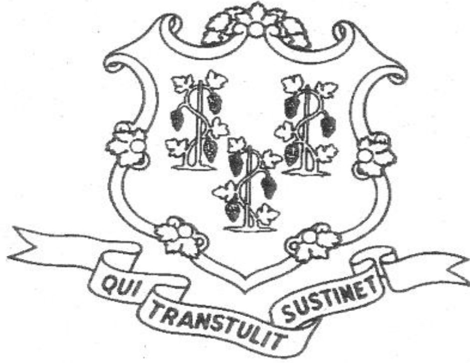
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2017

Name of Facility (as licensed) Mansfield Center for Nursing and Rehabilitation	
Address (No. & Street, City, State, Zip Code) 100 Warren Circle, Storrs, CT 06268	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2132-C			07-5402

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	2132-C		

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)	License No.	Report for Year Ended	Page	of
Mansfield Center for Nursing and Rehabilitation	2132-C	9/30/2017	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Mansfield Center for Nursing and Rehabilitation [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. (A)

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.

(A) Subject to Desk Audit Review

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

(Notary Seal)

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

Data Required for Real Wage Adjustment

Name of Facility	Period Covered:	From	To
Mansfield Center for Nursing and Rehabilitation		10/1/2016	9/30/2017

Address of Facility
100 Warren Circle, Storrs, CT 06268

Report Prepared By	Phone Number	Date
Marcum LLP	203-781-9600	11/21/2017

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
860-487-2300	9/30/2017	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Mansfield Center for Nursing and Rehabilitation	100 Warren Circle, Storrs, CT 06268

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2132-C			07-5402

Type of Facility (Check appropriate box(es))

- ☑ Chronic and Convalescent Nursing Home only (CCNH)
- ☐ Rest Home with Nursing Supervision only (RHNS)
- ☐ (Specify)

Type of Ownership (Check appropriate box)

○ Proprietorship ○ LLC ○ Partnership ○ Profit Corp. ⊙ Non-Profit Corp. ○ Government ○ 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? ○ Yes ⊙ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
James Fidanza	00914

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
N/A		

Name of Partners/Members	Business Address	Title	% Owned
N/A			

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Mansfield Center for Nursing and Rehabilita	2132-C	9/30/2017	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
New Samaritan Corporation	127 Washington Ave., 5th Floor East, North Haven, CT 06473	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
See Attached			
Names of Stockholders Owning at Least 10% of Shares			

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Mansfield Center for Nursing and Rehabilitation	2132-C	9/30/2017	3B	37

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

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Mansfield Center for Nursing and Rehabilitation	2132-C	9/30/2017	4	37

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	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	%**				
New Samaritan Corporation	127 Washington Ave., 5th Floor East, North Haven, CT 06473	○	⦿		Corporate Oversight	PG 16, M13	120,000	120,000
Mansfield Retirement Community	1 Silo Road, Storrs, CT 06268	⦿	○		Truck Use	PG 16, L6	2,565	2,565
Elderly Housing Management, Inc.	127 Washington Ave., 5th Floor East, North Haven, CT 06473	○	⦿		Pass through on pension expense	PG 15, 1a7	162,534	162,534
New Samaritan Corporation	127 Washington Ave., 5th Floor East, North Haven, CT 06473	○	⦿		Loan/Intercompany	PG 31, A8	1,215,385	1,215,385
Mansfield Retirement Community	1 Silo Road, Storrs, CT 06268	⦿	○		Sponsor Fee	PG 16, M13	10,597	10,597
		○	○					
		○	○					
		○	○					
		○	○					

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Mansfield Center for Nursing and Rehabilitatio	2132-C	9/30/2017	5	37

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

Not Applicable - Only One Level of Care

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

Not Applicable - Only One Level of Care

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.

Not Applicable - Only One Level of Care

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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
Mansfield Center for Nursing and Rehabilitation	2132-C	9/30/2017	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers: Yes	No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Connecticut Business Systems, 50 Rockwell Road, Newington, CT 06111	○	⊙	Copier Machine	07/14/14	60 Months	1,447	1,447
Hasler, Inc. 478 Wheelers Farm Road, Milford, CT 06461	○	⊙	Postage Machine	04/15/16	36 Months	843	843
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ○ No

Total *** 2,290

* 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.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Mansfield Center for Nursing and R	2132-C	9/30/2017	7	37

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

◉ Accrual ○ Cash ○ Modified Cash

Is the accounting basis for this period the same as for the previous period? ◉ Yes ○ No

If "No," explain.

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

	Service	Amount
1	Audit, Tax and Cost Reports	$ 35,799
2		$
3		$
4		$
	Charge for Services Provided	$ 35,799

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

◉ Yes ○ No Page 15 Line 1d

Legal Services Information

	Name of Legal Firm or Independent Attorney	Telephone Number
1	Wiggin and Dana LLP	860-297-3700
2	Robert Noonan & Associates	860-349-7010
3	Reid & Riege, PC	
4		
5		

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

1. 20 Church Street #7, Hartford, CT 06103
2. 6 Way Road, Suite 314, Middlefield, CT 06455
3.
4.
5.

Services Provided by This Firm (*describe fully*)

	Service	Amount
1	Resident Issue	$ 83
2	Employee Issue	$ 348
3	Collections (Disallowed)	$ 244
4		$
5		$
	Charge for Services Provided	$ 675

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

◉ Yes ○ No Page 15, Line 1e

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30 Total	Period 10/1 Thru 6/30 CCNH	Period 10/1 Thru 6/30 RHNS	Period 10/1 Thru 6/30 (Specify)	Period 7/1 Thru 9/30 Total	Period 7/1 Thru 9/30 CCNH	Period 7/1 Thru 9/30 RHNS	Period 7/1 Thru 9/30 (Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	98	98			98	98			98	98		
B. On last day of THIS report period					98	98						
2. Number of Residents												
A. As of midnight of PREVIOUS report period	88	88			88	88			94	94		
B. As of midnight of THIS report period	89	89			94	94			89	89		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,912	4,912			3,583	3,583			1,329	1,329		
B. Medicaid (Conn.)	18,864	18,864			14,156	14,156			4,708	4,708		
C. Medicaid (other states)												
D. Private Pay	6,889	6,889			5,149	5,149			1,740	1,740		
E. State SSI for RCH												
F. Other (Specify) Commercial Insurance	2,012	2,012			1,504	1,504			508	508		
G. Total Care Days During Period (3A thru F)	32,677	32,677			24,392	24,392			8,285	8,285		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	7	7			7	7						
B. Other Bed Reserve Days	106	106			66	66			40	40		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	32,790	32,790			24,465	24,465			8,325	8,325		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Mansfield Center for Nursing and Rehabilitat	2132-C	9/30/2017	9	37

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	RHNS	(Specify)	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.

Change in Resident Days	CCNH	RHNS	(Specify)
1st change			
2nd change			
3rd change			
4th change			

6. Number of Residents and Rates on September 30 of Cost Year

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	14	48		27				
Per Diem Rate								
a. One bed rm.	Various	229.16		435.00				
b. Two bed rms.	Various	229.16		415.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	1,967	1,967		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1	1		
2. Restorative Treatments				
C. Other	18,916	18,916		
D. ***Total Physical Therapy Treatments***	20,884	20,884		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	167	167		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	497	497		
D. ***Total Speech Therapy Treatments***	664	664		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,918	1,918		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	18,778	18,778		
D. ***Total Occupational Therapy Treatments***	20,696	20,696		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Mansfield Center for Nursing and Rehabilitation	2132-C	9/30/2017	10	37

Are time records maintained by all individuals receiving compensation? ⦿ Yes ○ No

Item	Total Cost and Hours					
	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)	125,708	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	253,851	11,623				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	570,858	29,201				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	268,698	17,051				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	153,452	6,267				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	102,911	6,201				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant	37,732	746				
b. Other Accountants	10,260	540				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	207,386	4,160				
b. RN						
1. Direct Care	1,033,269	28,392				
2. Administrative**	367,514	11,493				
c. LPN						
1. Direct Care	744,601	25,024				
2. Administrative**						
d. Aides and Attendants	1,591,535	103,192				
e. Physical Therapists	516,726	15,218				
f. Speech Therapists	1,928	38				
g. Occupational Therapists	292,106	7,986				
h. Recreation Workers	199,482	8,951				
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	150,801	5,670				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	6,628,818	283,832				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
	0					
Total	$ -	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
	0					
Physician Services - Medicare (Dislowed)	$ 1,041	6				
Medical Records Consultant	$ 7,233	Fixed Fee				
Total	$ 8,274	6	$ -	-	$ -	-

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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
Mansfield Center for Nursing and Rehabilitation	2132-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.

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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
Mansfield Center for Nursing and Rehabilitation	2132-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* **										
James A. Fidanza	125,708			Non-Discrim.	Day to Day Operations of Nursing Facility	2,080	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.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Mansfield Center for Nursing and Rehabilitation	2132-C	9/30/2017	13	37

Item	Total Cost and Hours					
	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian	660	17				
2. Dentist	5,653	15				
3. Pharmacist	7,619	Monthly				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker	990	11				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	29,600	513				
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	42,886	780				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	450	Fixed Fee				
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	8,274	6				
B-13 Total Fees Paid in Lieu of Salaries	96,132	1,341				

* 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Shannon Haynes, 354 Darling Road, Salem, CT 06420	Dietitian	○	◉	
Celtic Consulting, 135 South Road, Suite 3, Farmington, CT 06032	Medical Record Consultant	○	◉	
Hartford Hospital, PO Box 310911, Newington, CT 06131-0911	Physician Services	○	◉	
Deberey Hinchey, 46 Cherry Hill Road, Norwich, CT 06360	Social Services	○	◉	
University of CT, 343 Mansfield Road, Unit 2073, Storrs, CT 06269	Speech Therapy	○	◉	
Charles Shooks, 90 Quarry St. Willimantic, CT 06226	Medical Director	○	◉	
Omnicare Consultants, P.O. Box 715268, Columbus, OH 43271	Pharmacy Services	○	◉	
Windham Community Memorial Hospital, 181 Patricia Genova Drive, Newington, CT 06111	Physician Services	○	◉	
SDX Swallowing, 21 Waterville Road, Avon, CT 06001	Speech Therapy	○	◉	
LM Physician Association, PO Box 415858, Boston, MA 02241-5858	Physician Services	○	◉	
CT Multispecialty Group, PO Box 587, Rocky Hill, CT 06067-0587	Physician Services	○	◉	
Preventive Services, LLC, 1717 N Sam Houston Parkway W, Houston, TX 77038	Preventative Services	○	◉	
Pain Management Center of New England, 270 Farmington Avenue Suite 337, Farmington, CT	Pain Management	○	◉	
HHC Physicianscare, PO Box 417695, Boston, MA 02241-7695	Physician Services	○	◉	
Retina Consultants PC, 191 Main Street, Manchester, CT 06040	Optical Services	○	◉	
Healthdrive Dental, 888 Worcester St., Wellesley, MA 02482	Dental Services	○	◉	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Mansfield Center for Nursing and Rehabilitation	2132-C	9/30/2017	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	196,638	196,638		
2. Disability Insurance	$				
3. Unemployment Insurance	$	11,172	11,172		
4. Social Security (F.I.C.A.)	$	487,412	487,412		
5. Health Insurance	$	423,259	423,259		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	162,534	162,534		
8. Uniform Allowance	$				
9. Other (*Specify*) See Attached Schedule	$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	31,068	31,068		
d. Accounting and Auditing	$	35,799	35,799		
e. Legal (*Services should be fully described on Page 7)*	$	675	675		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	21,085	21,085		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	14,318	14,318		
2. Cellular Phones	$	500	500		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*) See Attached Schedule	$				
3. Resident Day User Fee	$	561,087	561,087		
Subtotal	$	1,945,547	1,945,547		

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

(Carry Subtotals forward to next page)

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

Mansfield Center for Nursing and Rehabilitation Attachment Page 15
9/30/2017

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
	0		
Total	$ -	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
	0		
Total	$ -	$ -	$ -

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Mansfield Center for Nursing and Rehabilitation	2132-C	9/30/2017	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,945,547	1,945,547		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	3,565	3,565		
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	1,646	1,646		
5. Education Expenses Related to Seminars and Conventions	$	2,029	2,029		
6. Automobile Expense (*not purchase or depreciation*)	$	2,565	2,565		
7. Other (*Specify*) See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	2,302	2,302		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$	3,386	3,386		
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	$	5,334	5,334		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	9,905	9,905		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	286	286		
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	112,930	112,930		
12. Administrative Management Services**	$				
13. Other (*Specify*) See Attached Schedule	$	143,617	143,617		
C-14 Total Administrative & General Expenditures	$	2,233,112	2,233,112		

* 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)
	0		
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
	0		
Advertising and Promotions	$ 3,386		
Total Other Advertising	$ 3,386	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
	(0)		
Leading Age	$ 9,146		
AALTCN	$ 199		
ICNC	$ 40		
CAHCF	$ 350		
ALTCFM	$ 170		
Total Dues	$ 9,905	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
	0		
Total Contributions	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
	0		
NSC/Inter Co. Fees	$ 120,000		
Licenses	$ 1,851		
MCR Sponsorship Fee	$ 10,597		
Employee Relations	$ 317		
Employee Background Checks	$ 2,922		
Unemployment Tax Consultant	$ 5,900		
Time Card Machine Rental	$ 2,030		
Total Other Administrative and General	$ 143,617	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page | of
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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 #
N/A			

*** 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
Mansfield Center for Nursing and Rehabilitation	2132-C	9/30/2017	18 | 37

	Item		Total	CCNH	RHNS	(Specify)
2.	Dietary					
	a. In-House Preparation & Service					
	1. Raw Food	$	223,262	223,262		
	2. Non-Food Supplies	$	32,268	32,268		
	3. Other (*Specify*)______________________ Dishes and Utensils	$	374	374		
	b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
	c. Management Services**	$				
	d. Other (*Specify*)__________________________	$				
2E.	***Total Dietary Expenditures*** (2a + b + c + d)	$	255,904	255,904		

			Total	CCNH	RHNS	(Specify)
2F.	Dietary Questionnaire					
G.	Resident Meals:	Total no. of meals served per day:*				

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No		
I.	Did you receive revenue from employees?	○ Yes	⊙ 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?	⊙ Yes	○ No	If yes, specify cost.	
L.	Is any revenue collected from these people?	⊙ Yes	○ No	If yes, specify amt.	$1,856
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				Page 30, Line IV 1
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.	
O.	Is any revenue collected from employees?	○ Yes	⊙ 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	License No.	Report for Year Ended	Page of
Mansfield Center for Nursing and Rehabilitation	2132-C	9/30/2017	19 | 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. $	15,056	15,056		
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)*	$				
c. Management Services**	$				
d. Other (*Specify*) Other Laundry Supplies	$	67,049	67,049		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	82,105	82,105		

3F. Laundry Questionnaire

	Question	Yes	No	
G.	Is cost of employee laundry included in 3E?	○ Yes	⊙ No	If yes, specify cost.
H.	Did you receive revenue from employees?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
K.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
L.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	

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

** 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
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Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping a. In-House Care	Sq. Ft. Serviced by Personnel					
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$				
b. Purchased Services (*by contract other than through Management Services*)	Sq. Ft. Serviced by Personnel					
(*Complete Schedule C-2 att. Page 21*)	Amt.	$				
c. Management Services*		$				
d. Other (*Specify*)		$	35,547	35,547		
Housekeeping Supplies						
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	35,547	35,547		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	220,868	220,868		
b. Medicine Cabinet Drugs		$	4,891	4,891		
c. Medical and Therapeutic Supplies		$	141,264	141,264		
d. Ambulance/Limousine***		$	27,682	27,682		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	7,302	7,302		
f. X-rays and Related Radiological Procedures***		$	27,014	27,014		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***		$	2,148	2,148		
i. Recreation		$	8,199	8,199		
j. Other (Specify)**** See Attached Schedule		$	34,455	34,455		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	473,823	473,823		

* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.
*** Facility should self-disallow the expense on Page 29 of the Cost Report.
**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
	0		
Physical Therapy Supplies	$ 495		
Speech Therapy Supplies	$ 137		
OT-Supplies (Disallowed)	$ 1,474		
Patient Supplies (Disallowed)	$ 1,220		
Medical Records Supplies (Disallowed)	$ (1,188)		
Equipment Rental/Oxygen Concentrator (Disallowed)	$ 2,741		
Medical Equipment Rental (Disallowed)	$ 4,707		
Cable TV	$ 24,732		
Patient Transportation (Disallowed)	$ 76		
Physician Services - Other (Disallowed)	$ 61		
Total Other Resident Care	$ 34,455	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
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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
MDI Achieve, Inc.	Avenue South, Suite 100, Bloomington, MN 55438	○	○		Matrix Software License Fee	10,926			16	m11
Founders Technology Group, LLC	F, Southington, CT 06489	○	○		IT Consultants	30,912			16	m11
ADP	100 Corporate Drive, Windsor, CT 06095	○	○		Payroll Service Fees	42,716			16	m11
Willimantic Waste	4185 Recycling Way, Willimantic, CT 06226	○	○		Rubbish Removal	17,215			22	6f
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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).

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

Name of Facility	License No.	Report for Year Ended	Page of
Mansfield Center for Nursing and Rehabilitati	2132-C	9/30/2017	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	26,023	26,023		
b. Heat	$	42,525	42,525		
c. Light & Power	$	93,585	93,585		
d. Water	$	32,566	32,566		
e. Equipment Lease (*Provide detail on page 6*)	$	2,290	2,290		
f. Other (*itemize*)	$	96,739	96,739		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	293,728	293,728		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	43,828	43,828		
b. Building & Building Improvements	$	126,346	126,346		
c. Non-Movable Equipment	$	21,185	21,185		
d. Movable Equipment	$	50,579	50,579		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	241,938	241,938		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	7,161	7,161		
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	7,161	7,161		
9. Rental payments on leased real property less real estate taxes included in item 10b	$				
10. Property Taxes					
a. Real estate taxes paid by owner	$	132,483	132,483		
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	5,684	5,684		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	387,266	387,266		

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

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Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
	0		
Maintenance Supplies	$ 36,068		
Maintenance Purchased Services (No contract over $10k)	$ 36,466		
Grounds Keeping	$ 5,348		
Rubbish Removal	$ 17,215		
Maintenance Equipment Rental	$ 32		
Snow Removal	$ 1,610		
Total Other Repairs and Maintenance	$ 96,739	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Mansfield Center for Nursing and Rehabilitation	2132-C	9/30/2017	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	1,696,961		1,696,961	938,398	S/L	Various	43,806	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	890		890		S/L	20	22	
A-4. Subtotal								43,828
B. **Building and Building Improvements**								
1. Acquired prior to this report period	6,318,600		6,318,600	4,866,749	S/L	Various	121,163	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	106,059		106,059		S/L	Various	5,183	
B-4. Subtotal								126,346
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	253,075		253,075	155,303	S/L	Various	20,799	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	8,993		8,993		S/L	Various	386	
C-4. Subtotal								21,185

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. Truck	X		9	94	7,674		7,674	7,674	S/L	Various		
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			Var	Var	940,570		940,570	763,722	S/L	Various	47,481	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			Var	Var	49,491		49,491		S/L	Various	3,098	
D-3. Subtotal												50,579
E. ***Total Depreciation***												241,938

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Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
3/31/2017	Flagpole	$ 890	20	$ 22	
Total additions for Land Improvements		$ 890		$ 22	*
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:					
Various	Please see attached	$ 106,059	Various	$ 5,183	
Total additions for Building Improvements		$ 106,059		$ 5,183	*
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:					
Various	Please see attached	$ 8,993	Various	$ 386	
Total additions for Non-Movable Equipment		$ 8,993		$ 386	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

***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:					
Various	Please see attached	$ 49,491	Various	$ 3,098	
Total additions for Movable Equipment		$ 49,491		$ 3,098	*
Deletions:					
Total deletions for Movable Equipment		$ -		$ -	**

***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:					
Total additions for Leasehold Improvement		$ -		$ -	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Mansfield Center for Nursing and Rehabilitation	2132-C	9/30/2017	24	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. Refinance 2012		2012	10	71,609	27,451	S/L		7,161	
2.									
3.									
B-4. Subtotal									7,161
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									7,161

* Straight-line method must be used.
** Specify which of the following bases were used:
A. Minimum of 5 years or 60 months.
B. Life of mortgage; OR
C. Remaining Life of Lease; OR
D. Actual Life if owned by Related Party.

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

Name of Facility	License No.	Report for Year Ended	Page of
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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	01/12/93
2. Date Structure Completed	01/31/94
3. If **NOT** Original Owner, Date of Purchase	N/A
4. Date of Initial Licensure	02/01/94
5. Total Licensed Bed Capacity	98
6. Square Footage	41,770
7. Acquisition Cost	
a. Land	750,000
b. Building	4,096,093

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	12/07/12			
c. Interest Rate for the Cost Year	3.75%			
d. Term of Mortgage (number of years)	10			
e. Amount of Principal Borrowed	5,000,000			
f. Principal balance outstanding as of 9/30/2017	591,325			
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.

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

Name of Facility	License No.	Report for Year Ended	Page of
Mansfield Center for Nursing and Re	2132-C	9/30/2017	26 | 37

Item			Total	CCNH	RHNS	(Specify)
12. Interest A. Building, Land Improvement & Non-Movable Equipment 1. First Mortgage		$	26,952	26,952		
Name of Lender United Bank	Rate 3.75%					
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)		$	26,952	26,952		

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Mansfield Center for Nursing and	2132-C	9/30/2017	27 | 37

Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:			26,952	26,952		
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*) $ Vendors (Self Disallow)			38	38		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $			26,990	26,990		
14. Insurance a. Insurance on Property (buildings only) $						
b. Insurance on Automobiles $						
c. Insurance other than Property (as specified above) 1. Umbrella (*Blanket Coverage*) $			123,023	123,023		
2. Fire and Extended Coverage $						
3. Other (*Specify*) $						
14d. ***Total Insurance Expenditures (14a + b + c)*** $			123,023	123,023		
15. ***Total All Expenditures (A-13 thru C-14)*** $			10,636,448	10,636,448		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Mansfield Center for Nursing and Rehabilitation	2132-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.	10	A12G	Occupational Therapy	$	292,106	292,106		
4.			Other - See attached Schedule	$				
Page 13 - Professional Fees								
5.			Resident Care Physicians **	$				
6.			Occupational Therapy	$				
7.			Other - See attached Schedule	$	1,041	1,041		
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.	15	1c	Bad Debts	$	31,068	31,068		
10.	15	1e	Accounting & Legal	$	244	244		
11.			Telephone	$				
12.	15	1h2	Cellular Telephone	$	200	200		
13.			Life insurance premiums on the life of Owners, Partners, Operators	$				
14.			Gifts, flowers and coffee shops	$				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	$				
16.			Travel for purposes of attending 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)	$	2,565	2,565		
18.	16	m2/3	Unallowable Advertising *	$	3,386	3,386		
19.			Income Tax / Corporate Business Tax	$				
20.	16	m10	Fund Raising / Contributions	$				
21.			Unallowable Management Fees	$				
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	134,479	134,479		
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)	$	465,089	465,089		

(*Carry Subtotal forward to next page*)

* All except "Help Wanted".

** 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)
13	12	Physician Services - Medicare (Disllowed)	1,041		
Total Other Fees Adjustments			$ 1,041	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M13	NSC/Inter Co. Fees	$ 120,000		
16	L2	Other Benefits	3,565		
16	M13	Employee Relations	317		
16	M13	MCR Sponsorship Fee	10,597		
Total Other A&G Adjustments			$ 134,479	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Mansfield Center for Nursing and Rehabilitation	2132-C	9/30/2017	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	465,089	465,089		
Page 20 - Resident Care Supplies*								
27.	20	5a2	Prescription Drugs	$	220,868	220,868		
28.	20	5d	Ambulance/Limousine	$	27,682	27,682		
29.	20	5f	X-rays, etc	$	27,014	27,014		
30.	20	5h	Laboratory	$	2,148	2,148		
31.	20	5c	Medical Supplies	$	19,938	19,938		
32.	20	5e2	Oxygen (non emergency)	$	7,302	7,302		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	30,223	30,223		
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$	866	866		
36.			Depreciation on Unallowable Motor Vehicles	$				
37.			Unallowable Property and Real Estate Taxes	$				
38.			Rental of Building Space or Rooms	$				
39.			Other - See Attached Schedule	$				
Page 27 - Insurance								
40.			Mortgage Insurance	$				
41.			Property Insurance	$				
Other - Miscellaneous								
42.			Research or Experimental Activities	$				
43.			Radio and Television Revenue	$				
44.			Vending Machine Revenue	$				
45.			Purchase Discounts and Allowances	$				
46.			Duplications of functions or services	$				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	$				
48.			Interest Income on Accounts Rec	$				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	$	2,194	2,194		
Not For Profit Providers Only								
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	$	22,578	22,578		
51.			***Total Amount of Decrease (Items 1 - 50)***	$	825,902	825,902		

*** 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.

Attachment Page 29

Mansfield Center for Nursing and Rehabilitation
9/30/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Cable	$ 21,132		
20	5j	OT-Supplies (Disallowed)	1,474		
20	5j	Patient Supplies (Disallowed)	1,220		
20	5j	Medical Records Supplies (Disallowed)	(1,188)		
20	5j	Equipment Rental/Oxygen Concentrator (Disallowed)	2,741		
20	5j	Medical Equipment Rental (Disallowed)	4,707		
20	5j	Patient Transportation (Disallowed)	76		
20	5j	Physician Services - Other (Disallowed)	61		
Total Other Ancillary Costs			$ 30,223	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Depreciation on unallowable mattresses	$ 866		
Total Excess Movable Equipment Depreciation			$ 866	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30	IV 1	Meals sold to guests	$ 1,856		
30	IV 7	Barber and Beauty Revenue	$ 300		
27	12 D	Vendor Interest	$ 38		
Total Other Adjustments			$ 2,194	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7b	Intangible Asset Depreciation	$ 22,578		
Total Unallowable Building Interest			$ 22,578	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Mansfield Center for Nursing and Rehabi	2132-C	9/30/2017	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	7,842,670	7,842,670		
b. Medicaid Room and Board Contractual Allowance **	$	(3,517,841)	(3,517,841)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	2,487,772	2,487,772		
b. Medicare Room and Board Contractual Allowance **	$	(479,110)	(479,110)		
4. a. Private-Pay Residents and Other	$	3,282,286	3,282,286		
b. Private-Pay Room and Board Contractual Allowance **	$	(926)	(926)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	210,892	210,892		
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$	70,557	70,557		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$				
2. a. Medical Supplies - Medicare	$	22,815	22,815		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$	2,180	2,180		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	590,050	590,050		
b. Physical Therapy - Medicare Contractual Allowance **	$				
c. Physical Therapy - Non-Medicare	$	218,513	218,513		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	43,999	43,999		
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$	10,221	10,221		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	626,377	626,377		
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$	229,174	229,174		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	51,345	51,345		
b. Other *(Specify)* - Non-Medicare	$	(530,644)	(530,644)		
III. Total Resident Revenue (Section I. thru Section II.)	$	11,160,330	11,160,330		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	1,856	1,856		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	107,028	107,028		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$	300	300		
8. Other (*Specify*)	$	499,389	499,389		
V. Total Other Revenue (1 thru 8)	$	608,573	608,573		
VI. Total All Revenue (III +V)	$	11,768,903	11,768,903		

* *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)
		0		
30 II6a	IV Therapy - Medicare	$ 20,039		
30 II6a	Lab - Medicare	$ 46,025		
30 II6a	X Ray - Medicare	$ 19,163		
30 II6a	Oxygen - Medicare	$ 2,713		
30 II6a	Ancillary Allowance - Medicare	$ (36,595)		
Total Other Resident Revenue - Medicare		$ 51,345	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
		0		
30 II6b	IV Therapy - Medicaid	$ 2,714		
30 II6b	IV Therapy - Other	$ 3,537		
30 II6b	Lab - Other	$ 18,407		
30 II6b	X Ray - Other	$ 7,493		
30 II6b	Oxygen - Medicaid	$ 1,503		
30 II6b	Oxygen - Other	$ 565		
30 II6b	Ancillary Allowance	$ (564,863)		
Total Other Resident Revenue		$ (530,644)	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
			0		
30 IV5	Dividend and Interest Income on Mutual Funds and Bonds	4,695,273	$ 107,028		
Total Interest Income			$ 107,028	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
		0		
30 IV8	Unrestricted Contributions	$ 8,323		
30 IV8	Insurance Proceeds (No related expense in cost report)	$ 3,175		
30 IV8	Class Action Suit Income (No related expense in cost report)	$ 2		
30 IV8	Realized Gains on Investments in Mutual Funds and Bonds	$ 83,657		
30 IV8	Unrealized Gains on Investments in Mutual Funds and Bonds	$ 404,232		
Total Other Revenue		$ 499,389	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page of
Mansfield Center for Nursing and Reha	2132-C	9/30/2017	31 | 37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 2,085,031
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 891,796
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 65,917
5. Prepaid Expenses				$ 167,968
a. Prepaid Insurance and Gross Up		116,035		
b. Prepaid Taxes		35,161		
c. Prepaid Comp. Consulting		2,576		
d. Prepaid Other		14,196		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 5,910,658
Investments		4,695,273		
Due from Affiliates		1,215,385		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 9,121,370
B. Fixed Assets				
1. Land				$ 750,000
2. Land Improvements	*Historical Cost	1,697,851		$ 715,625
	Accum. Depreciation	982,226	Net	
3. Buildings	*Historical Cost	6,424,659		$ 1,431,564
	Accum. Depreciation	4,993,095	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	262,068		$ 85,580
	Accum. Depreciation	176,488	Net	
6. Movable Equipment	*Historical Cost	990,061		$ 175,760
	Accum. Depreciation	814,301	Net	
7. Motor Vehicles	*Historical Cost	7,674		$
	Accum. Depreciation	7,674	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 14,519
Software (net)		1,684		
CR vs. TB Adjustment		12,835		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 3,173,048

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Mansfield Center for Nursing and Reha	2132-C	9/30/2017	32 | 37

Account			Amount
		Total Brought Forward:	$ 12,294,418
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 (*itemize*)			$
6. Loans to Owners or Related Parties (*itemize*)			$
Name and Address	Amount	Loan Date	
7. Other Assets (*itemize*)			$ 158,498
Bed Licenses		121,500	
Mortgage Refinancing (net)		36,998	
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)			$ 158,498
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$ 12,452,916

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Mansfield Center for Nursing and Rehabilitati	2132-C	9/30/2017	33 | 37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 169,236
2. Notes Payable (*itemize*)					$ 8,469
CL&P Note Payable		8,469			
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)					$ 447,803
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 19,618
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$ 421,958
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 473,711
Insurance Gross Up	21,989	Accrued Other	73,516		
Deferred Revenue	117,647				
Provider Tax Payable	141,064				
Accrued Pension	119,495				
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 1,540,795

* 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	License No.	Report for Year Ended	Page of
Mansfield Center for Nursing and Rehabilit	2132-C	9/30/2017	34 | 37

Account	Amount
Total Brought Forward:	1,540,795
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

Account	Amount
2. Mortgages Payable	$ 169,367
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

Account		Amount
4. Other Long-Term Liabilities (*itemize*)		$ 29,221
CL&P Note Payable - Long Term	2,227	
Patient Trust	26,994	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 198,588
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 1,739,383

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

Name of Facility	License No.	Report for Year Ended	Page of
Mansfield Center for Nursing and Reh	2132-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 (*Equity)*	$
4. Reserve for leasehold real properties on which fair rental value is based	$
5. Reserve for funds set aside as donor restricted	$
6. Total Reserves	$
B. **Net Worth**	
1. Owner's Capital	$
2. Capital Stock	$
3. Paid-in Surplus	$
4. Treasury Stock	$
5. Cumulated Earnings	$ 9,576,107
6. Gain or Loss for Period 10/1/2016 thru 9/30/2017	$ 1,137,426
7. Total Net Worth	$ 10,713,533
C. ***Total Reserves and Net Worth***	$ 10,713,533
D. ***Total Liabilities, Reserves, and Net Worth***	$ 12,452,916

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page of
Mansfield Center for Nursing and Rehab	2132-C	9/30/2017	36 | 37

	Account	Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2016	$ 9,576,107
B.	Total Revenue (*From Statement of Revenue Page 30*)	$ 11,768,903
C.	Total Expenditures (*From Statement of Expenditures Page 27*)	$ 10,631,477
D.	Net Income or Deficit	$ 1,137,426
E.	Balance	$ 10,713,533
F.	Additions	
	1. Additional Capital Contributed (*itemize*) Total Expenses Pg. 27 $10,636,448 Depreciation Difference (4,971) Total Expenses $10,631,477	
	2. Other (*itemize*)	
F-3.	Total Additions	$
G.	Deductions	
	1. Drawings of Owners/Operators/Partners (*Specify*)	$

Name and Address (*No., City, State, Zip*)	Title	Amount

	Account	Amount
	2. Other Withdrawings *(Specify)*	$

Purpose	Amount

	Account	Amount
	3. Total Deductions	$
H.	***Balance at End of Period*** 09/30/17	$ 10,713,533

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Mansfield Center for Nursing and	2132-C	9/30/2017	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed

Printed Name of Preparer	
Matthew S. Bavolack	

Address	Phone Number
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