider No. 07-5113A
--------------------------	------	------	-----------	-----------------------------------

Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)	

Type of Ownership (Check appropriate box)			
<input type="checkbox"/> Proprietorship	<input type="checkbox"/> LLC	<input type="checkbox"/> Partnership	<input checked="" type="radio"/> Profit Corp.
<input type="checkbox"/> Non-Profit Corp.	<input type="checkbox"/> Government	<input type="checkbox"/> Trust	

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

Has there been any change in ownership or operation during this report year?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," explain fully.
---	---------------------------	-------------------------------------	--------------------------

Administrator		
Name of Administrator Alan Bates	Nursing Home Administrator's License No.:	1951

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

Name N/A	License No.:	

General Information and Questionnaire
Corporate Owners

Name of Facility Greentree Manor & Nursing Rehabilitation Ce	License No. 842C	Report for Year Ended 9/30/2017	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address		State(s) in Which Incorporated	
Greentree Manor Nursing & Rehabilitation Center	4 Greentree Drive, Waterford, CT 06385		CT	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Martin Sbriglio, RN, NHA	4 Greentree Drive, Waterford, CT 06385	Owner	50	
Robert Sbriglio, MD, MPH	4 Greentree Drive, Waterford, CT 06385	Owner	25	
Kenneth Kopchik, MBA, NHA	4 Greentree Drive, Waterford, CT 06385	Owner	25	
Names of Stockholders Owning at Least 10% of Shares				
Martin Sbriglio, RN, NHA	4 Greentree Drive, Waterford, CT 06385	Owner	50	
Robert Sbriglio, MD, MPH	4 Greentree Drive, Waterford, CT 06385	Owner	25	
Kenneth Kopchik, MBA, NHA	4 Greentree Drive, Waterford, CT 06385	Owner	25	

General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitation Center	842C	9/30/2017	3B	37

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

Owner(s) of Facility

N/A

General Information and Questionnaire Related Parties*

Name of Facility Greentree Manor & Nursing Rehabilitation Center	License No. 842C	Report for Year Ended 9/30/2017	Page 4	of 37
---	---------------------	------------------------------------	-----------	----------

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? Yes No

If "Yes," provide the following information:

Name of Related Individual or Company <small>Please see attached for related parties</small>	Business Address	Also Provides Goods/Services to Non-Related Parties		Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No %**				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				

* Use additional sheets if necessary.

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

Greentree Manor Nursing and Rehabilitation Center
 Cost Report 9/30/2017
 List of Related Parties
 Page 4

Name of Related Individual or Company	Address	Also Provides Goods/Services to Non-Related Parties		Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page #/Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No				
Ryders Health Management (RHM)	88 Ryders Lane, Suite 208, Stratford, CT 06614	X		Financial and Managerial Support	16/m12	259,239	259,239
Greentree Properties, LLC (Realty)	4 Greentree Drive, Waterford, CT 06385	X		Rental of Real Estate	22/9	600,000	600,000
RHM (CT Healthcare WC Trust)	PO Box 30393, Hartford, CT 06150	X		Workers Compensation Insurance	15/1a1	176,967	176,967
RHM (AFCO - CNA HealthPro)		X		Property Insurance	27/14a	11,025	11,025
RHM (AFCO - CNA HealthPro)		X		Auto Insurance	27/14b	2,517	2,517
RHM (IHP, Guardian Dental, Progressive Benefit Solutions, UNUM, AFLAC, Solutions EAP)		X		Liability Insurance	27/14c1	35,850	35,850
RHM (ADP Retirement Services, Inc.)	4801 Olympia Plaza Drive, Ste. 2000, Louisville, KY 40241	X		Health Insurance	15/1a5	263,747	263,747
Mystic & Aaron Healthcare	475 High Street, Mystic, CT 06355	X		401k Plan	15/1a7	7,944	7,944
Ryders Health Management (RHM)	88 Ryders Lane, Suite 208, Stratford, CT 06614	X		Loan to Facility	32/D7	244,353	244,353
Lighthouse Home Healthcare	129 Main Street, Old Saybrook, CT 06475	X		Loan to Facility	32/D7	51,252	51,252
Lord Chamberlain, Chamberlain Manor, Cheshire House, Mystic	7003 Main Street, Stratford, CT 06614	X		Loan from Facility	34/B4	66,534	66,534
						3,505,643	3,505,643

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility Greentree Manor & Nursing Rehabilitation Center	License No. 842C	Report for Year Ended 9/30/2017	Page 5	of 37
If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:				
Item		Method of Allocation		
Dietary		Number of meals served to residents		
Laundry		Number of pounds processed		
Housekeeping		Number of square feet serviced		
Nursing		Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants		
Direct Resident Care Consultants		Number of hours of resident care provided by EACH specialist (See listing page 13)		
Maintenance and operation of plant		Square feet		
Property costs (depreciation)		Square feet		
Employee health and welfare		Gross salaries		
Management services		Appropriate cost center involved		
All other General Administrative expenses		Total of Direct and Allocated Costs		
The preparer of this report must answer the following questions applicable to the cost information provided.				
1. In the preparation of this Report, were all costs allocated as required? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				
2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.				
3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)				
<input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility		License No.	Report for Year Ended 9/30/2017		Page 6	of 37
Greentree Manor & Nursing Rehabilitation Center		842C				
Name and Address of Lessor	Related * to Owners, Operators, Officers		Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No				
GE Capital, PO Box 642111, Pittsburgh, PA 15264-2111	<input type="radio"/>	<input type="radio"/>	03/18/15	60 Months	9,585	9,585
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
Is a Mileage Log Book Maintained for All Leased Vehicles ?			<input type="radio"/> Yes	<input checked="" type="radio"/> No	Total ***	
					9,585	

* 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 Greentree Manor & Nursing Rehab	License No. 842C	Report for Year Ended 9/30/2017	Page 7	of 37
---	---------------------	------------------------------------	-----------	----------

The records of this facility for the period covered by this report were maintained on the following basis:

- Accrual Cash Modified Cash

Is the accounting basis for this period the same as for the previous period? Yes No If "No," explain.

Independent Accounting Firm

Name of Accounting Firm 1 Marcum, LLP 2 3 4	Address (No. & Street, City, State, Zip Code) 555 Long Wharf Drive, New Haven, CT 06511
---	--

Services Provided by This Firm (*describe fully*)

1 Financial statements, Tax returns, reimbursement representation	\$ 9,296
2	\$
3	\$
4	\$
	Charge for Services Provided \$ 9,296

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

- Yes No Page 15, Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney 1 Partners Pharmacy 2 Murtha Cullina 3 Joseph D'Agostino 4 Kainen, Escalara & McHale 5 Ciccioello & Ciccioello	Telephone Number 860-240-6000 860-493-0870
--	--

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

- 1
2 PO Box 150435, Hartford, CT 06115-0435
3 88 Ryders Lane, Stratford, CT
4 21 Oak St, Hartford, CT 06103
5

Services Provided by This Firm (*describe fully*)

1 Settlement - Disallowed	\$ 12,857
2 Health care regulatory matters, general matter	\$ 1,920
3 Corporate matters - Disallowed	\$ 381
4 Williamson Settlement - Disallowed	\$ 26,070
5 Williamson Settlement - Disallowed	\$ 50,000
	Charge for Services Provided \$ 91,228

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

- Yes No Page 15, line 1e

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended			Page	of
		9/30/2017				
Greentree Manor & Nursing Rehabilitation Center	842C	Period 10/1 Thru 6/30			Period 7/1 Thru 9/30	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Total	Total
1. Certified Bed Capacity						
A. On last day of PREVIOUS report period	90	90			90	90
B. On last day of THIS report period	90	90			90	90
2. Number of Residents						
A. As of midnight of PREVIOUS report period	82	82			84	84
B. As of midnight of THIS report period	83	83			83	83
3. Total Number of Days Care Provided During Period						
A. Medicare	4,108	4,108			848	848
B. Medicaid (Conn.)	21,278	21,278			5,678	5,678
C. Medicaid (other states)						
D. Private Pay	2,833	2,833			864	864
E. State SSI for RCH						
F. Other (Specify) Hospice, Managed Care	1,097	1,097			264	264
G. Total Care Days During Period (3A thru F)	29,316	29,316			7,654	7,654
Total Number of Days Not Included in Figures in						
4. 3G for Which Revenue Was Received for Reserved Beds						
A. Medicaid Bed Reserve Days	143	143			31	31
B. Other Bed Reserve Days	1	1				
5. Total Resident Days (3G + 4A + 4B)	29,460	29,460			7,685	7,685

Schedule of Resident Statistics (Cont'd)

Name of Facility Greentree Manor & Nursing Rehabilitation Ce			License No. 842C			Report for Year Ended 9/30/2017			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days							CCNH	RHNS	(Specify)				
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid			Self-Pay			Other State Assisted				
	CCNH		CCNH	RHNS		CCNH	RHNS	(Specify)	R.C.H.	ICF-MR			
No. of Residents	9		64			10							
Per Diem Rate													
a. One bed rm.						\$455-\$445							
b. Two bed rms.			225.04			\$440-\$412							
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments							TOTAL	CCNH	RHNS	(Specify)			
A. Medicare - Part B							293	293					
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other							1,917	1,917					
D. Total Physical Therapy Treatments							2,210	2,210					
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B							42	42					
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other							56	56					
D. Total Speech Therapy Treatments							98	98					
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B							212	212					
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other							2,246	2,246					
D. Total Occupational Therapy Treatments							2,458	2,458					

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Greentree Manor & Nursing Rehabilitation Center	842C	9/30/2017	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	95,402	1,885				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	211,352	11,155				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	54,607	2,080				
c. Dietary Workers	335,601	23,036				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	199,876	17,272				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	40,031	1,833				
b. Other Maintenance Workers	39,937	2,201				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	34,835	2,136				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	99,902	2,081				
b. RN						
1. Direct Care	737,673	20,947				
2. Administrative**	215,794	6,483				
c. LPN						
1. Direct Care	699,995	26,038				
2. Administrative**						
d. Aides and Attendants	1,244,745	83,007				
e. Physical Therapists	177,688	5,831				
f. Speech Therapists	35,196	551				
g. Occupational Therapists	154,215	4,153				
h. Recreation Workers	83,593	3,906				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	93,607	3,718				
n. Marketing						
o. Other (Specify)						
See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	4,554,049	218,312				

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.
 ** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.
 *** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Total	\$ -	-	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Therapy Management Consultant	\$ 31,248	625				
Total	\$ 31,248	625	\$ -	-	\$ -	-

**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		
		9/30/2017	37				
Name	Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
Section I - Operators/Owners	842C						
Martin Sbriglio, RN, NHA					Ryders Health Management, 88 Ryders Lane, Suite 208, Stratford, CT 06614	2,056	130,000
Robert Sbriglio, MD, MPH					Lord Chamberlain, 7003 Main St, Stratford, CT 06614	2,120	132,500
Kenneth Kopchik, MBA, NHA					Mystic Healthcare, 475 High St., Mystic, CT 06355	2,124	117,791
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).							
Mrs. Margaret Sbriglio, NHA					Ryders Health Management, 88 Ryders Lane, Suite 208, Stratford, CT 06614	1,040	26,000

* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.
 ** Include all employment worked during the cost year.

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

Name of Facility (as licensed) Greentree Manor & Nursing Rehabilitation Center	License No. 842C	Report for Year Ended 9/30/2017		Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Page	of
		CCNH	RHNS						12	37
Section III - Administrators***										
Molly Narveaz - Dates of Service 10/1/16 - 12/4/16		16,346		Non Discriminatory	Administrative	323	A2			
Mike Rose - Dates of Service 11/21/16 - 1/14-17 paid \$15,385, Merissa Zilkic - Dates of Service		26,116		Non Discriminatory	Administrative	516	A2			
Alan Bates - Dates of Service 3/28/17 - 9/30/17		52,940		Non Discriminatory	Administrative	1,046	A2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Greentree Manor & Nursing Rehabilitation Center	842C	9/30/2017	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	660	13				
2. Dentist	13,661	137				
3. Pharmacist	7,859	79				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	82,583	1,652				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	49,200	492				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify) Medical Staff	476	5				
9. Speech Therapist						
a. Resident Care	8,505	170				
b. Other						
10. Occupational Therapist						
a. Resident Care	135,002	2,700				
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	31,248	625				
B-13 Total Fees Paid in Lieu of Salaries	329,194	5,873				

* 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 Greentree Manor & Nursing Rehabilitation Center		License No. 842C	Report for Year Ended 9/30/2017	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Healthdrive Dental, 888 Worcester St., Wellesley MA 02482	Dental Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Partners Pharmacy of CT, PO Box, 9689, Uniondate, NY 11555	Pharmacy Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Lauren Doherty, IPC Hospitalists of New England, PO Box 92284, Los Angeles, CA 90009	Medical Director, Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. William Coleman, PO Box 2081, Salem, CT 06420	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Michael Feltes, 31 Vauxhall St., New London, CT 06320	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. John Figueiredo, 1973 Highland Ave., Cheshire, CT 06410	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
Patricia Halvordson, 287 Judd Ave., Mystic, CT 06355	Dietician	<input type="radio"/>	<input checked="" type="radio"/>		
HealthPro, 307 International Circle, Suite 100, Hunt Valley, MD 21030	PT, ST, OT & Therapy Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Laura Clark, 122 Chestnut Hill Rd, Colchester, CT 06415	MDS Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitation Center	842C	9/30/2017	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 176,967	176,967		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$			
4. Social Security (F.I.C.A.)	\$ 421,590	421,590		
5. Health Insurance	\$ 263,747	263,747		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 7,944	7,944		
8. Uniform Allowance	\$ 20,538	20,538		
9. Other (<i>Specify</i>) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 105,286	105,286		
d. Accounting and Auditing	\$ 9,296	9,296		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 92,128	92,128		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 15,159	15,159		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 22,478	22,478		
2. Cellular Phones	\$ 2,688	2,688		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$			
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$			
2. Other (<i>Specify</i>) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 530,457	530,457		
Subtotal	\$ 1,668,279	1,668,279		

* 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**

Greentree Manor & Nursing Rehabilitation Center
9/30/2017

Attachment Page 15

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitation Center	842C	9/30/2017	16	37
Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	1,668,279	1,668,279		
i. Travel and Entertainment				
1. Resident Travel and Entertainment	\$ 250	250		
2. Holiday Parties for Staff	\$ 3,012	3,012		
3. Gifts to Staff and Residents	\$			
4. Employee Travel	\$ 3,752	3,752		
5. Education Expenses Related to Seminars and Conventions	\$ 2,371	2,371		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 176	176		
7. Other (<i>Specify</i>) See Attached Schedule	\$ 6,293	6,293		
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 4,541	4,541		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$			
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 18,596	18,596		
4. Fund-Raising***	\$			
5. Medical Records	\$ 12,960	12,960		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$			
7. Postage	\$ 3,684	3,684		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 6,842	6,842		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 436	436		
9. Subscriptions	\$			
10. Contributions*** See Attached Schedule	\$ 250	250		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 68,813	68,813		
12. Administrative Management Services**	\$ 259,239	259,239		
13. Other (<i>Specify</i>) See Attached Schedule	\$ 19,959	19,959		
C-14 Total Administrative & General Expenditures	\$ 2,079,452	2,079,452		

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

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Meals & Entertainment	\$ 6,293		
Total Other Travel and Entertainment	\$ 6,293	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Adv & Pub Rel Donations	\$ 18,596		
Total Other Advertising	\$ 18,596	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 6,492		
ICNC	\$ 40		
Alan Bates	\$ 310		
Total Dues	\$ 6,842	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Donations	\$ 250		
Total Contributions	\$ 250	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Fees & License	\$ 924		
Physician Care - Employee	\$ 6,458		
Bank Charges	\$ 7,182		
Bank Charges - Lease	\$ 509		
Fines & Penalties	\$ 50		
Unemployment Tax Management	\$ 1,496		
Managed Care Contract Consulting	\$ 3,291		
American Express	\$ 49		
Total Other Administrative and General	\$ 19,959	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Greentree Manor & Nursing Rehabilitation	License No. 842C	Report for Year Ended 9/30/2017	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 #
Ryders Health Management, 88 Ryders Lane, Suite 208, Stratford, CT 06614	259,239	Financial and Managerial Support	Page 16, Line m12

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
Greentree Manor & Nursing Rehabilitation Center	842C	9/30/2017		18	37
Item	Total	CCNH	RHNS	(Specify)	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$ 171,208	171,208			
2. Non-Food Supplies	\$ 18,940	18,940			
3. Other (Specify) _____	\$ _____				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ _____				
c. Management Services**	\$ _____				
d. Other (Specify) _____	\$ _____				
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 190,147	190,147			
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)	
G. Resident Meals: Total no. of meals served per day:*					
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No					
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)					

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

** 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 Greentree Manor & Nursing Rehabilitation Center		License No. 842C	Report for Year Ended 9/30/2017	Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*		Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$	2,160	2,160	
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***		Lbs.			
		Amt. \$			
3. Personal clothing of residents washed, ironed, and/or processed.***		Lbs.			
		Amt. \$			
4. Repair and/or purchase of linens.***		Lbs.			
		Amt. \$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	77,673	77,673	
c. Management Services**		\$			
d. Other (Specify) Laundry Supplies		\$	10,889	10,889	
3E. Total Laundry Expenditures (3a + b + c + d)		\$	90,722	90,722	
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
H. Did you receive revenue from employees?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
I. Where is the revenue received reported in the Cost Report?		(Page/Line Item)			
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K. Did you receive revenue from these people?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L. Where is the revenue received reported in the Cost Report?		(Page/Line Item)			

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

** 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.	Report for Year Ended		Page	of
Greentree Manor & Nursing Rehabilitation Cent		842C	9/30/2017		20	37
Item		Total	CCNH	RHNS	(Specify)	
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	29,026	29,026		
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$				
c.	Management Services*	\$				
d.	Other (<i>Specify</i>)	\$				
4E.	Total Housekeeping Expenditures (4a + b + c + d)	\$	29,026	29,026		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from	\$	161,965	161,965		
b.	Medicine Cabinet Drugs	\$	27,122	27,122		
c.	Medical and Therapeutic Supplies	\$				
d.	Ambulance/Limousine***	\$	9,211	9,211		
e.	Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	25,271	25,271		
f.	X-rays and Related Radiological Procedures***	\$	4,632	4,632		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	30,876	30,876		
i.	Recreation	\$	22,915	22,915		
j.	Other (<i>Specify</i>)**** See Attached Schedule	\$	276,418	276,418		
5K.	Total Resident Care Expenditures (5a - 5j)	\$	558,412	558,412		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Physician Care - Patients	\$ 18,504		
Medical Supplies	\$ 172,304		
Medical Supplements	\$ 26,204		
Medical Waste	\$ 1,579		
Medical Equipment	\$ 5,895		
Medical Equipment - Rental	\$ 30,374		
Medical Supplies - Medicare	\$ (172)		
Therapy Equipment	\$ 1,676		
OT - Part A	\$ 434		
OT - Managed Care	\$ 72		
PT Supplies	\$ 17,795		
OT Supplies	\$ 1,752		
Total Other Resident Care	\$ 276,418	\$ -	\$ -

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

Name of Facility		License No.	Report for Year Ended		Page of					
Greentree Manor & Nursing Rehabilitation Center		842C	9/30/2017		21 37					
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
ADP	1 ADP Plaza, Milford, CT 06460	<input type="radio"/>	<input checked="" type="radio"/>		Payroll processing services	28,573			16	m11
Point Click Care	PO Box 8500, Philadelphia, PA 19178	<input type="radio"/>	<input checked="" type="radio"/>		Computer software support services	17,411			16	m11
Allwaste, Inc.	PO Box 2472, Hartford, CT 06146	<input type="radio"/>	<input checked="" type="radio"/>		Disposal of garbage	21,158			22	6a
United Textile Rental Services	Pkwy, Mt Vernon, NY 10550-1724	<input type="radio"/>	<input checked="" type="radio"/>		Laundry services	80,194			19	3b
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

* List all contracted services over \$10,000. Use additional sheets if necessary.
 ** Refer to Page 4 for definition of related.
 *** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended			Page	of
Greentree Manor & Nursing Rehabilitation Ce	842C	9/30/2017			22	37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	132,369	132,369			
b. Heat	\$	41,684	41,684			
c. Light & Power	\$	90,973	90,973			
d. Water	\$	28,393	28,393			
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$	9,585	9,585			
f. Other <i>(itemize)</i>	\$					
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	303,005	303,005			
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$					
b. Building & Building Improvements	\$	192,986	192,986			
c. Non-Movable Equipment	\$	13,534	13,534			
d. Movable Equipment	\$	4,559	4,559			
*7e. Total Depreciation Costs (7a + b + c + d)	\$	211,079	211,079			
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other <i>(Specify)</i>	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	600,000	600,000			
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	102,309	102,309			
c. Personal property taxes	\$	5,662	5,662			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	919,049	919,049			

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

Greentree Manor & Nursing Rehabilitation Center
9/30/2017

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
1/1/2017	Electrical	\$ 1,902	10	\$ 143
2/1/2017	Strobe Synchronization	\$ 1,827	10	\$ 122
Total additions for Building Improvement		\$ 3,729		\$ 264 *
Deletions:				
Total deletions for Building Improvement		\$ -		\$ - **

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
12/16/2016	Satellite Dish	\$ 8,003	5	\$ 1,200
12/9/2016	Generator	\$ 1,008	5	\$ 168
2/7/2017	Doors	3452	7	328.76
Total additions for Non-Movable Equipment		\$ 12,463		\$ 1,697 *
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Amortization Schedule*

Name of Facility Greentree Manor & Nursing Rehabilitation Center	Date of Acquisition		License No. 842C	Report for Year Ended 9/30/2017			Page 24	of 37
	Month	Year		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations		
A. Organization Expense								
1. Goodwill	5	1998	15 Years	50,000	16,534			
2.								
3.								
A-4. Subtotal								
B. Mortgage Expense								
1.								
2.								
3.								
B-4. Subtotal								
C. Leasehold Improvements and Other								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								
D. Total Amortization								

* Straight-line method must be used.

** Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.

B. Life of mortgage; OR

C. Remaining Life of Lease; OR

D. Actual Life if owned by Related Party.

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

Name of Facility Greentree Manor & Nursing Rehabilia	License No. 842C	Report for Year Ended 9/30/2017	Page 25	of 37
---	---------------------	------------------------------------	------------	----------

11. Property Questionnaire

Part A

Is the property either owned by the Facility
 or leased from a Related Party?*

Yes

No

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

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

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

Part B - Owner and Related Parties

	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Variable	Variable		
b. Date Mortgage Obtained	04/26/11	07/18/13		
c. Interest Rate for the Cost Year	Variable	Variable		
d. Term of Mortgage (number of years)	10 Years	5 Years		
e. Amount of Principal Borrowed	6,000,000	388,000		
f. Principal balance outstanding as of				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Greentree Manor & Nursing Rehabili		842C	9/30/2017		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Greentree Manor & Nursing Rehabi		842C		9/30/2017		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$			
12. D. Other Interest Expense (Specify) Interest Expense				\$	4,621	4,621	
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	4,621	4,621	
14. Insurance							
a. Insurance on Property (buildings only)				\$	11,025	11,025	
b. Insurance on Automobiles				\$	2,517	2,517	
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$	35,850	35,850	
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. Total Insurance Expenditures (14a + b + c)				\$	49,392	49,392	
15. Total All Expenditures (A-13 thru C-14)				\$	9,107,069	9,107,069	

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitation Center				842C	9/30/2017	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	12g	Occupational Therapy	\$ 154,215	154,215		
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$ 135,002	135,002		
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 105,286	105,286		
10.	15	1e	Accounting & Legal	\$ 89,308	89,308		
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.	16	17	Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$ 6,293	6,293		
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m3	Unallowable Advertising *	\$ 18,596	18,596		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 250	250		
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 535	535		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 509,485	509,485		

* 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 Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m8a	Chamber of Commerce	\$ 436		
16	m13	Fines & Penalties	\$ 50		
16	m13	American Express	\$ 49		
Total Other A&G Adjustments			\$ 535	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitation Center				842C	9/30/2017	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 509,485	509,485		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 161,965	161,965		
28.	20	5d	Ambulance/Limousine	\$ 9,211	9,211		
29.	20	5f	X-rays, etc	\$ 4,632	4,632		
30.	20	5h	Laboratory	\$ 30,876	30,876		
31.			Medical Supplies	\$			
32.	20	500	Oxygen (non emergency)	\$ 25,271	25,271		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 2,258	2,258		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			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 For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51. Total Amount of Decrease (Items 1 - 50)				\$ 743,698	743,698		

*** 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.

Greentree Manor & Nursing Rehabilitation Center
9/30/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	OT Part A	\$ 434		
20	5j	OT - Managed Care	\$ 72		
20	5j	OT - Supplies	\$ 1,752		
Total Other Ancillary Costs			\$ 2,258	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

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

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility		License No.		Report for Year Ended		Page	of
Greentree Manor & Nursing Rehabiliation		842C		9/30/2017		30	37
Item	Total	CCNH	RHNS	(Specify)			
I. Resident Room, Board & Routine Care Revenue							
1. a. Medicaid Residents (<i>CT only</i>)	\$ 7,924,098	7,924,098					
b. Medicaid Room and Board Contractual Allowance **	\$ (3,496,623)	(3,496,623)					
2. a. Medicaid (<i>All other states</i>)	\$						
b. Other States Room and Board Contractual Allowance **	\$						
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,217,261	1,217,261					
b. Medicare Room and Board Contractual Allowance **	\$ 380,985	380,985					
4. a. Private-Pay Residents and Other	\$ 2,503,833	2,503,833					
b. Private-Pay Room and Board Contractual Allowance **	\$ (597,563)	(597,563)					
II. Other Resident Revenue							
1. a. Prescription Drugs - Medicare	\$ 116,769	116,769					
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (116,769)	(116,769)					
c. Prescription Drugs - Non-Medicare	\$ 64,810	64,810					
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$						
2. a. Medical Supplies - Medicare	\$						
b. Medical Supplies - Medicare Contractual Allowance **	\$						
c. Medical Supplies - Non-Medicare	\$ 238	238					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$						
3. a. Physical Therapy - Medicare	\$ 252,971	252,971					
b. Physical Therapy - Medicare Contractual Allowance **	\$ (252,971)	(252,971)					
c. Physical Therapy - Non-Medicare	\$ 319,659	319,659					
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$						
4. a. Speech Therapy - Medicare	\$ 36,709	36,709					
b. Speech Therapy - Medicare Contractual Allowance **	\$ (36,709)	(36,709)					
c. Speech Therapy - Non-Medicare	\$ 55,797	55,797					
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$						
5. a. Occupational Therapy - Medicare	\$ 301,749	301,749					
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (301,749)	(301,749)					
c. Occupational Therapy - Non-Medicare	\$ 301,331	301,331					
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$						
6. a. Other (<i>Specify</i>) - Medicare	\$						
b. Other (<i>Specify</i>) - Non-Medicare	\$ 25,049	25,049					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 8,698,874	8,698,874					
IV. Other Revenue*							
1. Meals sold to guests, employees & others	\$						
2. Rental of rooms to non-residents	\$						
3. Telephone	\$						
4. Rental of Television and Cable Services	\$						
5. Interest Income (<i>Specify</i>)	\$ 14	14					
6. Private Duty Nurses' Fees	\$						
7. Barber, Coffee, Beauty and Gift shops	\$						
8. Other (<i>Specify</i>)	\$						
V. Total Other Revenue (1 thru 8)	\$ 14	14					
VI. Total All Revenue (III + V)	\$ 8,698,888	8,698,888					

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Oxygen	\$ 7,411		
	C/A - Oxygen	\$ (7,411)		
	X-Ray	\$ 3,297		
	C/A - X-Ray	\$ (3,297)		
	Lab	\$ 70,607		
	C/A - Lab	\$ (70,607)		
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	X-Ray Private Insurance	\$ 178		
	X-Ray Managed Care	\$ 1,534		
	Oxygen - Managed Care	\$ 3,154		
	Lab - Private Insurance	\$ 1,956		
	Lab - Managed Care	\$ 18,226		
Total Other Resident Revenue		\$ 25,049	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Income		\$ 14		
Total Interest Income			\$ 14	\$ -	\$ -

Schedule of Other Revenue

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

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitat	842C	9/30/2017	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	150,486
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	777,627
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	25,394
a. Prepaid Expenses	24,505			
b. Prepaid Insurance	890			
c. _____				
d. _____				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	28,755
Medicaid Advances	12,810			
Loans & Exchanges	(334)			
Refunds	16,279			
A-9. Total Current Assets (Lines A1 thru 8)			\$	982,262
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost	7,214,398	\$	4,414,013
	Accum. Depreciation	2,800,384	Net	
4. Leasehold Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
5. Non-Movable Equipment	*Historical Cost	395,347	\$	17,180
	Accum. Depreciation	378,167	Net	
6. Movable Equipment	*Historical Cost	519,512	\$	21,413
	Accum. Depreciation	498,099	Net	
7. Motor Vehicles	*Historical Cost	100,831	\$	2,500
	Accum. Depreciation	98,331	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	11,098
Computer Software	11,098			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	4,466,204

* 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
Greentree Manor & Nursing Rehabilitat	842C	9/30/2017	32	37
Account			Amount	
Total Brought Forward:			\$	5,448,466
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Non-Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
5. Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
6. Motor Vehicles				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
7. Minor Equipment-Not Depreciable				
C-8 Total Leasehold or Like Properties (C1 thru 7)				
\$				
D. Investment and Other Assets				
1. Deferred Deposits				
\$				
2. Escrow Deposits				
\$				
3. Organization Expense				
	*Historical Cost	50,000		
	Accum. Depreciation	16,534	Net	\$ 33,466
4. Goodwill (Purchased Only)				
\$				
5. Investments Related to Resident Care (<i>itemize</i>)				
\$				
6. Loans to Owners or Related Parties (<i>itemize</i>)				
\$				
Name and Address		Amount	Loan Date	
7. Other Assets (<i>itemize</i>)				
\$ 362,139				
Due from Mystic & Aaron Manor		244,353		
Due from Ryders Health Management		51,252		
Due from Lighthouse Home Health		66,534		
D-8. Total Investments and Other Assets (Lines D1 thru 7)				
\$ 395,605				
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)				
\$ 5,844,071				

* 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
Greentree Manor & Nursing Rehabilitation Ce		842C	9/30/2017	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	728,965
2. Notes Payable (<i>itemize</i>)				\$	

3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	79,456
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	352,324
Patient Fund		19,299	Accrued PTO	101,714	
Accrued Expenses		(7,548)			
Accrued User Fee		231,893			
AFLAC - Individual		6,966			
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	1,160,746

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Greentree Manor & Nursing Rehabilitation C	License No. 842C	Report for Year Ended 9/30/2017	Page 34	of 37
Account			Amount	
Total Brought Forward:			1,160,746	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				
Name of Lender	Purpose	Amount	Date Due	\$
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$ 280,000
Name and Address of Lender	Amount	Loan Date		
Robert Sbriglio, MD	140,000			
Martin Sbriglio, RN	140,000			
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 3,505,643
Due to Chamberlain Manor		25,000		
Due to Cheshire House		81,184		
Due to Lord Chamberlain		182,594		
Due to Mystic & GT Realty		3,216,865		
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 3,785,643
C. Total All Liabilities (Lines A-13 + B-5)				\$ 4,946,389

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

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitat	842C	9/30/2017	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	1,304,862
6. Gain or Loss for Period			\$	(408,180)
	10/1/2016	thru 9/30/2017		
7. Total Net Worth			\$	897,682
C. Total Reserves and Net Worth			\$	897,682
D. Total Liabilities, Reserves, and Net Worth			\$	5,844,071

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Greentree Manor & Nursing Rehabilitat	842C	9/30/2017	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2016			\$	1,305,862
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	8,698,888
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	9,107,068
D. Net Income or Deficit			\$	(408,180)
E. Balance			\$	897,682
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount	
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period			\$	897,682
				09/30/17

I. Preparer's/Reviewer's Certification

Name of Facility Greentree Manor & Nursing Rehabilitation		License No. 842C	Report for Year Ended 9/30/2017	Page 37	of 37
<i>Check appropriate category</i>					
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input type="checkbox"/> (Specify)	
Preparer/Reviewer Certification					
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>					
Signature of Preparer <i>Elizabeth Maglio</i>		Title <i>Controller</i>	Date Signed <i>2/14/18</i>		
Printed Name of Preparer Elizabeth Maglio					
Address 88 Ryders Lane, Stratford, CT 06614			Phone Number 203-381-1327		