

State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2017

Name of Facility (as licensed) Manchester Manor Health Care Center	
Address (No. & Street, City, State, Zip Code) 385 West Center St., Manchester, CT 06040	
Type of Facility <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

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

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

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General Information

Name of Facility (as licensed) Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2017	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Manchester Manor Health Care Center [facility name], for the cost report period beginning October 1, 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
Printed Name (Administrator) William Nelson			Printed Name (Owner) Paul Liistro		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Manchester Manor Health Care Center		Period Covered:	From 10/1/2016	To 9/30/2017
Address of Facility 385 West Center St., Manchester, CT 06040				
Report Prepared By CJLC LLC		Phone Number 860-610-9009	Date	
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 860-646-0129		Report for Year Ended 9/30/2017	Page 2	of 37
Name of Facility (as shown on license) Manchester Manor Health Care Center		Address (No. & Street, City, State, Zip) 385 West Center St., Manchester, CT 06040		
License Numbers:	CCNH 2237-C	RHNS	(Specify)	Medicare Provider No. 07-5333
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input checked="" type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?				
<input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator William Nelson		Nursing Home Administrator's License No.:	1716	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

General Information and Questionnaire
Corporate Owners

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2017	Page 3A	of 37
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated	

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
N/A			

Names of Stockholders Owning at Least 10% of Shares			

General Information and Questionnaire
Related Parties*

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2017	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Manchester Manor Realty, LLP	385 West Center St., Manchester, CT 06040	<input type="radio"/>	<input checked="" type="radio"/>		Rent	22/9	530,498	530,498
Vernon Manor Health Care	180 Regan Road, Vernon, CT 06066	<input type="radio"/>	<input checked="" type="radio"/>		Shared Office Staff	10/A4	265,017	265,017
Vernon Manor Health Care	180 Regan Road, Vernon, CT 06066	<input type="radio"/>	<input checked="" type="radio"/>		Common Pension Plan	15 / 1A7	70,004	N/A
Arbors of Hop Brook	403 West center St, Manchester, CT 06040	<input type="radio"/>	<input checked="" type="radio"/>		Manchester Manor is the nursing facility component of the CCRC	N/A	N/A	N/A
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					

* Use additional sheets if necessary.
 ** Provide the percentage amount of revenue received from non-related parties.

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2017	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (<i>See listing page 13</i>)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

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

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

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

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

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

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 Manchester Manor Health Care Center			License No. 2237-C		Report for Year Ended 9/30/2017		Page of 6 37		
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed		
	Yes	No							
Pitney Bowes PO Box 856460, Louisville, KY 40285	<input type="radio"/>	<input checked="" type="radio"/>	Carriage House Postage Machine Allocation 40%	08/13/13	63 months	2,424	2,424		
Novareus US, Inc. 111 North Canal, Suite 165, Chicago, IL 60606	<input type="radio"/>	<input checked="" type="radio"/>	Airborne Infection Control	02/01/14		16,080	16,080		
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input 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 type="radio"/> No	Total ***
								18,504	

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

General Information and Questionnaire
Accounting Basis

Name of Facility Manchester Manor Health Care Cen	License No. 2237-C	Report for Year Ended 9/30/2017	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:
 Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm 1 CJLC, LLC 2 Cohn Reznick, LLP 3 4	Address (No. & Street, City, State, Zip Code) 225 Pitkin Street, East Hartford, CT 06108 350 Church St., Hartford, CT 06103-1136
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Services Provided by This Firm (*describe fully*)

1 Medicaid and Medicare Cost Report, Financial Statements, Reimbursement Consulting	\$ 27,572
2 Tax Returns, Corporate Matters	\$ 5,430
3	\$
4	\$
	Charge for Services Provided \$ 33,002

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No Pg 15/1d

Legal Services Information

Name of Legal Firm or Independent Attorney 1 Jackson Lewis, LLP 2 Murtha Cullina, LLP 3 Erisa Pros LLC 4 5	Telephone Number (914)514-6060 (860)240-6000 (678)443-40003
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Address (*No. & Street, City, State, Zip Code*)
 1 PO Box 416019, Boston, MA 02241
 2 185 Asylum St., Hartford, CT 06103
 3 5901 Peachtree Dunwoody Rd, Atlanta GA
 4
 5

Services Provided by This Firm (*describe fully*)

1 Consulting on Employee Matters	\$ 1,955
2 General & Collectoin Matters (Disallowed)	\$ 4,947
3 Benefit Consulting	\$ 493
4	\$
5	\$
	Charge for Services Provided \$ 7,395

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No Pg 15/1e

Schedule of Resident Statistics

Name of Facility Manchester Manor Health Care Center		License No. 2237-C			Report for Year Ended 9/30/2017				Page 8	of 37			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	126	126			126	126			126	126			
B. On last day of THIS report period	126	126			126	126			126	126			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	115	115			115	115			116	116			
B. As of midnight of THIS report period	116	116			116	116			116	116			
3. Total Number of Days Care Provided During Period													
A. Medicare	5,144	5,144			3,840	3,840			1,304	1,304			
B. Medicaid (Conn.)	23,029	23,029			17,238	17,238			5,791	5,791			
C. Medicaid (other states)													
D. Private Pay	13,237	13,237			9,717	9,717			3,520	3,520			
E. State SSI for RCH													
F. Other (Specify)													
G. Total Care Days During Period (3A thru F)	41,410	41,410			30,795	30,795			10,615	10,615			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days													
B. Other Bed Reserve Days													
5. Total Resident Days (3G + 4A + 4B)	41,410	41,410			30,795	30,795			10,615	10,615			

Schedule of Resident Statistics (Cont'd)

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2017	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? Yes No
 If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH (1)	RHNS (2)	(Specify) (3)	Lost			Gained			CCNH	RHNS	(Specify)	
				(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-IID
No. of Residents								
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.								
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	1,517	1,517		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	21	21		
C. Other	6,508	6,508		
D. Total Physical Therapy Treatments	8,046	8,046		

8. Total Number of Speech Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	534	534		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	1,462	1,462		
D. Total Speech Therapy Treatments	1,996	1,996		

9. Total Number of Occupational Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	1,342	1,342		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	16	16		
C. Other	6,435	6,435		
D. Total Occupational Therapy Treatments	7,793	7,793		

Report of Expenditures - Salaries & Wages

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2017	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	120,836	2,086				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	487,919	25,387				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	526,241	30,513				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	183,919	15,678				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	122,695	5,285				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	53,338	4,037				
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	206,909	4,179				
b. RN						
1. Direct Care	1,461,910	38,610				
2. Administrative**	288,683	5,910				
c. LPN						
1. Direct Care	1,103,459	35,689				
2. Administrative**	30,943	6,748				
d. Aides and Attendants	1,896,622	120,622				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	145,961	7,626				
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	225,968	7,837				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	6,855,402	310,206				

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

Name of Facility				License No.	Report for Year Ended			Page	of	
Manchester Manor Health Care Center				2237-C	9/30/2017			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
Manchester Manor Health Care Center				2237-C		9/30/2017			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
William Nelson (10/1/16 to 9/30/17)	120,836			Standard	Responsible for daily operations of the facility	2,086	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		
Manchester Manor Health Care Center	2237-C	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						
2. Dentist	7,560	107				
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	464,834	11,165				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	36,000	260				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	102,693	1,964				
b. Other						
10. Occupational Therapist						
a. Resident Care	440,813	9,215				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	29,600	391				
B-13 Total Fees Paid in Lieu of Salaries	1,081,500	23,102				

* 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.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Manchester Manor Health Care Center	2237-C	9/30/2017	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 173,916	173,916		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 104,491	104,491		
4. Social Security (F.I.C.A.)	\$ 509,858	509,858		
5. Health Insurance	\$ 429,850	429,850		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 70,004	70,004		
8. Uniform Allowance	\$ 13,654	13,654		
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*	\$ 57,813	57,813		
d. Accounting and Auditing	\$ 33,002	33,002		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 7,395	7,395		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 43,944	43,944		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 56,680	56,680		
2. Cellular Phones	\$ 7,124	7,124		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 610	610		
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	\$			
Subtotal	\$ 1,508,341	1,508,341		

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended		Page	of
Manchester Manor Health Care Center	2237-C	9/30/2017		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:		1,508,341	1,508,341		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$ 6,032	6,032			
2. Holiday Parties for Staff	\$ 26,792	26,792			
3. Gifts to Staff and Residents	\$ 274	274			
4. Employee Travel	\$ 10,159	10,159			
5. Education Expenses Related to Seminars and Conventions	\$ 15,609	15,609			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 5,108	5,108			
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 3,209	3,209			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 59,701	59,701			
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 6,484	6,484			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 9,536	9,536			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 372	372			
9. Subscriptions	\$ 15,605	15,605			
10. Contributions*** See Attached Schedule	\$ 257	257			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 260,042	260,042			
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$ 10,389	10,389			
C-14 Total Administrative & General Expenditures	\$ 1,937,909	1,937,909			

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

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
ADVERTISING-PUBLIC RELATIONS	\$ 59,701		
Total Other Advertising	\$ 59,701	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 8,936		
ALTCFM	\$ 213		
HFMA	\$ 387		
Total Dues	\$ 9,536	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
CONTRIBUTIONS - GIFTS	\$ 257		
Total Contributions	\$ 257	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
EMPLOYMENET SCREENING EXP	\$ 5,472		
LICENSE FEES	\$ 1,916		
BANKING FEES/ADMIN FEES	\$ 4,704		
EMPLOYEE PHYSICALS	\$ (1,703)		
Total Other Administrative and General	\$ 10,389	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	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 #

*** 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
Manchester Manor Health Care Center	2237-C	9/30/2017	18	37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 283,032	283,032		
2. Non-Food Supplies	\$ 50,048	50,048		
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) _____ VENDING MACHINE	\$ 2,950	2,950		
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 336,029	336,029		
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 Manchester Manor Health Care Center		License No. 2237-C	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. \$	10,854	10,854		
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. \$	19,528	19,528		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$				
c. Management Services**	\$				
d. Other (Specify)	\$				
3E. Total Laundry Expenditures (3a + b + c + d)	\$	30,382	30,382		
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
Manchester Manor Health Care Center		2237-C	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. \$	73,433	73,433		
	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)	\$	73,433	73,433		
5.	Resident Care (Supplies)**					
	a. Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from	\$	388,250	388,250		
	b. Medicine Cabinet Drugs	\$	11,684	11,684		
	c. Medical and Therapeutic Supplies	\$	316,906	316,906		
	d. Ambulance/Limousine***	\$				
	e. Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	76,312	76,312		
	f. X-rays and Related Radiological Procedures***	\$	20,913	20,913		
	g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
	h. Laboratory***	\$				
	i. Recreation	\$	14,352	14,352		
	j. Other (Specify)**** See Attached Schedule	\$	35,017	35,017		
5K.	Total Resident Care Expenditures (5a - 5j)	\$	863,432	863,432		

* 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.

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

Name of Facility Manchester Manor Health Care Center			License No. 2237-C		Report for Year Ended 9/30/2017				Page of 21 37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
ADP	100 Corporate Dr, Windsor, CT 06095	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Services	70,541			16	m11
Wescom Solutions	3500 American Blvd W. Suite 155, Bloomington	<input type="radio"/>	<input type="radio"/>		Point Click Care	34,844			16	m11
		<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"/>							

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Manchester Manor Health Care Center	2237-C	9/30/2017			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 203,601	203,601				
b. Heat	\$ 43,217	43,217				
c. Light & Power	\$ 98,196	98,196				
d. Water	\$ 35,844	35,844				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 18,504	18,504				
f. Other (<i>itemize</i>)	\$ 51,575	51,575				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 450,937	450,937				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$ 10,612	10,612				
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$ 29,662	29,662				
d. Movable Equipment	\$ 103,345	103,345				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 143,618	143,618				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 170,210	170,210				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 170,210	170,210				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 530,498	530,498				
10. Property Taxes						
a. Real estate taxes paid by owner	\$ 134,351	134,351				
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$ 24,554	24,554				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,003,232	1,003,232				

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
WASTE REMOVAL	\$ 31,791		
SNOW REMOVAL	\$ 19,783		
Total Other Repairs and Maintenance	\$ 51,575	\$ -	\$ -

Manchester Manor Health Care Center
9/30/2017

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
6/2/2017	Repairs in chain link fences	\$ 3,722	5	\$ 248
8/7/2017	Asphalt repairs	\$ 3,186	8	\$ 66
Total additions for Land Improvements		\$ 6,909		\$ 315 *
Deletions:				
Total deletions for Land Improvements		\$ -		\$ - **

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

*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:				
2/14/2017	Wet sprinkler system	\$ 2,728	5	\$ 364
3/31/2017	Grease Trap	\$ 12,589	20	\$ 315
1/4/2017	Boiler Circulator Pump	\$ 2,670	15	\$ 134
1/27/2017	Ductless Heat Pump	\$ 5,206	10	\$ 347
4/25/2017	Walk In Cooler Evaporator	\$ 2,267	5	\$ 189
8/28/2017	Condensor	\$ 6,820	15	\$ 38
9/27/2017	Dry Sprinkler System	\$ 5,318	7	\$ -
9/28/2017	Boiler	\$ 136,460	20	\$ -
Total additions for Non-Movable Equipment		\$ 174,057		\$ 1,386 *
Deletions:				

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

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
12/31/2016	Mobile Vitals Equipment	\$ 8,008	10	\$ 601
10/31/2016	Ricoh Copiers	\$ 3,928	5	\$ 720
5/25/2017	Ice machine	\$ 3,216	10	\$ 107
4/7/2017	Bladder Scanner	\$ 7,443	7	\$ 532
4/3/2017	Admission Office Furniture	\$ 2,739	7	\$ 196
Total additions for Movable Equipment		\$ 25,335		\$ 2,155 *
Deletions:				
9/30/2017	Various fully depreciated items	\$ (21,966)		
Total deletions for Movable Equipment		\$ (21,966)		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
11/7/2016	Office Renovations	\$ 7,300	15	\$ 446
4/3/2017	Carpeting	\$ 4,247	5	\$ 425
6/29/2017	Boiler/Tank Room	\$ 4,287	5	\$ -
8/21/2017	Family Meeting Room Walls	\$ 6,354	5	\$ 106
4/20/2017	Dining Room Flooring	\$ 7,551	10	\$ 315
5/2/2017	Dining Room Wallcovering	\$ 6,862	5	\$ 572
6/4/2017	Dining Room Sink/Cabinets/Counter	\$ 3,726	15	\$ 83
1/24/2017	Nurses Station Flooring	\$ 5,090	10	\$ 339
9/30/2017	Resident Room Renovations	8,375	10	\$ -
1/1/2017	Med Room Cabinets / Counters	7,227	15	\$ 361
Total additions for Leasehold Improvement		\$ 61,019		\$ 2,647 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Manchester Manor Health Care Center			License No. 2237-C		Report for Year Ended 9/30/2017			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
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	Var	Var	Var	6,385,296	2,638,465	Var		167,564	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				61,019				2,647	
C-4. Subtotal									170,210
D. Total Amortization									170,210

* Straight-line method must be used.

** Specify which of the following bases were used:

- A. Minimum of 5 years or 60 months.
- B. Life of mortgage; OR
- C. Remaining Life of Lease; OR
- D. Actual Life if owned by Related Party.

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

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2017	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description		Total			
1. Date Land Purchased		1/1/1970			
2. Date Structure Completed		1/1/1970			
3. If NOT Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity		126			
6. Square Footage		42,099			
7. Acquisition Cost					
a. Land		42,000			
b. Building		424,160			
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			
b. Date Mortgage Obtained		08/23/11			
c. Interest Rate for the Cost Year		Libor + 2%			
d. Term of Mortgage (number of years)		20			
e. Amount of Principal Borrowed		1,800,000			
f. Principal balance outstanding as of					
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
Manchester Manor Health Care Center		2237-C	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
Manchester Manor Health Care Ce		2237-C		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)				\$	724	724	
INTEREST EXPENSE - OPERATIONS							
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	724	724	
14. Insurance							
a. Insurance on Property (buildings only)				\$	64,180	64,180	
b. Insurance on Automobiles				\$	1,868	1,868	
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$			
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. Total Insurance Expenditures (14a + b + c)				\$	66,048	66,048	
15. Total All Expenditures (A-13 thru C-14)				\$	12,699,030	12,699,030	

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Manchester Manor Health Care Center				2237-C	9/30/2017	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.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$ 440,813	440,813		
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 57,813	57,813		
10.	15	1e	Accounting & Legal	\$ 4,947	4,947		
11.	30	IV3	Telephone	\$ 1,247	1,247		
12.	15	1h2	Cellular Telephone	\$ 5,684	5,684		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.	16	L5	Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$ 2,800	2,800		
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.	16	L6	Automobile Expense (e.g. personal use)	\$ 5,108	5,108		
18.	16	m3	Unallowable Advertising *	\$ 59,701	59,701		
19.	15	1j	Income Tax / Corporate Business Tax	\$ 360	360		
20.			Fund Raising / Contributions	\$ 257	257		
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 32,141	32,141		
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)				\$ 610,870	610,870		

* 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	L3	EMPLOYEE WELFARE	\$ 26,792		
16	L2	EMPLOYEE AWARDS & RECEPTIONS	\$ 274		
16	M13	BANKING FEES/ADMIN FEES	\$ 4,704		
		CHAMBER OF COMMERCE DUES	\$ 372		
Total Other A&G Adjustments			\$ 32,141	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
Manchester Manor Health Care Center				2237-C	9/30/2017	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 610,870	610,870		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 388,250	388,250		
28.			Ambulance/Limousine	\$			
29.	20	5f	X-rays, etc	\$ 20,913	20,913		
30.			Laboratory	\$			
31.	20	5c	Medical Supplies	\$ 131,060	131,060		
32.	20	5e	Oxygen (non emergency)	\$ 76,312	76,312		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 35,017	35,017		
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.	27	14B	Property Insurance	\$ 1,868	1,868		
Other - Miscellaneous							
42.			Research or Experimental Activities	\$			
43.	30	IV3 &	Radio and Television Revenue	\$ 2,136	2,136		
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	\$ 491	491		
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)			\$ 1,266,916	1,266,916		

*** 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.

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
Manchester Manor Health Care Center	2237-C	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>)	\$ 10,672,385	10,672,385				
b. Medicaid Room and Board Contractual Allowance **	\$ (5,490,798)	(5,490,798)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 2,535,824	2,535,824				
b. Medicare Room and Board Contractual Allowance **	\$ 381,006	381,006				
4. a. Private-Pay Residents and Other	\$ 5,358,686	5,358,686				
b. Private-Pay Room and Board Contractual Allowance **	\$ (296,132)	(296,132)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 202,411	202,411				
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$ 139,003	139,003				
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	\$ 658,522	658,522				
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$ 317,060	317,060				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 144,926	144,926				
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$ 63,628	63,628				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 662,589	662,589				
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$ 330,361	330,361				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$ (1,314,169)	(1,314,169)				
b. Other (<i>Specify</i>) - Non-Medicare	\$ (806,752)	(806,752)				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 13,558,550	13,558,550				
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$ 1,247	1,247				
4. Rental of Television and Cable Services	\$ 2,136	2,136				
5. Interest Income (<i>Specify</i>)	\$ 16,457	16,457				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 1,316	1,316				
V. Total Other Revenue (1 thru 8)	\$ 21,155	21,155				
VI. Total All Revenue (III +V)	\$ 13,579,705	13,579,705				

* 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 - MED A	\$ 2,607		
	LABORATORY - MED A	\$ 153,813		
	RADIOLOGY - MED A	\$ 17,187		
	MEDICARE PART A CONT. ALLOW.	\$ (1,448,330)		
	MED B PHYSICIAN SERVICES	\$ 2,210		
	GLUCOSE - MED B	\$ 27,820		
	MEDICARE PART B CONTR. ALLOW.	\$ (64,257)		
	MEDICARE B SEQUESTER C/A	\$ (5,219)		
Total Other Resident Revenue - Medicare		\$ (1,314,169)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	MEDICAID ANCILLARY CONTR ALLOW	\$ (20,985)		
	OXYGEN - MGD	\$ 1,111		
	LABORATORY - MGD	\$ 83,334		
	X-RAY - MGD	\$ 13,336		
	MANAGED CARE CONT. ALLOW ANC	\$ (867,900)		
	C/A MNGD CARE B ANCILLARIES	\$ (15,494)		
	MANAGED CARE B SEQUESTER C/A	\$ (154)		
Total Other Resident Revenue		\$ (806,752)	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	INTEREST INCOME - RESERVES		\$ 7		
	INTEREST - LATE PAYMENT		\$ 491		
	DIVIDEND INCOME		\$ 15,959		
Total Interest Income			\$ 16,457	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	VENDING MACHINE	\$ 7,248		
	MISCELLANEOUS - OTHER	\$ 1,019		
	REALIZED GAIN OR LOSS	\$ (9,951)		
	GAIN/LOSS-SALE OF FIXED ASSETS	\$ 3,000		
Total Other Revenue		\$ 1,316	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Manchester Manor Health Care Center	2237-C	9/30/2017	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	1,053,477
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	945,728
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	83,623
4. Inventories			\$	
5. Prepaid Expenses			\$	13,322
a. PREPAID OTHER	13,322			
b. _____				
c. _____				
d. _____				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

A-9. Total Current Assets (Lines A1 thru 8)			\$	2,096,150
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	405,526	\$	115,072
	Accum. Depreciation	290,454		Net
3. Buildings	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		Net
4. Leasehold Improvements	*Historical Cost	6,446,316	\$	3,637,641
	Accum. Depreciation	2,808,675		Net
5. Non-Movable Equipment	*Historical Cost	746,580	\$	436,342
	Accum. Depreciation	310,239		Net
6. Movable Equipment	*Historical Cost	1,150,750	\$	239,686
	Accum. Depreciation	911,064		Net
7. Motor Vehicles	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	2,679
CONSTRUCTION IN PROGRESS	2,679			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	4,431,420

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2017	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	6,527,569
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 _____ Accum. Depreciation _____ Net	\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address		Amount	Loan Date	

7. Other Assets (<i>itemize</i>)			\$	

D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	6,527,569

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

G. Balance Sheet (cont'd)

Name of Facility Manchester Manor Health Care Center		License No. 2237-C	Report for Year Ended 9/30/2017	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	800,978
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>)				\$	285,513
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>)				\$	60,310
RESIDENT FUND PAYABLE		9,183			
RECOUPMENT/HELD APPLIED I		57,733			
LOANS/EXCHANGES - FSA		(6,607)			
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	1,146,801

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2017	Page 34	of 37
Account				Amount
Total Brought Forward:				1,146,801
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>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$

B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$
C. Total All Liabilities (Lines A-13 + B-5)				\$ 1,146,801

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

Name of Facility	License No.	Report for Year Ended	Page	of
Manchester Manor Health Care Center	2237-C	9/30/2017	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			\$	4,500,094
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	
6. Gain or Loss for Period			\$	880,675
	10/1/2016	thru 9/30/2017		
7. Total Net Worth			\$	5,380,769
C. Total Reserves and Net Worth			\$	5,380,769
D. Total Liabilities, Reserves, and Net Worth			\$	6,527,570

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Manchester Manor Health Care Center	2237-C	9/30/2017	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2016			\$	5,079,469
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	13,579,705
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	12,699,030
D. Net Income or Deficit			\$	880,675
E. Balance			\$	5,960,144
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		09/30/17	\$	5,960,144

I. Preparer's/Reviewer's Certification

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	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	Title	Date Signed		
Printed Name of Preparer				
CJLC LLC				
Address		Phone Number		
225 Pitkin Street, East Hartford, CT 06108		860-610-9009		