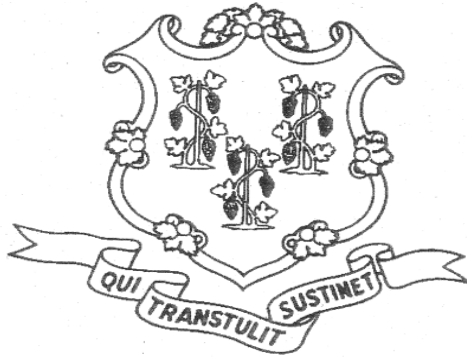


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2020

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 Chronic and Convalescent Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input type="checkbox"/> Supervision only <input type="checkbox"/> (Specify) (CCNH) (RHNS)	
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020

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 9/30/2020	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, 2019 and ending September 30, 2020, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) Paul Liistro			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 10/1/2019	To 9/30/2020	
Address of Facility 385 West Center St., Manchester, CT 06040				
Report Prepared By CJLC LLC	Phone Number 860-610-9009	Date 2/12/2021		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid \$				
2. Laundry wages paid \$				
3. Housekeeping wages paid \$				
4. Nursing wages paid \$				
5. All other wages paid \$				
6. Total Wages Paid \$				
7. Total salaries paid \$				
8. Total Wages and Salaries Paid (As per page 10 of Report) \$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility		Report for Year Ended		Page	of
860-646-0129		9/30/2020		2	37
Name of Facility (as shown on license)			Address (No. & Street, City, State, Zip)		
Manchester Manor Health Care Center			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			Nursing Home Administrator's License No.:	531	
Paul Liistro					
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		

General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Manchester Manor Health Care Center	2237-C	9/30/2020	3B	37

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

Owner(s) of Facility

N/A

**General Information and Questionnaire
Related Parties***

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2020	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	543,761	543,761
Vernon Manor Health Care	180 Regan Road, Vernon, CT 06066	<input type="radio"/>	<input checked="" type="radio"/>		Shared Office Staff	10/A4	57,509	57,509
Arbors of Hop Brook	403 West center St, Manchester, CT 06040	<input type="radio"/>	<input checked="" type="radio"/>		Common Pension Plan	15 / 1A7	75,773	75,773
Arbors of Hop Brook	403 West center St, Manchester, CT 06040	<input type="radio"/>	<input checked="" type="radio"/>		Shared Insurance Plan	15/1A5	452,384	452,384
Vernon Manor Health Care Center	180 Regan Road, Vernon, CT 06066	<input type="radio"/>	<input checked="" type="radio"/>		Shared Operational Staff	10/12	16,615	16,615
		<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"/>					

* 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 9/30/2020	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			License No.	Report for Year Ended			Page	of	
Manchester Manor Health Care Center			2237-C	9/30/2020			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							
MailFinance 385 West Center St, Manchester, CT 06040	<input type="radio"/>	<input checked="" type="radio"/>	Postage Machine	07/23/18	63 months	2,057	2,057		
	<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 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 checked="" type="radio"/>							
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input checked="" type="radio"/> No	Total ***	2,057

* 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 Ce	License No. 2237-C	Report for Year Ended 9/30/2020	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 William T Craig CPA, LLC 3 4	Address (No. & Street, City, State, Zip Code) 225 Pitkin Street, East Hartford, CT 06108 140-16 Masons Island Rd, Ste 2a, Mystic, CT 06355
--	--

Services Provided by This Firm (*describe fully*)

1 Cost Reporting, Financial Statements, Reimbursement Consulting	\$ 20,102
2 Tax Returns, Corporate Matters	\$ 6,300
3	\$
4	\$
	Charge for Services Provided \$ 26,402

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 4 5	Telephone Number (914)514-6060 (860)240-6000
--	--

Address (*No. & Street, City, State, Zip Code*)
 1 PO Box 416019, Boston, MA 02241
 2 185 Asylum St., Hartford, CT 06103
 3
 4
 5

Services Provided by This Firm (*describe fully*)

1 Employment Matters	\$ 942
2 Regulatory and Resident Issues	\$ 2,858
3	\$
4	\$
5	\$
	Charge for Services Provided \$ 3,800

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 9/30/2020				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	112	112			112	112			80	80			
B. As of midnight of THIS report period	84	84			80	80			84	84			
3. Total Number of Days Care Provided During Period													
A. Medicare	5,103	5,103			3,719	3,719			1,384	1,384			
B. Medicaid (Conn.)	20,603	20,603			16,620	16,620			3,983	3,983			
C. Medicaid (other states)													
D. Private Pay	6,364	6,364			5,080	5,080			1,284	1,284			
E. State SSI for RCH													
F. Other (Specify) Insurance	4,354	4,354			3,224	3,224			1,130	1,130			
G. Total Care Days During Period (3A thru F)	36,424	36,424			28,643	28,643			7,781	7,781			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days	299	299			269	269			30	30			
B. Other Bed Reserve Days	82	82			71	71			11	11			
5. Total Resident Days (3G + 4A + 4B)	36,805	36,805			28,983	28,983			7,822	7,822			

Schedule of Resident Statistics (Cont'd)

Name of Facility Manchester Manor Health Care Center			License No. 2237-C			Report for Year Ended 9/30/2020			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	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	12		51		21								
Per Diem Rate													
a. One bed rm.	RUGS		218.40		545.00								
b. Two bed rms.					445.00								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								1,172	1,172				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								3	3				
C. Other								5,527	5,527				
D. Total Physical Therapy Treatments								6,702	6,702				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								409	409				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								1	1				
C. Other								1,929	1,929				
D. Total Speech Therapy Treatments								2,339	2,339				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								1,041	1,041				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								2	2				
C. Other								4,909	4,909				
D. Total Occupational Therapy Treatments								5,952	5,952				

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2020	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)	91,618	1,541				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	557,565	21,992				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	515,252	26,519				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	195,765	14,253				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	149,786	6,243				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	69,772	4,532				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	255,782	4,428				
b. RN						
1. Direct Care	1,354,512	35,096				
2. Administrative**	281,165	4,310				
c. LPN						
1. Direct Care	1,166,119	36,170				
2. Administrative**	89,128	4,512				
d. Aides and Attendants	1,923,626	106,278				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	153,547	8,006				
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	191,724	5,811				
n. Marketing						
o. Other (Specify) See Attached Schedule	13,170	649				
<i>A-13. Total Salary Expenditures</i>	7,008,530	280,340				

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

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

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

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

Name of Facility Manchester Manor Health Care Center				License No. 2237-C	Report for Year Ended 9/30/2020			Page 11	of 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		9/30/2020			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***										
Jonah Kraus (10/1/19 to 6/4/20)	90,178			Standard	Responsible for daily operations of facility	1,541	A2			
Paul Liistro (6/5/20-9/30/20)	Unpaid			Standard	Responsible for daily operations of facility	680	A2			
Section IV - Assistant Administrators										

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

** Include **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	9/30/2020	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	6,391	88				
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	409,017	5,738				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	57,300	226				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
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	92,610	1,104				
b. Other						
10. Occupational Therapist						
a. Resident Care	382,946	6,816				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	29,200	309				
B-13 Total Fees Paid in Lieu of Salaries	977,464	14,281				

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

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

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

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	9/30/2020		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 158,581	158,581			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 73,735	73,735			
4. Social Security (F.I.C.A.)	\$ 510,075	510,075			
5. Health Insurance	\$ 452,384	452,384			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 75,773	75,773			
8. Uniform Allowance	\$ 7,516	7,516			
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*	\$ 153,268	153,268			
d. Accounting and Auditing	\$ 26,402	26,402			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 3,800	3,800			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 42,612	42,612			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 56,502	56,502			
2. Cellular Phones	\$ 6,128	6,128			
i. Appraisal (<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	\$ 20	20			
3. Resident Day User Fee	\$				
Subtotal	\$ 1,566,796	1,566,796			

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

(Carry Subtotals forward to next page)

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

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

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

Schedule of Dues

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

Schedule of Contributions

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

Schedule of Other Administrative and General

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

Schedule C-1 - Management Services*

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2020	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

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

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

Name of Facility Manchester Manor Health Care Center		License No. 2237-C	Report for Year Ended 9/30/2020	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$	263,728	263,728		
2. Non-Food Supplies	\$	11,361	11,361		
3. Other (Specify) _____	\$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)					
c. Other (Specify) _____ Supplies	\$	23,897	23,897		
2D. Total Dietary Expenditures (2a + b + c + d)		\$	298,987	298,987	
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.

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 9/30/2020	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. \$	12,011	12,011	
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)	\$	788	788	
c.	Other (Specify) Supplies	\$	9,457	9,457	
3D. Total Laundry Expenditures (3a + b + c)		\$	22,256	22,256	
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.

*** 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	9/30/2020		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. \$	63,349	63,349		
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. Other (<i>Specify</i>)		\$			
4D.	Total Housekeeping Expenditures (4a + b + c)		\$ 63,349	63,349		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from	\$	247,407	247,407		
	b. Medicine Cabinet Drugs	\$	84,836	84,836		
	c. Medical and Therapeutic Supplies	\$	254,009	254,009		
	d. Ambulance/Limousine***	\$				
	e. Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	63,873	63,873		
	f. X-rays and Related Radiological Procedures***	\$				
	g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
	h. Laboratory***	\$	44,380	44,380		
	i. Recreation	\$	8,115	8,115		
	j. Direct Management Services*	\$				
	k. Indirect Management Services*	\$				
	l. Other (Specify)**** See Attached Schedule	\$	287,614	287,614		
5M.	Total Resident Care Expenditures (5a - 5j)		\$ 990,233	990,233		

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

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

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

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

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 9/30/2020	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	46,123				16	m11
Wescom Solutions	3500 American Blvd W. Suite 155, Bloomington	<input type="radio"/>	<input checked="" type="radio"/>		Point Click Care	39,474				16	m11
KIT Consulting	285 Old Enfield Rd, Belchertown MA	<input type="radio"/>	<input checked="" type="radio"/>		IT Consulting	89,772				16	m11
Celtic Consulting	507 E Main St #308, Torrington, CT	<input type="radio"/>	<input checked="" type="radio"/>		Clinical Consulting	12,849				16	m11
		<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 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 checked="" 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	9/30/2020			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 167,976	167,976				
b. Heat	\$ 25,275	25,275				
c. Light & Power	\$ 103,394	103,394				
d. Water	\$ 35,557	35,557				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 2,057	2,057				
f. Other (<i>itemize</i>)	\$ 46,754	46,754				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 381,013	381,013				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$ 7,917	7,917				
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$ 42,299	42,299				
d. Movable Equipment	\$ 81,885	81,885				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 132,100	132,100				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 178,836	178,836				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 178,836	178,836				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 543,760	543,760				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 140,795	140,795				
c. Personal property taxes	\$ 20,110	20,110				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,015,601	1,015,601				

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

Manchester Manor Health Care Center
9/30/2020

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
8/19/2020	Repave Parking Lot	\$ 2,047	10	
Total additions for Land Improvements		\$ 2,047		\$ - *
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:				
10/25/2019	Intercom	\$ 3,930	10	
9/2/2020	Phone System Addition	\$ 1,216	10	
8/14/2020	Portable Heat Pumps	\$ 6,106	15	
1/15/2020	Fire Proection System Replacements	\$ 13,811	10	
2/18/2020	Heat Pump	\$ 3,015	10	
3/20/2020	IAQ Device HVAC - COVID	\$ 6,418	15	
3/31/2020	Split System 5 Ton HVAC	\$ 9,412	15	
4/30/2020	HVAC UV Lites Wiring	\$ 1,153	15	
4/27/2020	IAQ Units	\$ 1,176	15	
4/21/2020	IAQ Units	\$ 2,634	15	
Total additions for Non-Movable Equipment		\$ 48,871		\$ - *
Deletions:				

Total deletions for Non-Movable Equipment		\$	-	\$ -

**

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Amortization Schedule*

Name of Facility Manchester Manor Health Care Center			License No. 2237-C		Report for Year Ended 9/30/2020			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	6,277,929	2,891,731			178,836	
2. Disposals (attach schedule)	Var	Var	Var						
3. Acquired during this report period (attach schedule)				63,269					
C-4. Subtotal									178,836
D. Total Amortization									178,836

* 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 9/30/2020	Page 25	of 37
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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	01/01/70			
2. Date Structure Completed	01/01/70			
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 Cent	2237-C	9/30/2020	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		9/30/2020		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) Vendor Interest				\$ 914	914		
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$ 914	914		
14. Insurance							
a. Insurance on Property (buildings only)				\$ 68,696	68,696		
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$			
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. Total Insurance Expenditures (14a + b + c)				\$ 68,696	68,696		
15. Total All Expenditures (A-13 thru C-14)				\$ 12,771,827	12,771,827		

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Manchester Manor Health Care Center				2237-C	9/30/2020	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	B10	Occupational Therapy	\$ 382,946	382,946		
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 153,268	153,268		
10.	15	1d	Accounting	\$			
10a.			Legal	\$			
11.	30	IV3	Telephone	\$ 486	486		
12.	15	1h2	Cellular Telephone	\$ 4,688	4,688		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	L3	Gifts, flowers and coffee shops	\$ 42,272	42,272		
15.	16	15	Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$ 3,450	3,450		
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.	16	16	Automobile Expense (e.g. personal use)	\$ 1,755	1,755		
18.	16	m3	Unallowable Advertising *	\$ 21,529	21,529		
19.	15	k2	Income Tax / Corporate Business Tax	\$			
20.	16	m10	Fund Raising / Contributions	\$ 5,943	5,943		
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 2,014	2,014		
Page 18 - Dietary Expenditures							
24.	30	IV8	Meals to employees, guests and others who are not residents	\$ 3,297	3,297		
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)				\$ 621,649	621,649		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

** Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total 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 Dues	\$ 233		
16	m13	Prof Services - Collections	\$ 697		
30	IV4	Rental of TV Income	\$ 1,084		
Total Other A&G Adjustments			\$ 2,014	\$ -	\$ -

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	9/30/2020	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 621,649	621,649		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 247,407	247,407		
28.			Ambulance/Limousine	\$			
29.	20	5f	X-rays, etc	\$			
30.	20	5h	Laboratory	\$ 44,380	44,380		
31.	20	5c	Medical Supplies	\$ 83,918	83,918		
32.	20	5e2	Oxygen (non emergency)	\$ 63,873	63,873		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 9,604	9,604		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.	30	IV5	Interest Income on Account Rec.	\$ 215	215		
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 1,071,046	1,071,046		

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

Manchester Manor Health Care Center
9/30/2020

Schedule of Other Ancillary Costs

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

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
Manchester Manor Health Care Center	2237-C	9/30/2020			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 9,123,752	9,123,752				
b. Medicaid Room and Board Contractual Allowance **	\$ (4,267,212)	(4,267,212)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 2,485,295	2,485,295				
b. Medicare Room and Board Contractual Allowance **	\$ (2,010,354)	(2,010,354)				
4. a. Private-Pay Residents and Other	\$ 5,003,578	5,003,578				
b. Private-Pay Room and Board Contractual Allowance **	\$ (355,588)	(355,588)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 163,547	163,547				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ 889,575	889,575				
c. Prescription Drugs - Non-Medicare	\$ 166,262	166,262				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$ 987,520	987,520				
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$ 340,514	340,514				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 284,005	284,005				
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$ 54,002	54,002				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 956,705	956,705				
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$ 326,456	326,456				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$ 383,017	383,017				
b. Other (<i>Specify</i>) - Non-Medicare	\$ (709,323)	(709,323)				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 13,821,751	13,821,751				
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$ 486	486				
4. Rental of Television and Cable Services	\$ 1,084	1,084				
5. Interest Income (<i>Specify</i>)	\$ 261	261				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 31,623	31,623				
V. Total Other Revenue (1 thru 8)	\$ 33,454	33,454				
VI. Total All Revenue (III +V)	\$ 13,855,205	13,855,205				

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Med A & Med B Ancillaries	\$ 775,771		
	Med A & Med B Contractual Allowances	\$ (1,237,298)		
	Medicare HHS Stimulus Payments	\$ 844,544		
	Total Other Resident Revenue - Medicare	\$ 383,017	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

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

Schedule of Other Revenue

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

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Manchester Manor Health Care Center	2237-C	9/30/2020	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	2,297,496
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	703,416
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	19,806
a. _____				
b. _____				
c. _____				
d. See Schedule		19,806		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	7,226

See Schedule		7,226		
A-9. Total Current Assets (Lines A1 thru 8)			\$	3,027,944
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	399,954		
	Accum. Depreciation	310,403		
	Net		\$	89,551
3. Buildings	*Historical Cost	_____		
	Accum. Depreciation	_____		
	Net		\$	
4. Leasehold Improvements	*Historical Cost	6,341,198		
	Accum. Depreciation	3,070,567		
	Net		\$	3,270,631
5. Non-Movable Equipment	*Historical Cost	772,577		
	Accum. Depreciation	331,789		
	Net		\$	440,788
6. Movable Equipment	*Historical Cost	975,604		
	Accum. Depreciation	953,258		
	Net		\$	22,346
7. Motor Vehicles	*Historical Cost	_____		
	Accum. Depreciation	_____		
	Net		\$	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	3,823,315

* 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
Manchester Manor Health Care Center	2237-C	9/30/2020	32	37
Account			Amount	
Total Brought Forward:			\$	6,851,259
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>)			\$	

See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	6,851,259

* 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
Manchester Manor Health Care Center	2237-C	9/30/2020	33	37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable			\$	445,368
2. Notes Payable (<i>itemize</i>)			\$	

See Schedule				
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>)			\$	372,780
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>)			\$	2,515,928

See Schedule				2,515,928
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	3,334,076

* 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 9/30/2020	Page 34	of 37
Account				Amount
Total Brought Forward:				3,334,076
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>)				\$

See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$
C. Total All Liabilities (Lines A-13 + B-5)				\$ 3,334,076

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	9/30/2020	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			\$	2,433,805
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	
6. Gain or Loss for Period			\$	1,083,378
	10/1/2019	thru 9/30/2020		
7. Total Net Worth			\$	3,517,183
C. Total Reserves and Net Worth			\$	3,517,183
D. Total Liabilities, Reserves, and Net Worth			\$	6,851,259

H. Changes in Total Net Worth

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2020	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2019			\$	7,834,218
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	13,855,205
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	12,771,827
D. Net Income or Deficit			\$	1,083,378
E. Balance			\$	8,917,596
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			\$	8,917,596

I. Preparer's/Reviewer's Certification

Name of Facility Manchester Manor Health Care Center	License No. 2237-C	Report for Year Ended 9/30/2020	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 Address		Phone Number		
225 Pitkin Street, East Hartford, CT 06108		860-610-9009		
Annual Report Contact		Phone Number		
CJLC		860-610-9009		
Annual Report Contact Email Address				
annualreports@cjlc.com				