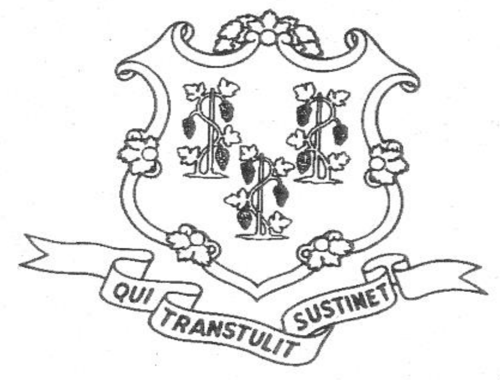
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2015

Name of Facility (as licensed)		
Marlborough Health Care Center, Inc.		
Address (No. & Street, City, State, Zip Code) 85 Stage Harbor Rd., Marlborough, CT 06447		
Type of Facility		
☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	200RH			07-5384

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	75064		

For Department Use Only

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

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CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Marlborough Health Care Center, Inc	75064	9/30/2015	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Bloomfield Health [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Marlborough Health Care Center, Inc.

Signed (Administrator)		Date	Signed (Owner)	Date
[signature]		2/6/16	[signature]	03/09/16
Printed Name (Administrator) Thomas Harris			Printed Name (Owner) Marvin Ostreicher	
Subscribed and Sworn to before me:	State of N.Y.	Date 2/8/16	Signed (Notary Public) [signature]	Comm. Expires 7/01/18
Address of Notary Public				

(Notary Seal)

GLORIA G. ALARIO
NOTARY PUBLIC STATE OF NEW YORK
NO. 01AL6077129 NASSAU COUNTY
TERM EXPIRES JULY 01, 2018

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 Marlborough Health Care Center, Inc.		Period Covered:	From 10/1/2014	To 9/30/2015
Address of Facility 85 Stage Harbor Rd., Marlborough, CT 06447				
Report Prepared By Blum Shapiro & Co.		Phone Number 860-561-4000	Date 2/8/2016	

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.

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CSP-2 Rev. 10/2005

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
(860) 295-9531	9/30/2015	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Marlborough Health Care Center, Inc.	85 Stage Harbor Rd., Marlborough, CT 06447

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	200RH			07-5384

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.:
Thomas Harris	000723

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

Name	License No.:

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	3A of 37

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

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Marlborough Health Care Center, Inc.	85 Stage Harbor Rd., Marlborough, CT 06447	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Agnes Zitter	9 Dogwood Lane Lawrence, NY 11559	President	50
Marvin Ostreicher	181 Wildacre Ave Lawrence, NY 11559	Secretary	50
Names of Stockholders Owning at Least 10% of Shares			
Agnes Zitter	9 Dogwood Lane Lawrence, NY 11559	President	50
Marvin Ostreicher	181 Wildacre Ave Lawrence, NY 11559	Secretary	50

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	3B	37

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

Owner(s) of Facility

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CSP-4 Rev. 10/2005

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	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	%**				
See attachment.		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					

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

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CSP-4 Rev. 10/2005

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	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		Cost Reported	Actual Cost to the Related Party
		Yes	No	%**		Page #	Line #		
Preferred Therapy Solutions	850 Silas Deane Highway Wethersfield CT 06109	☑	☐	24%	PT/OT/ST/Consulting	13	5a , 9a, 10a, 12	549,719	522,649
National Health Care Associates - Aetna	850 Silas Deane Highway Wethersfield CT 06109	☐	☑		Health Insurance Trust***	15	1a5	449,379	449,379
NOA Diagnostics	6851 Jericho Turnpike, Suite 150 Syosset, NY 11791	☑	☐	79%	Radiology	20	5f	15,131	13,898
National Health Care Associates	46 Stauderman Ave, Lynbrook, NY 11563	☐	☑		Shared Expenses	16	12	422,503	422,503
850 Silas Deane Realty	850 Silas Deane Highway, Wethersfield, CT 06109	☐	☑		Rent , Other Expense	16	12	1,577	1,577
Stauderman Realty	46 Stauderman Ave, Lynbrook, NY 11563	☐	☑		Rent , Other Expense	16	12	4,902	4,902
Maple View Manor of Connecticut, LLC	856 Maple Street, Rocky Hill ,CT 06067	☐	☑		Reimbursement for Nursing Employee	13	B 12	12,275	12,275
Harbor Hill Care Center, Inc.	11 Church Street, Middletown, CT 06457	☐	☑		Reimbursement for Marketing Employee/Advertising Promotion	16	M 3/13	31,837	31,837
Millborough Realty	85 Stage Harbor Road, Marlborough, CT 06447	☐	☑		Lease of facility	22	9	360,000	360,000
Procare LTC Pharmacy of CT	1492 Highland Ave., Cheshire CT 06410	☑	☐	83%	Drugs/OTC's/Rx Consultants	20 / 13	5a2,b,c,j / B3,12	332,667	312,223

* Use additional sheets if necessary.
** Provide the percentage amount of revenue received from non-related parties.
*** Consolidated for all National Healthcare CT Facilities, control and ownership pass upon transfer of funds to insurance company manager. Information required by previous state auditor.

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	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.

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

See page 17 attachment

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.

N/A

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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
Marlborough Health Care Center, Inc.	200RH	9/30/2015	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					
Reliable Health Systems, Nostrand Ave, Brooklyn, NY 11230	○	⊙	Computer Equipment	10/01/08	60 / ongoing	5,439	5,439
Lexus Financial	○	⊙	Car	03/07/12	36 months	6,978	3,489
Lexus Financial	○	⊙	Car	03/13/15	27 months	6,072	3,542
Wells Fargo Financial, PO Box 6434 Carol Stream, IL 60197	○	⊙	Copier	12/10/12	39 months	2,513	2,513
Toshiba Financial 45 Corporate Ave Plainville CT, 06062	○	⊙	Copier	08/01/12	36 months	403	403
De Lage Landen PO Box 41602, Philadelphia, PA 19101-1602	○	⊙	Copier	01/01/15	39 months	1,532	1,150
De Lage Landen PO Box 41602, Philadelphia, PA 19101-1602	○	⊙	Copier	11/01/14	39 months	709	650
	○	⊙					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total ***** 17,186

* 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.

Leased on 11/1/2014. See page 2

de lage landen

Lease Agreement

FTN31027T-001

LESSEE		
	Full Legal Name MARLBOROUGH HEALTH CARE CENTER	Phone Number 8602959531
	Billing Address 85 STAGE HARBOR RD, MARLBOROUGH, CT, 06447	Purchase Order Requisition Number
	Equipment Location (if not same as above)	Send Invoice to Attention of

EQUIPMENT INFORMATION	Equipment Make	Model Number	Serial Number	Quantity	Description (Attach separate Schedule A If Necessary)
	Toshiba e-	Studio457	Copier w/MR3028 RADF/MJ1032N Inner Finisher/Stand (1 ea)		

PAYMENT INFORMATION	Number of Lease Payments	Lease Payment	(PLUS) Applicable Sales Tax	(EQUALS) Total Lease Payment	Term of Lease in Months	End of Lease Option	Payment Frequency
	39	120.11	+ 7.63	= 127.73	39	Fair Market Value	Monthly
			+	=		End of Lease Purchase Option shall be FMV unless another option is indicated.	

Security Deposit	(PLUS) First Period Payment	(PLUS) Other	(EQUALS) Total Payment Enclosed
	+	+	=

TERMS AND CONDITIONS

1. Lease: You (the "Lessee") agree to lease from us (the "Lessor") the Equipment listed above and on any attached schedule (the "Lease"). You authorize us to adjust the Lease payments by up to 15% if the cost of the Equipment or taxes differs from the supplier's estimate. This lease is effective on the date that it is accepted and signed by us, and the term of this Lease begins on that date or any later date that we designate (the "Commencement Date") and continues thereafter for the number of months indicated above. Lease payments are due as invoiced by us. As you will have possession of the Equipment from the date of its delivery, if we accept and sign this Lease you will pay us interim rent for the period from the date the Equipment is delivered to you until the Commencement Date, as reasonably calculated by us based on the Lease payment, the number of days in that period, and a month of 30 days. Your Lease obligations are absolute, unconditional and are not subject to cancellation, reduction, setoff or counterclaim. You agree to pay us a fee of $75 to reimburse our expenses for preparing financing statements, other documentation costs and all ongoing administration costs during the term of this Lease. Security deposits are non-interest-bearing and may be applied to cure a Lease default. If you are not in default, we will return the deposit to you when the Lease is terminated. If a payment is not made when due, you will to pay us a late charge of 10% of the payment or $10, whichever is greater. We will charge you a fee of $25 for any check that is returned. ONLY WE ARE AUTHORIZED TO WAIVE OR CHANGE ANY TERM, PROVISION OR CONDITION OF THE LEASE.

2. Title: Unless you have a $1.00 purchase option, we will have title to the Equipment. If you have a $1.00 purchase option and/or the lease is deemed to be a security agreement, you grant us a security interest in the Equipment and all proceeds thereof. You authorize us to file Uniform Commercial Code ("UCC") financing statements on the equipment.

3. Equipment Use, Maintenance and Warranties: We are leasing the Equipment to you "AS-IS" AND MAKE NO WARRANTIES, EXPRESS OR IMPLIED, INCLUDING WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE. We transfer to you any manufacturer warranties. You are required at your cost to keep the Equipment in good working condition and to pay for all supplies and repairs. If the Lease Payment includes the cost of maintenance and/or service provided by a third party, you agree that we are not responsible to provide the maintenance or service and you will make all claims related to maintenance and service to the third party. You agree that any claims related to maintenance or service will not impact your obligation to pay all Lease Payments when due.

4. Assignment: You agree not to transfer, sell, sublease, assign, pledge or encumber either the Equipment or any rights under this Lease without our prior written consent. You agree that we may sell, assign, or transfer the Lease and the new owner will have the same rights and benefits we now have and will not have to perform any of our obligations and the rights of the new owner will not be subject to any claims, defenses, or setoffs that you may have against us or any supplier.

5. Risk of Loss and Insurance: You are responsible for all risks of loss or damage to the Equipment and if any loss occurs you are required to satisfy all of your Lease obligations. You will keep the Equipment insured against all risks of loss or damage for an amount equal to its replacement cost. You will list us as the sole loss payee for the insurance and give us written proof of the insurance. If you do not provide such insurance, you agree that we have the right, but not the obligation, to obtain such insurance, and add an insurance fee to the amount due from you, on which we may make a profit. We are not responsible for any losses or injuries caused by the Equipment and you will reimburse us and defend us against any such claims. This indemnity will continue after the termination of this Lease. You will obtain and maintain comprehensive public liability insurance naming us as an additional insured with coverages and amounts acceptable to us.

6. Taxes: You agree to pay when due, either directly or as reimbursement to us, all sales, use and personal property taxes and charges in connection with ownership and use of the Equipment. We may charge you a processing fee for administering property tax filings. You will indemnify us on an after-tax basis against the loss of any tax benefits anticipated at the Commencement Date arising out of your acts or omissions.

7. End of Lease: You will give us at least 60 days but not more than 120 days written notice (to our address below) before the expiration of the initial Lease term (or any renewal term) of your intention to purchase or return the Equipment. With proper notice you may: a) purchase all the Equipment as indicated above under "End of Lease Option"(fair market value purchase option amounts will be determined by us based on the Equipment's in place value); or b) return all the Equipment in good working condition at your cost in a timely manner, and to a location we designate. If you fail to notify us, or if you do not (i) purchase or (ii) return the Equipment as provided herein, this Lease will automatically renew at the same payment amount for consecutive 60-day periods.

8. Default and Remedies: You are in default on this Lease if: a) you fail to pay a Lease Payment or any other amount when due; or b) you breach any other obligation under the Lease or any other Lease with us. If you are in default on the Lease we may: (i) declare the entire balance of unpaid Lease Payments for the full Lease term immediately due and payable to us; (ii) sue you for and receive the total amount due on the Lease plus the Equipment's anticipated end of Lease fair market value or fixed price purchase option (the "Residual") with future Lease Payments and the Residual discounted to the date of default at the lesser of (A) a per annum interest rate equivalent to that of a U.S. Treasury constant maturity obligation (as reported by the U.S. Treasury Department) that would have to a repayment term equal to the remaining Lease term, all as reasonably determined by us, or (B) 6% per annum, plus reasonable collection and legal costs; (iii) charge you interest on all monies due at the rate of 18% per year or the highest rate permitted by law from the date of default; and (iv) require that you immediately return the Equipment to us or we may peaceably repossess it. Any return or repossession will not be considered a termination or cancellation of the Lease. If the Equipment is returned or repossessed we will sell or re-rent the Equipment at terms we determine, at one or more public or private sales, with or without notice to you, and apply the net proceeds (after deducting any related expenses) to your obligations. You remain liable for any deficiency with any excess being retained by us.

9. Miscellaneous: You agree the Lease is a Finance Lease as defined in Article 2A of the "UCC". You acknowledge we have given you the name of the Equipment supplier and that you may have rights under the contract with the supplier and may contact the supplier for a description of these rights. If requested, you will sign a separate Equipment acceptance certificate. **This Lease was made in Pennsylvania ("PA"), is to be performed in PA and shall be governed and construed in accordance with the laws of PA. You consent to jurisdiction, personal or otherwise, in any state or federal court in PA and irrevocably waive a trial by jury.** You agree to waive any and all rights and remedies granted to you under Sections 2A-508 through 2A-522 of the UCC. You agree that the Equipment will only be used for business purposes and not for personal, family or household use and will not be moved from the above location without our consent. You agree that a facsimile copy of the Lease with facsimile signatures may be treated as an original and will be admissible as evidence of the Lease. We may inspect the Equipment during the Lease term.

LESSEE SIGNATURE

You agree that this is a non-cancelable lease. The Equipment is: ☐ NEW ☐ USED

Lessee (Full Legal Name): MARLBOROUGH HEALTH CARE CENTER

Signature: [signature]

Print Name: MICHAEL BOKOW

Title: MATERIALS MGMT | Date: 12/3/14

LESSOR

DE LAGE LANDEN FINANCIAL SERVICES, INC.
Lease Processing Center: 1111 Old Eagle School Road, Wayne, PA 19087-8608
PHONE: (800) 735-3273 • FAX: (800) 776-2329

Commencement Date: | Lease Number:

Accepted By:

GUARANTY

I unconditionally guaranty prompt payment of all the Lessee's obligations. The Lessor is not required to proceed against the Lessee or the Equipment or enforce other remedies before proceeding against me. I waive notice of acceptance and all other notices or demands of any kind to which I may be entitled. I consent to any extensions or modification granted to the Lessee and the Lessee and the release and/or compromise of any obligations of the Lessee or any other guarantors without releasing me from my obligations. This is a continuing guaranty and will remain in effect in the event of my death and may be enforced by or for the benefit of any assignee or successor of the Lessor. **This guaranty is governed by and constituted in accordance with the Laws of the Commonwealth of Pennsylvania and I consent to non-exclusive jurisdiction in any state or federal court in Pennsylvania and waive trial by jury.**

Signature: | Date:

Print Name:

ACCEPTANCE

The equipment has been received, put in use, is in good working order and is satisfactory and acceptable.

Signature: | Date:

Print Name: | Title:

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Corporate Office
45 Corporate Avenue
Plainville, CT 06062
800-634-4810
P: 860-793-9994 F: 860-793-9954
www.theofficeworksinc.com

Branch Office
100 Mill Plain Road, 3rd Floor
Danbury, CT 06810
P: 203-942-2640

SALES ORDER

Date 11/11/2014 PO# ______ Terms ______

BILL TO Marlborough Health Care Center
Address 85 Stage Harbor Road
City Marlborough State CT 06447
Billing Contact ______
Billing Phone 860-295-9531

SHIP TO ______
Address ______
City ______ State ____ Zip ______
Ship to Phone ______
Ship to Fax ______

ITEM DESCRIPTION	SERIAL NUMBER	QTY	UNIT PRICE	EXTENDED PRICE
Toshiba e-Studio457 Digital Copier		1		39 Month Lease
MR3028 RADF		1		$120.11 per month
MJ1032N Inner Finisher		1		Zero Down
Stand355/455		1		FMV Lease End Option
Power Filter 15 amp		1		

1) The Seller retains a security interest in all the equipment and supplies described in this Agreement until the purchase price is paid in full.
2) In the event Buyer makes default in payment the Buyer will be liable for the payment of any legal fees or costs incurred in sustaining or protecting the security interest or in enforcing the terms of the security agreement, and upon demand the Buyer agrees to make the equipment available to the Seller at a location to be determined by seller.
3) If there is a third party associated with this transaction, the lessee shall abide by the terms of the lease agreement. The Office Works, Inc. shall in no way be held responsible if the lessee fails to fulfill any terms set forth in the associated lease agreement.

Returned Equipment	Make/Model	Equip. ID# & Serial Number	End Meter
	Toshiba e-Studio455se	ID4883/SSCQH145096	

Hard-drive Options Upon Equipment Removal: Remove & Replace ______ Erase ______ Ignore ______

Notes / Provisions:

The Office Works Inc. will remove and return the Toshiba e-Studio455se to the leasing company at no charge.

Customer Authorization

Authorized Signature X [signature]
Print Name /Title X MICHAEL BROWN / MATERIALS MGMT
Date X 12/3/14

The Office Works, Inc. Authorization

Accepted By ______
Print Name ______
Title ______

MASTER MAINTENANCE AGREEMENT

The Office Works, Inc.
Farmington Valley Corporate Park
45 Corporate Avenue
Plainville, CT 06062
800-634-4810
P: 860-793-9994 F: 860-793-9954
www.theofficeworksinc.com

BILLING INFORMATION

BILL TO Marlborough Health Care Center
Address 85 Stage Harbor Road
City Marlborough State CT Zip 06447
Billing Contact 860-295-9531
Lease Billed By De Lage Landen
PO # ____
Machine ID # ____
Serial # ____
Make/Model Toshiba e-Studio457

EQUIPMENT LOCATION

SHIP TO ____
Address ____
City ____ State ____ Zip ____
Meter Contact ____
*Please Select Preferred Method of Contact Below

☐ Meter Contact E-mail ____
☐ Meter Contact Fax ____
☐ Meter Contact Phone ____

ALL INCLUSIVE SERVICE MAINTENANCE AGREEMENT	X	Includes labor, travel, parts & supplies, excludes paper, staples and freight.
FULL SERVICE MAINTENANCE AGREEMENT		Includes labor, travel and parts, excludes supplies and freight.

Notes **State sales tax will be applied when applicable.**

Start Meter ____
Contract Effective Dates ____ to ____

Base Charge ____ | M (A S Q M*)
Overage Billed ____ (A S Q M*) * A= annually, S= semi-annually, Q= quarterly, M= monthly

COPIES

Black Copy Allowance ____
Color Copy Allowance ____
Overage Rates 0.0065 (BLACK) ____ (COLOR)

PRINTS

Black Print Allowance ____
Color Print Allowance ____
Overage Rates ____ (BLACK) | ____ (COLOR)

FOR THE FIXED CHARGES THAT ARE SUBJECT TO THE TERMS SET FORTH IN THIS AGREEMENT THE OFFICE WORKS, INC'S FIELD SERVICE DEPARTMENT WILL PROVIDE TECHNICAL REPAIR SERVICE IN ORDER TO MAINTAIN THE ABOVE "EQUIPMENT" IN PROPER OPERATING CONDITION. CUSTOMER ACKNOWLEDGES TO HAVE READ AND UNDERSTOOD THE TERMS AND CONDITIONS OF THIS AGREEMENT WHICH ARE CONTAINED ON BOTH SIDES OF THIS DOCUMENT AND WHICH CONSTITUTES THE ENTIRE AGREEMENT BETWEEN THE PARTIES. THERE ARE NO ORAL UNDERSTANDINGS, TERMS OR CONDITIONS; AND THE PARTIES MAY NOT RELY UPON ANY REPRESENTATIONS, EXPRESSED OR IMPLIED, NOT CONTAINED IN THIS AGREEMENT. THIS AGREEMENT IS NOT VALID UNTIL ACCEPTED BY THE OFFICE WORKS, INC.

CUSTOMER AUTHORIZATION

Authorized Signature [signature] Title ____
Print Name MICHAEL BOKOW Date ____
At this time I decline Maintenance Agreement Coverage ____ Intials

THE OFFICE WORKS, INC AUTHORIZATION

Authorized Signature ____ Title ____
Print Name ____ Date ____

TERMS AND CONDITIONS

EFFECTIVE DATE OF AGREEMENT: The undersigned hereby requests that the equipment listed on the reverse side hereof, be placed under maintenance agreement and billed according to the terms and conditions of this agreement. The term of this agreement shall commence upon the date indicated on the front of this agreement and The Office Works, Inc.'s acceptance of the contract. This agreement will automatically renew for successive (1) year terms and number of copy/prints allowance proportional and subject to the receipt by The Office Works, Inc. of the maintenance charge in effect at the renewal date, provided the customer is not then in default. This agreement will be coterminous with the equipment lease, if applicable.

GENERAL SCOPE OF COVERAGE: This agreement covers labor and all parts for adjustments and repairs as required by normal use of the equipment except as hereinafter provided. Damage to the equipment or its parts arising from misuse, abuse, negligence, or causes beyond The Office Works, Inc.'s control are not covered. The Office Works, Inc. may terminate this agreement in the event the equipment is modified, damaged, altered or serviced by personnel other than those employed by The Office Works, Inc., or if parts, accessories or components not authorized by The Office Works, Inc. are fitted to the equipment.

No change, alteration or amendment of the terms or conditions of this agreement are authorized or effective unless they have been agreed to in writing by an officer of the The Office Works, Inc. No course of dealing of any other customer shall constitute an amendment to the terms hereof or alter any of the terms of this agreement.

No terms or warranties are authorized unless they appear on the original of this agreement. The Office Works, Inc. disclaims all warranties, expressed or implied, including any implied warranties of merchantability, fitness for use, or fitness for particular purpose. The Office Works, Inc. shall not be responsible for direct, incidental or consequential damages, including but not limited to damages arising out of the use or performance of the equipment or the loss of use of the equipment.

Authorization to move equipment may be subject to the terms and conditions of lease contracts. Customer shall give The Office Works, Inc. thirty (30) days prior written notice if customer desires to move equipment covered under this agreement. The Office Works, Inc., at its option, may terminate service under this agreement in whole or in part in the event the equipment is moved without consent of The Office Works, Inc. The Office Works, Inc. reserves the right to increase the cost of this agreement for servicing equipment in a new location. A relocation, removal and/or reinstallation fee will be charged.

Reinstallation of drivers and/or installation of connected devices due to changes in network operating systems or malfunction of devices other than listed on this contract are not covered and will be billed by The Office Works, Inc. at the current published hourly rates.

EXTENT OF SERVICES: Labor performed during a service call includes lubrication and cleaning of the equipment, adjustments and repair or replacement of parts required by wear and tear resulting from normal use. Replaced parts become the property of The Office Works, Inc. Unlimited service calls, including travel time and mileage under this agreement will be made during normal business hours at the customer's installation address. The Office Works, Inc.'s normal business hours for service are from 8:00 a.m. to 4:30 p.m., Monday through Friday, excluding holidays. Customer understands that alterations, attachments, specification changes, parts or service necessitated by negligence, accident, use of unsuitable supplies or unauthorized interference with the equipment will be charged the rates in effect at the time of service.

REPAIR AND REPLACEMENT OF PARTS: All parts necessary to the operation of the equipment, with the exception of the exclusions listed below and subject to the general scope of coverage will be furnished free of charge during a service call included in the maintenance service provided by this agreement. When and in its sole discretion The Office Works, Inc. determines a shop reconditioning is necessary as a direct result of expected materials wear and age factors caused by normal office environment usage, to keep the equipment in working condition, The Office Works, Inc. will remove equipment from customer environment and return to our shop for repair. If the customer does not authorize such reconditioning, The Office Works, Inc. may discontinue service of the equipment under this agreement or may refuse to renew this agreement upon its expiration. Thereafter The Office Works, Inc. will be available on a "Per Call" basis at current published rates.

EXCLUSIONS: This agreement does not cover connected devices that allow the equipment to interface with networks and communications systems. The Office Works, Inc. will troubleshoot network related issues and perform maintenance on connected devices on a time and material billable basis.

External electrical, telephone or cabling are not covered under this agreement. Any charges by an outside source for improvements or repairs made to external electrical, telephone or cabling are solely the customer's responsibility. All equipment is required to have electrical connections through a power surge protector approved by The Office Works, Inc.

This agreement does not cover service necessitated as a result of malfunction of equipment when unauthorized parts, attachments or supplies that are not approved by The Office Works, Inc. are used with the equipment. This agreement does not cover service required as a result of alterations or malfunctioning computer or network hardware or network operating system, application, and/or network operating software. If it is determined that such changes, alterations or malfunctions make it impractical for The Office Works, Inc. to continue service, The Office Works, Inc. reserves the right to terminate this agreement.

This agreement does not cover the cost to overhaul, rebuild, remove, relocate or return equipment. This agreement does not apply to any loss or damage to equipment through accident, abuse, misuse, theft, neglect, acts of third parties, fire, water, casualty or any other natural force, whether direct, indirect consequential or inconsequential. The cost of repairing equipment caused by lighting strikes on electrical or phone lines are excluded. Losses and damages occurring from any of the foregoing are specifically excluded from this agreement.

This agreement excludes the following services where applicable: paper, transparencies, staples and freight.

BILLING: Base Charges will be billed approximately one (1) month in advance of the base billing cycle indicated on the front page of this agreement. Overages will be billed in arrears within ten (10) days following end date of overage billing cycle indicated on the front of this agreement. Meter readings will be collected via auto-email, auto-fax or by phone when customer has requested. Auto-meter requests require customer to have internet connectivity. Meter readings for agreements with semi-annual or annual billing cycles will be obtained periodically during the contract effective dates to ensure customer has not exceeded copy/print allowance(s). The Office Works, Inc. will estimate meters when they are not provided. Estimates will be based on available customer usage data.

INVOICING: All payment(s) should be remitted to the address indicated on the invoice(s). Payment terms are thirty (30) days from the invoice date. **Base charge invoices for new agreements are due upon receipt**, except where the agreement has been incorporated into the purchase of the equipment.

DEFAULT: Customer will be considered in "default" if scheduled payment(s) are not received within fifteen (15) days from due date. Customer agrees that should they have any past due balances with The Office Works, Inc. for any reason, at the sole discretion of The Office Works, Inc., support under this agreement shall be suspended until such past due balances shall and have been satisfied. The Office Works, Inc. reserves the right to terminate or delay service and/or supplies for any or all equipment associated with customer until customers account is paid current. Customer agrees to pay The Office Works, Inc costs and expenses of collection including the maximum attorney's fee permitted by law.

RENEWAL/CANCELLATION: This agreement shall automatically renew at the end of the current term for a successive one (1) year term, upon no less than thirty (30) days notification from the Office Works, Inc. The agreement invoice shall be deemed as written notification of its intention to renew. Upon The Office Works, Inc's re-assessment of the agreement, new agreement terms may be issued, and cost may be adjusted annually at the beginning of a new agreement term.

Customer must provide written notification thirty (30) days prior to desired termination effective date, of its intent to cancel this agreement. This contract may not be transferred if equipment is sold or title is transferred. This agreement is non-refundable.

TRAINING: The Office Works, Inc., at no additional charge, will train a reasonable number of key-operators designated by the customer, in operation of the equipment hardware. The Office Works, Inc. will train the customer for up to a total of two (2) hours on the installation and operation of software for up to two (2) workstations. Additional training and installation is available for an additional charge, at current published rates.

The customer will be responsible for daily care and cleaning of the top-glass, slit glass, dusting equipment, replenishing supplies and clearing jams. The customer shall adhere to manufacturer's specifications and/or operating manuals in operating equipment.

GOVERNING LAW: This agreement shall be governed by and construed according to the laws of the State of Connecticut, applicable to aggreement wholly negotiated, executed and performed in said state.

FORCE MAJEURE: The Office Works, Inc. shall not be liable for damages or delays in performance or failures to perform its obligations under this agreement caused by circumstances beyond its reasonable control including, but not limited to, delays or failure to perform caused by work stoppages, delays or losses in shipping, acts of governments, delay in manufacturing, including but not limited to bad weather, import and the governmental restrictions, accidents and delays or failure to perform by its suppliers.

INDEMNIFICATION: Not withstanding anything to the contrary herein, The Office Works, Inc. indemnity is limited to acts or omissions of gross negligence by The Office Works, Inc. and in no event shall The Office Works, Inc. be liable, in aggregate, for more the Fair Market Value of the Agreement ("Aggregate Indemnification Cap"). It is understood that the Aggregate Indemnification Cap is in fact an aggregate indemnification obligation, and not on a "per occurrence" basis indemnification obligation. It is further understood that any indemnification obligation by The Office Works, Inc. may have under this agreement shall be satisfied by recourse to insurance funds available under The Office Works, Inc. Comprehensive General Liability Insurance Policy.

NON-DISCRIMINATION: The Office Works, Inc. agrees and warrants that in the performance of this agreement, it will not discriminate or permit discrimination against any person or group or persons on the grounds of race, creed, color, age, religion or national origin in any manner prohibited by the laws of the United States or of the State of Connecticut, Massachusetts or New York.

LEASE
CLOSED END MOTOR VEHICLE LEASE AGREEMENT
NEW JERSEY

DEAL# 107725

LEXUS FINANCIAL SERVICES

Lease Date 03/13/2015

1. Parties

LESSOR (DEALER) NAME AND ADDRESS	LESSEE AND CO-LESSEE NAME AND LESSEE'S BILLING ADDRESS	VEHICLE GARAGING ADDRESS, IF DIFFERENT THAN LESSEE'S BILLING ADDRESS
LEXUS OF ENGLLEWOOD 53-59 ENGLE STREET ENGLEWOOD, NJ 07631 62	MARLBOROUGH HEALTH CARE CENTER MARVIN J OSTREICHER 85 STAGE HARBOR RD MARLBOROUGH CT 06445	
PHONE NUMBER: 2015683900	COUNTY:	COUNTY: 78

This is a Lease for the Vehicle described below. The words **"you"**, **"your"** and **"yours"** refer to the Lessee and any Co-Lessee. The words **"we"**, **"us"** and **"our"** refer to the Lessor, and after assignment, the Toyota Lease Trust ("TLT") and any subsequent assignee. Lexus Financial Services, a division of Toyota Motor Credit Corporation ("LFS") will be servicing this Lease on behalf of TLT. By signing this Lease, you are leasing this Vehicle according to all of the terms of this Lease.

2. Description of Leased Vehicle. You are leasing from us, and received in satisfactory condition, the following Vehicle:

New, Used or Demo	Year	Make	Model	Body Style	Vehicle Identification No.	Odometer Mileage
NEW	2015	LEXUS	RX350	5DR	2T2BK1BA7FC308145	10

Primary Use: ☐ Personal, Family or Household ☐ Business, Agricultural or Commercial

Transmission: ☐ Auto ☐ Manual

Brakes: ☐ Power ☐ Manual

Steering: ☐ Power ☐ Manual

☐ Air Conditioning

☐ Engine Cylinders ______

(If applicable) ☐ Monroney Label MSRP $ 50669.00

If the Odometer Mileage reads 1,000 miles or more, the prior use of the vehicle was:

☐ Personal, Family or Household Use ☐ Demonstrator ☐ Livery ☐ Daily Rental ☐ Police ☐ Prior Wreckage ☐ Unknown

FEDERAL CONSUMER LEASING ACT SEGREGATED DISCLOSURES

3. Amount Due at Lease Signing or Delivery	4. Monthly Payments	5. Other Charges (not part of your Monthly Payment)	6. Total of Payments
(Itemized in Section 7 below) $ 3145.00	Your first Monthly Payment of $ 506.01 is due on 03/13/2015, followed by 26 payments of $ 506.01 due on the 13TH of each month. The total of your Monthly Payments is $ 13662.27.	Disposition fee (if you do not purchase the Vehicle) $ 350.00 Total $ 350.00	(The amount you will have paid by the end of the Lease) $ 16651.26

Itemization of Amount Due at Lease Signing or Delivery

7. Amount Due at Lease Signing or Delivery:

a. Capitalized Cost Reduction	$ 2059.99
b. First Monthly Payment	$ 506.01
c. Refundable Security Deposit	$ N/A
d. Title Fees	$ N/A
e. Registration Fees	$ 250.00
f. License Fees	$ N/A
g. Tax on Capitalized Cost Reduction	$ N/A
h. Acquisition Fee	$ N/A
i.	$ N/A
j. Doc Fee	$ 329.00
k. Total	$ 3145.00

8. How the Amount Due at Lease Signing or Delivery will be Paid:

a. Net Trade-In Allowance	$ N/A
b. Rebates and Noncash Credits	$ 2006.00
c. Amount to be Paid in Cash	$ 1139.00
d. Total	$ 3145.00

9. Your Monthly Payment is determined as shown below:

9a. Gross Capitalized Cost. The agreed upon value of the Vehicle ($6226.85) and any items you pay over the Lease Term (such as service contracts, insurance, and any outstanding prior credit or lease balance). For an itemization of this amount, see Section 13.	$ 47421.85
b. Capitalized Cost Reduction. The amount of any net trade-in allowance, rebate, noncash credit, or cash you pay that reduces the Gross Capitalized Cost.	− $ 2059.99
c. Adjusted Capitalized Cost. The amount used in calculating your Base Monthly Payment.	= $ 45361.86
d. Residual Value. The value of the Vehicle at the end of the Lease used in calculating your Base Monthly Payment.	− $ 34454.92
e. Depreciation and any Amortized Amounts. The amount charged for the Vehicle's decline in value through normal use and for other items paid over the Lease Term.	= $ 10906.94
f. Rent Charge. The amount charged in addition to the Depreciation and any Amortized Amounts.	+ $ 1939.66
g. Total of Base Monthly Payments. The Depreciation and any Amortized Amounts plus the Rent Charge.	= $ 12846.60
h. Lease Payments. The number of payments in your Lease.	÷ 27
i. Base Monthly Payment	= $ 475.80
j. Monthly Sales/Use Tax	+ $ 30.21
k. ______	+ $ N/A
l. Total Monthly Payment ("Monthly Payment")	= $ 506.01

Early Termination. You may have to pay a substantial charge if you end this Lease early. The charge may be up to several thousand dollars

9. Your Monthly Payment is determined as shown below:

9a. Gross Capitalized Cost. The agreed upon value of the Vehicle ($6226.85) and any items you pay over the Lease Term (such as service contracts, insurance, and any outstanding prior credit or lease balance). For an itemization of this amount, see Section 13.		$ 47421.85
b. Capitalized Cost Reduction. The amount of any net trade-in allowance, rebate, noncash credit, or cash you pay that reduces the Gross Capitalized Cost.	–	$ 2059.99
c. Adjusted Capitalized Cost. The amount used in calculating your Base Monthly Payment.	=	$ 45361.86
d. Residual Value. The value of the Vehicle at the end of the Lease used in calculating your Base Monthly Payment.	–	$ 34454.92
e. Depreciation and any Amortized Amounts. The amount charged for the Vehicle's decline in value through normal use and for other items paid over the Lease Term.	=	$ 10906.94
f. Rent Charge. The amount charged in addition to the Depreciation and any Amortized Amounts.	+	$ 1939.66
g. Total of Base Monthly Payments. The Depreciation and any Amortized Amounts plus the Rent Charge.	=	$ 12846.60
h. Lease Payments. The number of payments in your Lease.	÷	27
i. Base Monthly Payment	=	$ 475.80
j. Monthly Sales/Use Tax	+	$ 30.21
k. ______	+	$ N/A
l. Total Monthly Payment ("Monthly Payment")	=	$ 506.01

Early Termination. You may have to pay a substantial charge if you end this Lease early. The charge may be up to several thousand dollars. The actual charge will depend on when the Lease is terminated. The earlier you end the Lease, the greater this charge is likely to be.

10. Excessive Wear and Use. You may be charged for excessive wear based on our standards for normal use and for mileage in excess of 22,500 miles over the odometer mileage disclosed above, at the rate of .25 per mile.

11. Purchase Option at End of Lease Term. You have an option to purchase the Vehicle at the end of the Lease Term for $ 34454.92.

12. Other Important Terms. See your Lease documents for additional information on early termination, purchase options and maintenance responsibilities, warranties, late and default charges, insurance, and any security interest, if applicable.

Gross Capitalized Cost Itemization and Other Items

13. Itemization of Gross Capitalized Cost

You will pay for the following items over the Lease Term, as part of your Monthly Payment:

a. Agreed Upon Value of the Vehicle		$ 46226.85
b. Taxes	+	N/A
c. Initial Title, License and Registration Fees	+	N/A
d. Mechanical Breakdown Protection and/or Maintenance Agreement	+	N/A
e. Credit Life and/or Disability Insurance	+	N/A
f. Outstanding Prior Credit or Lease Balance	+	N/A
g. Acquisition Fee	+	700.00
h. EXCESS WEAR AND U	+	495.00
i.	+	N/A
j. Gross Capitalized Cost	=	47421.85

14. Lease Term, Scheduled Maturity Date and Total Cost of this Lease

The Lease Term of this Lease is 27 months, and the Scheduled Maturity Date of this Lease is 06/12/2017.

The total cost of this Lease, assuming you do not default and you exercise the purchase option at the Scheduled Maturity Date, is $0756.18. This disclosure is required by New Jersey law and is calculated in a manner specified under the law. We calculated this amount by adding the amount of the Purchase Option at End of Lease Term (Section 11), plus the Amount Due at Lease Signing or Delivery (Section 3) (minus the First Monthly Payment (Section 7(b) and Refundable Security Deposit (Section 7(c)), plus the total of your Monthly Payments (Section 4). Because this disclosure is based on certain assumptions and does not include all costs (such as insurance), your actual total cost of this Lease may differ.

15. Required Insurance

You must provide the following insurance during the Lease Term, with the Lessee and/or Co-Lessee as an insured driver. No other types of insurance are required:

a) primary automobile liability insurance with minimum limits for bodily injury or death of
   i) 1$.000 for any one person, and
   ii) 3$.000 for any one accident, and
   iii) 5$000 for property damage; and

b) physical damage insurance for the full value of the Vehicle, with a maximum deductible of $1,000.

17. Vehicle Maintenance and Damage

You are responsible for all maintenance, repair, service, and operating expenses of the Vehicle. You agree to follow the owner's manual and maintenance schedule, and to provide us with written proof of such maintenance. You are responsible for all damage to the Vehicle and for its loss, seizure or theft. You must tell us immediately if any of these events happen, and cooperate with your insurance company.

18. Warranty

If the Vehicle is a new or a demo Vehicle, the Vehicle is subject to the standard new warranty from the manufacturer. If the Vehicle is used, it is not covered by a warranty unless identified below:

X ☐ Remainder of standard new vehicle warranty from manufacturer

☐ Used vehicle warranty from manufacturer

YOU ARE LEASING THIS VEHICLE "AS IS." THERE ARE NO WARRANTIES AS TO THE VEHICLE'S CONDITION, MERCHANTABILITY, SUITABILITY, OR FITNESS FOR A PARTICULAR PURPOSE.

19. Optional Insurance and Other Products

You are not required to buy any of the Optional Insurance or Other Products listed below to enter into this Lease, and they are not a factor in our credit decision. These insurance and other products will not be provided unless the appropriate box is checked, all information is filled in, you initial below, and you are accepted by the Provider. By your initials below, you agree that you have received a notice of the terms of the insurance or product, and you want to obtain the insurance or product for the premium or charge shown. A portion of the premium or charge shown may be retained by the Lessor (Dealer).

☐ **Optional Credit Life Insurance** $ N/A Beginning Coverage

______ Insured(s)

______ Provider $ N/A Premium ____/____ Lessee / Co-Lessee Initials

☐ **Optional Credit Disability Insurance** $ N/A Maximum Monthly Coverage

______ Provider $ N/A Premium ____/____ Lessee / Co-Lessee Initials

☐ **Optional Mechanical Breakdown Protection** N/A miles/ N/A months *Coverage*

______ Provider $ N/A Premium or Charge ____/____ Lessee / Co-Lessee Initials

☐ Optional Maintenance Agreement

j. Gross Capitalized Cost = 47421.85

14. Lease Term, Scheduled Maturity Date and Total Cost of this Lease

The Lease Term of this Lease is 27 months, and the Scheduled Maturity Date of this Lease is 06/12/2017.

The total cost of this Lease, assuming you do not default and you exercise the purchase option at the Scheduled Maturity Date, is $0756.18. This disclosure is required by New Jersey law and is calculated in a manner specified under the law. We calculated this amount by adding the amount of the Purchase Option at End of Lease Term (Section 11), plus the Amount Due at Lease Signing or Delivery (Section 3) (minus the First Monthly Payment (Section 7(b) and Refundable Security Deposit (Section 7(c)), plus the total of your Monthly Payments (Section 4). Because this disclosure is based on certain assumptions and does not include all costs (such as insurance), your actual total cost of this Lease may differ.

15. Required Insurance

You must provide the following insurance during the Lease Term, with the Lessee and/or Co-Lessee as an insured driver. No other types of insurance are required:

a) primary automobile liability insurance with minimum limits for bodily injury or death of
   - i) 1$.000 for any one person, and
   - ii) 3$.000 for any one accident, and
   - iii) 5$000 for property damage; and

b) physical damage insurance for the full value of the Vehicle, with a maximum deductible of $1,000.

See Section 24 for additional information.

You have provided us today with the following insurance information:

Insurance Provider	Policy No.	Insurance Coverage Verification By: Dealer Employee
		JONAS

Agent's Name / Address	Agent's Phone No.

16. Estimated Official Fees and Taxes $ 1378.17

This is an estimate of the total amount you will pay over the Lease Term for official and license fees, registration, title, and taxes (including personal property taxes), whether included in your Total Monthly Payment (Section 9.l), the Amount Due at Lease Signing or Delivery (Section 7) or billed separately. The actual total of Official Fees and Taxes may be higher or lower than this estimate depending on the tax rates in effect or the value of the Vehicle at the time a fee or tax is assessed. **This estimate is based on your current address and may increase if you move or if tax rates change. You are responsible for paying any increases.** See Section 28 for additional information.

RANTIES AS TO THE VEHICLE'S CONDITION, MERCHANTABILITY, SUITABILITY, OR FITNESS FOR A PARTICULAR PURPOSE.

19. Optional Insurance and Other Products

You are not required to buy any of the Optional Insurance or Other Products listed below to enter into this Lease, and they are not a factor in our credit decision. These insurance and other products will not be provided unless the appropriate box is checked, all information is filled in, you initial below, and you are accepted by the Provider. By your initials below, you agree that you have received a notice of the terms of the insurance or product, and you want to obtain the insurance or product for the premium or charge shown. A portion of the premium or charge shown may be retained by the Lessor (Dealer).

☐ **Optional Credit Life Insurance** $ N/A Beginning Coverage

Insured(s)

Provider $ N/A Premium ____/____ Lessee / Co-Lessee Initials

☐ **Optional Credit Disability Insurance** $ N/A Maximum Monthly Coverage

Provider $ N/A Premium ____/____ Lessee / Co-Lessee Initials

☐ **Optional Mechanical Breakdown Protection** N/A miles/ N/A months Coverage

Provider $ N/A Premium or Charge ____/____ Lessee / Co-Lessee Initials

☐ **Optional Maintenance Agreement**

Provider $ N/A Premium or Charge ____/____ Lessee / Co-Lessee Initials

Total Premiums and Charges $ N/A

20. Complete Agreement or Modification

By your initials, you acknowledge that this Lease contains the entire agreement for the Lease of this Vehicle. There are no other agreements. Any change to this Lease must be in writing, and signed by you and by us.

____/____ Lessee / Co-Lessee Initials

21. Agreement to Arbitrate

By initialing below, you agree that at the request of either you or us any controversy or claim (defined in Section 47 of this Lease) between you and us shall be determined by neutral binding arbitration. See Section 47 for further terms and conditions.

____/____ Lessee / Co-Lessee Initials

Lease Signatures and Notices

NOTICE TO LESSEE AND CO-LESSEE: (1) DO NOT SIGN THIS LEASE BEFORE YOU READ BOTH SIDES OF IT OR IF IT CONTAINS ANY BLANK SPACES; (2) YOU ARE ENTITLED TO A COMPLETELY FILLED IN COPY OF THIS LEASE WHEN YOU SIGN IT.

By signing below, you acknowledge that: (1) You have read the entire Lease, including the back side; (2) You agree to all of the provisions of this Lease; (3) You have received a completely filled-in copy of this Lease; (4) This is a lease; you have no ownership interest in the Vehicle unless and until you exercise your option to purchase set forth in this Lease.

NOTICE: THE LESSEE AND THE LESSOR SHALL BE ENTITLED TO REVIEW THE CONTRACT FOR ONE BUSINESS DAY BEFORE SIGNING THE CONTRACT.

Lessee Signature ____________________ Co-Lessee Signature ____________________

Notice Regarding Assignment. As part of a like-kind exchange program, Toyota Motor Credit Corporation ("TMCC") has engaged TQI Exchange, LLC ("TQI") as a qualified intermediary. Lessor is hereby notified that TMCC has assigned to TQI its rights (but not its obligations) in agreements to acquire the Vehicle.

The Lessor hereby accepts this Lease and assigns to the Toyota Lease Trust all rights, title and interest in the Lease and in the Vehicle, and Lessor's rights under any guaranty executed in connection with this Lease, with full powers to the Toyota Lease Trust to collect and discharge all obligations related to this Lease, any guaranty, and this assignment.

Lessor LEXUS OF ENGLEWOOD By ____________ Title ____________ Date 03/13/2015

DEAL#107725

Addendum#	B82901
Plan Code	
Addendum Effective Date	03/13/2015
Addendum Purchase Price	

EXCESS WEAR & USE PROTECTION

Closed-End Motor Vehicle Lease Agreement Addendum

Selling Dealer Information

Name LEXUS OF ENGLEWOOD			Dealer Code
Address 53-59 ENGLE STREET			
City ENGLEWOOD	State NJ	Zip 07631	Telephone 2015683900

Customer/Lessee Information

Customer/Lessee Name MARLBOROUGH HEALTH CARE CENTER			
Co-Lessee Name OSTREICHER,MARVIN J			
Address 85 STAGE HARBOR RD			
City MARLBOROUGH	State CT	Zip 06445	Telephone (860)295-9531

Vehicle and Lease Agreement Information

Make LEXUS	Model RX350	Model Year 2015	Mileage 10
Vehicle Identification Number 2T2BK1BA7FC308145			
Lease Agreement Term (months) 27		Lease Agreement Start Date 03/13/2015	

Lessor Information

Lexus Financial Services, a division of Toyota Motor Credit Corporation ("LFS"), or Toyota Lease Trust ("TLT"), as described on Your Lease Agreement			
Address 260 INTERSTATE NO CIR			
City ATLANTA	State GA	Zip 30339-2111	Telephone

The purchase of this Closed-End Motor Vehicle Lease Agreement Addendum ("Addendum") is strictly voluntary. You agree to purchase the Excess Wear & Use Protection described in this Addendum for the additional charge stated above as the "Addendum Purchase Price." Excess Wear & Use Protection is not required in order for You to obtain credit, or to obtain any particular or more favorable lease terms. The terms stated herein shall have the meaning set forth in the Lease Agreement.

Your LFS or TLT Lease Agreement referenced above (the "Lease"), provides that You are responsible for the estimated cost to repair damage to the Vehicle that results from excessive wear and use during the Term of the Lease. This Addendum modifies the excess wear and use clause of the Lease. The term of this Addendum must equal the Lease Term.

Benefit Provided

In return for the payment of the Addendum Purchase Price, and subject to the terms, limitations, exclusions and conditions of this Addendum, We agree to waive Your responsibility for excess wear and use charges at lease end:

- Without any deductible,
- For each single event damage valued at $2,000 or less,
- For each missing part or equipment valued at $250 or less,
- Up to a maximum total waiver of $7,500

This is not an insurance product but a debt waiver. Excess Wear & Use Protection is not a substitute for collision or property damage insurance.

By Your signature below, You acknowledge that You have read and understand both sides of this Addendum, that You have received a completed copy of this Addendum, and that You accept this Addendum as part of the Lease. Please retain Your copy of this Addendum.

	03/13/2015
Signature of Customer/Lessee	Date
Signature of Co-Lessee	Date
	03/13/2015
Signature of Selling Dealer	Date

DESCRIPTION 2015 / 9424C RX 350
COLOR SILVER LINING MET
VIN 2T2BK1BA7FC308145
PORT/PLANT Lewiston, NY/TMMC

S T A N D A R D   E Q U I P M E N T

STANDARD FEATURES

* 3.5 Liter 270HP Four Cam 24-Valve V6 Engine
* with Variable Valve Timing (VVT-i)

* 6-Sp Automatic Transmission w/"Snow Mode"

* Full Time Active Torque Control All-Wheel Drive

* 18" Aluminum Alloy Wheels w/ All-Season Tires

* 10 Airbags: Driver & Front Passenger: Front, Knee
* & Side (6), Rear Side (2), Side Curtain (2)

* Anti-Lock Braking System (ABS) w/ Electronic
* Brakeforce Distribution (EBD) & Brake Assist

* Automatic On/Off Headlamps / Integrated Fog Lamps

* LED Daytime Running Lamps (DRL)

* Vehicle Theft-Deterrent Sys w/Engine Immobilizer

* Safety Connect: Automatic Collision Notification,
* Stolen Vehicle Location, Emergency Assist Button
* (SOS), and Enhanced Roadside Assistance
* (1-year trial subscription included)

* Lexus 12 speaker Premium Display Audio Syste
* HD Radio w/iTunes tagging, USB iPod/MP3 Cont
* SiriusXM Satellite Radio (90-day All Access trial
* subscription included)

* Backup Camera

* Auto Dual Zone Climate Control Sys w/Rear Ve

* 10-Way Power Front Seats

* Power Tilt-and-Telescopic Steering Column

* Reclining/Sliding 40/20/40 Split Rear Seat

* Power Back Door

* Rear View Mirror- Auto Dimming, Homelink Ga
* Door

* SmartAccess Passive Entry System

* Genuine Wood Interior Trim

* Multi-Information Display with Lexus Personaliz
* Settings, Trip Computer & Outside Temp Displa

* Tonneau Cover

EPA DOT Fuel Economy and Environment

Gasoline Vehicle

Fuel Economy

20 MPG combined city/hwy

18 city **24** highway

Small SUVS range from 17 to 33 MPG. The best vehicle rates 119 MPGe.

5.0 gallons per 100 miles

You **spend $ 2,000** more in fuel costs over 5 years compared to the average new vehicle.

Fuel Economy & Greenhouse Gas Rating (tailpipe only): 5 (scale 1 – 10 Best)

Smog Rating (tailpipe only): 5 (scale 1 – 10 Best)

This vehicle emits 445 grams CO2 per mile. The best emits 0 grams per mile (tailpipe only). Producing and distributing fuel also create emissions; learn more at fueleconomy.gov.

Actual results will vary for many reasons, including driving conditions and how you drive and maintain your vehicle. The average new vehicle gets 24 MPG and costs $11,000 to fuel over 5 years. Cost estimates are based on 15,000 miles per year at $3.50 per gallon. MPGe is miles per gasoline gallon equivalent. Vehicle emissions are a significant cause of climate change and smog.

fueleconomy.gov
Calculate personalized estimates and compare vehicles

5-DR SUV

Dealer Name / Address:
LEXUS OF ENGLEWOOD
53-59 ENGLE STREET
ENGLEWOOD NJ07631

Ship to: (Dealer, unless otherwise indicated)

INSTALLED OPTIONS

MANUFACTURER'S SUGGESTED RETAIL PRICE	**$ 42,370.00**
** Comfort Pkg: Xenon HID Headlamps, LED Foglamps, Rain-sensing wipers/Heated & Ventilated Fr Seats	1,390.00
** DVD Premium Audio for Navigation	N/C
** Navigation System with Voice Command Lexus Enform w/Destination Assist & eDestination SiriusXM NavTraffic, NavWeather, Stocks, Sports & Fuel prices (1-yr trial subscription included), App Suite (Complimentary)	1,915.00
** Intuitive Parking Assist	500.00
** Premium Package w/Blind Spot Monitor System: Leather Trim Interior, Blind Spot Monitor System, One-Touch Open/Close Moonroof, Power-folding Electrochromic Heated Outside Mirrors, Driver's Seat/Steering/Mirror Memory-3 settings, Roof Rails	2,760.00
** Wood & Leather Trimmed Steering Wheel & Shift Knob	330.00
** All Weather Floor Mats w/Cargo	225.00
** Cargo Net,Cargo Mat,Wheel Locks & Key Glove	254.00
SUB-TOTAL	$ 49,744.00
DELIVERY, PROCESSING AND HANDLING FEE	925.00
TOTAL	**$ 50,669.00**

GOVERNMENT 5-STAR SAFETY RATINGS

Overall Vehicle Score ★★★★★
ased on the combined ratings of frontal, side and rollover.
hould ONLY be compared to other vehicles of similar size and weight.

Frontal Crash Driver / Passenger

ased on the risk of injury in a frontal impact.
hould ONLY be compared to other vehicles of similar size and weight.

Side Crash Front seat / Rear seat

ased on the risk of injury in a side impact.

Rollover ★★★★
ased on the risk of rollover in a single-vehicle crash.

ratings range from 1 to 5 stars (★★★★★) with 5 being the highest.
ource: National Highway Traffic Safety Administration (NHTSA)
www.safercar.gov or 1-888-327-4236

APPLICABLE FEDERAL TAXES NOT INCLUDED

Manufacturer's suggested retail price includes manufacturer's recommended pre-delivery service.

License and title fees, state, local and applicable federal taxes, and dealer installed options and accessories are not included in the manufacturer's suggested retail price.

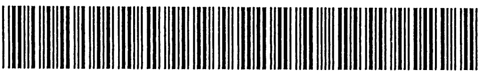
LEXUS NEW VEHICLE LIMITED WARRANTY
Limited warranty coverage highlights include
* 4YR / 50000 mile basic coverage
* 6YR / 70000 mile powertrain coverage
* 6YR / Unlimited mile corrosion perforation warranty

See your Warranty and Services Guide for details.

LEXUS IS PLEASED TO OFFER THE FOLLOWING OWNER SUPPORT PACKAGE WITH EACH NEW LEXUS
* 24 hour, 365 day/yr. roadside assistance plan
* Complimentary 1st and 2nd scheduled maintenance services
* Lodging for emergency breakdown 100 miles from home

An extended service contract may be available for this vehicle. Ask dealer for details

150209 706 JCB2



State of Connecticut
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CSP-7 Rev. 6/95

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Marlborough Health Care Center, I	200RH	9/30/2015	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 Blum Shapiro	29 S. Main St., West Hartford, CT 06127
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Review, preparation of Medicare and Medicaid cost reports, and year end tax services	$ 24,239
2		$
3		$
4		$
	Charge for Services Provided	$ 24,239

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

⊙ Yes ○ No   pg 15 1 d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Altus Global Trade Solutions	(800) 509-6060
2 Berchem & Moses P.C.	(203) 783-1200
3 Goldman Gruder & Wood	(203) 899-8900 Ext. 0000
4 Rogin Nassau, LLC	(860) 278-7480 Ext. 0000
5	

Address (*No. & Street, City, State, Zip Code*)
1 2400 Veterans Blvd Suite 300 Kenner LA 70062
2 75 Broad Street Milford, CT 06460
3 200 Connecticut Avenue Norwalk CT 06854
4 185 Asylym Street -22nd Floor Hartford CT 06103-3460
5

Services Provided by This Firm (*describe fully*)

1	Collections	$ 160
2	Labor	$ 5,310
3	Collections	$ 23,574
4	Reorganization/Refinance	$ 3,551
5		$
	Charge for Services Provided	$ 32,595

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

⊙ Yes ○ No   pg 15 1 e

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	8	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	120	120			120	120			120	120		
B. On last day of THIS report period	120	120			120	120			120	120		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	101	101			101	101			102	102		
B. As of midnight of THIS report period	99	99			102	102			99	99		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,678	4,678			3,360	3,360			1,318	1,318		
B. Medicaid (Conn.)	26,262	26,262			19,942	19,942			6,320	6,320		
C. Medicaid (other states)												
D. Private Pay	2,420	2,420			1,728	1,728			692	692		
E. State SSI for RCH												
F. Other (Specify)	3,239	3,239			2,245	2,245			994	994		
G. Total Care Days During Period (3A thru F)	36,599	36,599			27,275	27,275			9,324	9,324		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days	16	16			15	15			1	1		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	36,615	36,615			27,290	27,290			9,325	9,325		

2015 Cost Report - Page 8 attachment

Page 8, Line 3F: Total Number of Other Days Care Provided During the Period

Managed Care	1,026
Hospice	2,213
VA	-
	3,239

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CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	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	9	71		19				
Per Diem Rate								
a. One bed rm.	PPS	213.74		470.00				
b. Two bed rms.	PPS	213.74		410/435				
c. Three or more bed rms.	PPS	213.74		385.00				

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	1,569	1,569		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	631	631		
C. Other	11,583	11,583		
D. ***Total Physical Therapy Treatments***	13,783	13,783		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	357	357		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	59	59		
C. Other	961	961		
D. ***Total Speech Therapy Treatments***	1,377	1,377		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,493	1,493		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	461	461		
C. Other	11,053	11,053		
D. ***Total Occupational Therapy Treatments***	13,007	13,007		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	10	37

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

Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
	Total Cost and Hours					
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)	25,792	29				
2. Administrator(s) (Complete also Sec. III of Schedule A1)	124,576	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	169,032	8,770				
5. Dietary Service						
a. Head Dietitian	25,541	725				
b. Food Service Supervisor	56,627	2,080				
c. Dietary Workers	309,102	19,327				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	217,989	15,889				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	52,969	1,883				
b. Other Maintenance Workers	47,585	2,533				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	23,398	1,273				
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	165,225	3,582				
b. RN						
1. Direct Care	601,310	16,951				
2. Administrative**	160,336	4,561				
c. LPN						
1. Direct Care	848,379	28,547				
2. Administrative**						
d. Aides and Attendants	1,422,968	91,795				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	91,728	4,615				
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	128,298	4,277				
n. Marketing						
o. Other (Specify) See Attached Schedule	790	20				
A-13. Total Salary Expenditures	4,471,645	208,937				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH $	CCNH Hours	RHNS $	RHNS Hours	(Specify) $	(Specify) Hours
Director of Respiratory Therapy - Disallow	$ 790	20				
Total	$ 790	20	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH $	CCNH Hours	RHNS $	RHNS Hours	(Specify) $	(Specify) Hours
IV Therapy- Disallow	$ 11,570	Disallowed				
Consulting Fees - Rehabilitation Therapy and Ancillary	$ 16,453	Disallowed				
Consulting Fees - Nursing	$ 13,706	Disallowed				
Total	$ 41,729	Disallowed	$ -	-	$ -	-

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CSP-11 Rev. 10/2005

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
Marlborough Health Care Center, Inc.	200RH	9/30/2015	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										
Marvin J. Ostreicher, 184 Wildacre Ave, Lawrence, NY 11559	25,792			same as employees	Supervises operations, deals with DNS & financial management	29	A1	See attached		
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.

MARVIN J. OSTREICHER
TIME STUDY
Y/E SEPTEMBER 2015

	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	TOTAL
Augusta	3.00	8.50	7.00	4.00	7.50	7.50	1.50	4.50	7.50	5.50	4.50	6.50	**67.50**
Belair	5.00	5.50	7.00	3.00	5.50	4.50	2.50	2.00	3.00	5.00	6.50	5.00	**54.50**
Bloomfield	3.50	2.50	5.00	4.50	4.00	11.50	3.50	7.00	6.00	2.50	3.50	7.00	**60.50**
Brattleboro	5.50	4.00	3.00	4.00	4.50	4.50	1.00	3.50	8.00	3.00	4.50	7.00	**52.50**
Brentwood	2.50	9.50	2.50	7.00	3.00	7.00	7.50	3.50	3.00	4.00	2.50	4.00	**56.00**
Brewer	9.50	16.00	4.50	4.50	8.50	5.50	3.50	4.00	2.50	4.50	7.50	10.00	**80.50**
Bristol	3.50	2.00	4.50	12.50	6.50	3.00	3.50	6.50	8.50	4.00	1.00	4.50	**60.00**
Cambridge	5.50	4.00	5.00	16.00	5.00	6.00	1.50	7.00	4.50	3.00	3.50	8.50	**69.50**
Catskill	2.50	5.00	8.50	6.50	3.00	6.00	0.50	6.00	13.50	4.00	3.50	6.50	**65.50**
Cold Spring Hills	0.50	1.50	7.50	5.00	8.50	5.00	3.00	4.00	6.50	2.50	2.00	3.00	**49.00**
Colony	6.00	4.00	9.00	2.00	6.50	7.00	6.00	1.00	4.00	5.00	6.50	5.50	**62.50**
Country	7.00	8.50	3.00	7.00	3.50	6.00	4.00	6.50	9.00	5.00	5.50	10.50	**75.50**
Dover	2.00	0.50	9.50	5.00	2.50	4.00	2.00	1.00	4.50	6.00	1.50	3.50	**42.00**
Eastside	4.00	6.00	5.00	7.50	8.00	5.00	2.50	2.50	7.50	3.50	4.00	3.00	**58.50**
Eliot	0.50	5.00	9.00	4.50	2.00	2.00	2.50	2.50	6.50	1.50	4.50	2.50	**43.00**
Glen Falls	7.50	2.50	4.50	4.50	6.50	7.50	8.50	2.50	7.50	3.50	1.00	6.00	**62.00**
Hudson	1.00	7.00	12.50	2.50	6.00	1.50	4.00	0.50	12.00	4.50	2.50	5.50	**59.50**
Huntington	3.00	1.00	4.50	3.50	3.50	3.50	4.50	0.50	4.50	2.50	2.50	1.00	**34.50**
Kennebunk	1.00	6.50	6.50	2.00	2.00	7.50	3.00	0.50	5.50	2.50	12.00	0.00	**49.00**
Ludlowe	6.00	6.00	6.00	3.50	3.50	0.50	3.00	3.00	6.50	5.50	7.00	5.00	**55.50**
Maple View	4.50	5.50	9.50	3.00	6.00	7.50	6.50	5.50	2.00	9.00	3.50	5.00	**67.50**
Marlborough	0.50	1.00	3.00	5.50	2.00	2.50	3.50	0.50	3.00	4.00	1.00	2.00	**28.50**
Maywood	6.00	3.00	5.50	4.50	3.50	3.00	2.50	3.50	5.50	3.50	0.00	5.00	**45.50**
Milford	2.50	2.50	3.00	0.50	4.00	7.00	4.00	1.00	2.00	2.50	1.00	7.00	**37.00**
Newton Wellseley	4.50	4.50	3.00	4.00	3.00	7.50	2.50	0.00	2.00	3.00	0.00	1.50	**35.50**
Norway	5.50	2.00	2.50	2.00	3.50	5.50	5.00	3.50	1.50	5.00	5.50	4.50	**46.00**
Poughkeepsie	8.50	11.00	3.50	4.00	3.50	7.00	5.50	4.00	14.00	9.00	2.50	9.00	**81.50**
Regency	1.00	3.50	5.50	1.50	3.50	5.50	4.50	1.50	1.50	2.50	1.00	2.50	**34.00**
Reservoir	3.00	3.00	6.00	0.50	1.00	3.50	9.00	3.00	3.50	3.50	1.00	5.50	**42.50**
Riverside	3.00	6.50	4.50	1.50	5.50	2.00	5.50	4.00	4.00	4.50	7.00	2.00	**50.00**
Ross	7.00	5.50	3.50	5.50	6.00	5.00	6.50	6.50	4.00	2.50	4.50	2.00	**58.50**
Rutland	1.00	4.00	5.50	0.50	3.00	2.50	2.00	0.50	2.50	1.50	1.00	1.50	**25.50**
Sachem	4.50	2.50	5.00	4.00	2.50	7.00	2.50	2.50	2.00	3.00	5.50	2.50	**43.50**
Sands Point	0.50	3.00	4.00	0.50	6.50	7.00	6.50	0.50	2.50	2.50	2.50	2.50	**38.50**
Utica	2.00	4.50	3.50	4.50	4.50	6.00	3.00	0.50	6.00	6.50	2.50	4.00	**47.50**
Village Crest	0.50	3.00	4.50	3.50	4.50	7.00	9.50	3.00	2.50	5.00	4.00	0.50	**47.50**
Water's Edge	1.50	2.50	2.50	4.00	2.00	3.50	2.50	1.50	2.00	3.50	8.50	4.50	**38.50**
Westgate	1.00	2.00	3.50	7.50	4.50	3.00	3.50	0.00	1.00	0.00	2.00	4.50	**32.50**
Winship	5.50	4.50	9.50	4.00	4.00	3.00	4.00	1.00	3.50	4.00	1.50	11.00	**55.50**
Vacation	48.00	0.00	0.00	24.00	0.00	0.00	24.00	48.00	0.00	24.00	40.00	0.00	**208.00**
Sick	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
Personal	0.00	0.00	0.00	8.00	8.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**16.00**
Holiday	16.00	0.00	0.00	0.00	0.00	0.00	8.00	8.00	0.00	0.00	0.00	0.00	**32.00**
Total	**205.50**	**179.50**	**211.50**	**202.00**	**181.00**	**200.00**	**188.50**	**167.00**	**195.50**	**176.50**	**180.50**	**181.50**	**2269.00**

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	12	37

Name	Salary Paid: CCNH	Salary Paid: RHNS	Salary Paid: (Specify)	Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
Section III - Administrators* **										
See attached	124,576			same as employees	Supervises operations, deals with DNS & financial	2,080	A2	See attached		
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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	12	37

Name	Salary Paid: CCNH	Salary Paid: RHNS	Salary Paid: (Specify)	Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
Section III - Administrators* **										
Alan R. Bates (10/1/15-3/27/15)	53,924			same as employees	Management & supervision of healthcare facility	882	A2			
Richard A. Dimeola (3/28/15-5/1/15)	11,440			same as employees	Management & supervision of healthcare facility	208	A2			
Penni Martin (5/2/15-5/7/15)	Employee of management company			same as employees	Management & supervision of healthcare facility	40	A2			
Thomas Harris (5/8/15-9/30/15)	59,212			same as employees	Management & supervision of healthcare facility	950	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	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	2,459	70				
2. Dentist	6,315	Disallowed				
3. Pharmacist	2,268	12				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	249,064	4,654				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	64,800	288				
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	61,376	1,062				
b. Other						
10. Occupational Therapist						
a. Resident Care	235,880	4,796				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	22,967	309				
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	41,729	Disallowed				
B-13 Total Fees Paid in Lieu of Salaries	686,858	11,191				

* 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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CSP-14 Rev. 6/95

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
Marlborough Health Care Center, Inc.	200RH	9/30/2015	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Jane Querido, 177 Lexington Rd Glastonbury CT 06033	Consulting Fees- Dietary	○	◉	
Gerident Solutions, PO Box 290539, Wethersfield, CT 06129	Dentist	○	◉	
Procare LTC of Connecticut, 1492 Highland Ave, Cheshire, CT 06410	Pharmaceutical , Consulting Fees - Nursing, Therapy & Ancillary	◉	○	Common Ownership
Preferred Therapy Solutions, 850 Silas Deane Highway, Wethersfield, CT, 06109	PT/OT/ST/Consulting Fees- Therapy & Ancillary	◉	○	Common Ownership
CT Multispecialty, 100 Retreat Ave, Hartford, CT 06106	Medical Director	○	◉	
Dr. Thomas Larson, 78 East Wharf Rd, Madison, CT 06443	Medical Director	○	◉	
Middlesex Cardiology, 420 Saybrook Rd, Middletown, CT 06457-4700	Medical Director	○	◉	
Swallowing Diagnostics, P.O. Box 484, Avon, CT 06001	ST	○	◉	
Clinical Resources, 3338 Peachtree Road NE, Suite 102, Atlanta GA 30326	Pool RN - Nursing	○	◉	
IV Excellence, 32 Falls Ave, Oakville, CT, 06779	IV Nurse	○	◉	
Maple View Manor, 856 Maple Street, Rocky Hill, CT 06067	Consulting Fees- Nursing	◉	○	Affiliated Entity
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	197,411	197,411		
2. Disability Insurance	$				
3. Unemployment Insurance	$	85,565	85,565		
4. Social Security (F.I.C.A.)	$	331,147	331,147		
5. Health Insurance	$	454,031	454,031		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	11,421	11,421		
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*	$				
d. Accounting and Auditing	$	24,239	24,239		
e. Legal (*Services should be fully described on Page 7)*	$	32,595	32,595		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	26,259	26,259		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	43,001	43,001		
2. Cellular Phones	$	1,337	1,337		
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	$	666,776	666,776		
Subtotal	$	1,873,782	1,873,782		

* 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**

Marlborough Health Care Center, Inc.
9/30/2015

Attachment Page 15

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,873,782	1,873,782		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	1,724	1,724		
3. Gifts to Staff and Residents	$	5,991	5,991		
4. Employee Travel	$	6,933	6,933		
5. Education Expenses Related to Seminars and Conventions	$	7,553	7,553		
6. Automobile Expense (*not purchase or depreciation*)	$	1,586	1,586		
7. Other (*Specify*) See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$				
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$	27,732	27,732		
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	$	4,036	4,036		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	8,189	8,189		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	1,060	1,060		
9. Subscriptions	$	3,593	3,593		
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$	428,982	428,982		
13. Other (*Specify*) See Attached Schedule	$	151,489	151,489		
C-14 Total Administrative & General Expenditures	$	2,522,650	2,522,650		

* 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 Promotional Administration	$ 349		
Advertising Promotional Marketing	$ 27,383		
Total Other Advertising	$ 27,732	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 8,189		
Total Dues	$ 8,189	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Consulting Fees- Fiscal Operations	$ 1,737		
Consulting Fees- Marketing	$ 31,837		
Purchased Services- Fiscal Operations	$ 38,908		
Licenses and Permits- Administration	$ 315		
Penalties- Administration- Disallowed	$ 18		
Bank Charges- Administration-Disallowed	$ 57,495		
Background Checks - Administration	$ 3,796		
Crime Insurance- Administration- Disallowed	$ 819		
Miscellaneous Expenses- Administration-Disallowed	$ 13,467		
IT Services- Administration	$ 3,097		
Total Other Administrative and General	$ 151,489	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Marlborough Health Care Center, Inc.	License No. 200RH	Report for Year Ended 9/30/2015	Page of 17 | 37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
National Healthcare Associates, Inc.	428,982	See Attached	page 16, line M12

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

NHCA Manage

Report Date :10/1/2014 - 09/30/2015

		120	132	160	144	120	120	120	95	130	345	150
		Bloomfield	Bristol	Cambridge	Ludlowe	Maple View Manor	Marlborough	Milford	New Milford	Regency	Riverside	Water's Edge
	Intercompany adjustments (Troy)	(2,575.61)	(2,832.59)	(3,433.76)	(3,090.74)	(2,575.61)	(2,575.61)	(2,575.61)	(2,039.27)	(2,790.15)	(7,405.04)	(3,219.22)
310000-0000-00-000-0	Prior Period-National Healthcare Management- - -	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
400000-0000-00-000-0	Salary-National Healthcare Management- - -	282,655.95	310,874.90	376,848.26	339,185.53	282,655.95	282,655.95	282,655.95	225,193.75	306,200.82	812,641.54	353,304.40
400010-0000-00-000-0	Vacation-NY-Nat. Mgmt.- - -	1,567.09	1,722.79	2,088.64	1,880.49	1,567.09	1,567.09	1,567.09	1,241.08	1,697.60	4,505.76	1,958.10
401000-0000-04-000-0	FICA-National Healthcare Management-Fiscal Ope- -	18,621.21	20,480.28	24,826.55	22,345.41	18,621.21	18,621.21	18,621.21	14,742.89	20,172.35	53,536.57	23,275.64
401100-0000-04-000-0	FUI-National Healthcare Management-Fiscal Oper- -	454.22	499.51	605.53	545.03	454.22	454.22	454.22	359.66	492.04	1,305.89	567.74
401101-0000-00-000-0	FUI - NY-National Healthcare Management- - -	(3.74)	(4.11)	(4.99)	(4.49)	(3.74)	(3.74)	(3.74)	(2.96)	(4.05)	(10.75)	(4.68)
401200-0000-04-000-0	SUI-National Healthcare Management-Fiscal Oper- -	1,653.60	1,818.56	2,204.44	1,984.27	1,653.60	1,653.60	1,653.60	1,309.24	1,791.30	4,754.08	2,066.78
401202-0000-00-000-0	SUI - CT-National Healthcare Management- - -	(102.62)	(112.86)	(136.81)	(123.15)	(102.62)	(102.62)	(102.62)	(81.25)	(111.17)	(295.05)	(128.27)
401250-0000-00-000-0	NY MTA Tax-Nat. Mgmt.- - -	518.54	570.35	691.33	622.33	518.54	518.54	518.54	410.56	561.75	1,490.90	648.13
401300-0000-04-000-0	Health Insurance-National Healthcare-Fiscal Op- -	22,866.50	25,147.97	30,485.17	27,439.83	22,866.50	22,866.50	22,866.50	18,104.85	24,771.16	65,742.55	28,580.53
401400-0000-04-000-0	Workers Compensation-National Health-Fiscal Op- -	20.84	22.93	27.79	25.01	20.84	20.84	20.84	16.50	22.59	59.94	26.05
401600-0000-04-000-0	Disability Expense-National Healthca-Fiscal Op- -	502.39	552.47	669.75	602.81	502.39	502.39	502.39	397.73	544.21	1,444.30	627.88
401700-0000-04-000-0	Pension-National Healthcare Manageme-Fiscal Op- -	4,667.41	5,133.07	6,222.49	5,600.86	4,667.41	4,667.41	4,667.41	3,695.46	5,056.17	13,419.02	5,833.72
401800-0000-04-000-0	Employee Benefits - Other-National H-Fiscal Op- -	682.30	750.45	909.66	818.76	682.30	682.30	682.30	540.18	739.16	1,961.70	852.91
402000-0000-04-000-0	Holiday Expense-National Healthcare -Fiscal Op- -	1,473.35	1,620.36	1,964.25	1,768.02	1,473.35	1,473.35	1,473.35	1,166.53	1,596.08	4,235.95	1,841.54
410000-0000-04-000-0	Supplies-National Healthcare Managem-Fiscal Op- -	3,105.44	3,415.57	4,140.54	3,726.84	3,105.44	3,105.44	3,105.44	2,459.03	3,364.44	8,929.00	3,881.87
410000-0000-08-000-0	Supplies-National Healthcare Managem-Maintenan- -	15.27	16.78	20.36	18.33	15.27	15.27	15.27	12.09	16.54	43.90	19.09
410000-0000-09-000-0	Supplies-National Healthcare Managem-Housekeep- -	33.37	36.69	44.48	40.04	33.37	33.37	33.37	26.44	36.15	95.94	41.70
410000-0000-12-000-0	Supplies-National Healthcare Manageme-Security- -	2.53	2.79	3.38	3.04	2.53	2.53	2.53	2.01	2.74	7.28	3.17
411000-0000-04-000-0	Food-National Healthcare Management-Fiscal Ope- -	19.64	21.61	26.19	23.57	19.64	19.64	19.64	15.55	21.28	56.46	24.55
431000-0000-03-000-0	Consulting Fees-National Healthcare -Administr- -	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
431000-0000-04-000-0	Consulting Fees-National Healthcare -Fiscal Op- -	7,030.70	7,732.13	9,373.07	8,436.78	7,030.70	7,030.70	7,030.70	5,566.63	7,616.30	20,213.47	8,787.48
432000-0000-03-000-0	Accounting Fees-National Healthcare -Administr- -	2,283.74	2,511.85	3,044.88	2,740.45	2,283.74	2,283.74	2,283.74	1,807.96	2,473.99	6,565.68	2,854.65
433000-0000-03-000-0	Legal Fees-National Healthcare Manag-Administr- -	1,771.23	1,947.98	2,361.37	2,125.50	1,771.23	1,771.23	1,771.23	1,402.38	1,918.79	5,092.41	2,213.88
433100-0000-03-000-0	Legal Fees - Labor-National Healthca-Administr- -	(611.80)	(672.84)	(815.64)	(734.16)	(611.80)	(611.80)	(611.80)	(484.40)	(662.76)	(1,758.96)	(764.68)
440000-0000-03-000-0	Purch Services-National Healthcare M-Administr- -	8,257.92	9,082.05	11,009.45	9,909.64	8,257.92	8,257.92	8,257.92	6,538.34	8,946.10	23,742.37	10,321.68
440000-0000-08-000-0	Purch Services-National Healthcare M-Maintenan- -	688.71	757.44	918.16	826.58	688.71	688.71	688.71	545.29	746.15	1,980.08	860.81
440000-0000-09-000-0	Purch Services-National Healthcare M-Housekeep- -	900.89	990.69	1,200.92	1,080.87	900.89	900.89	900.89	713.22	975.72	2,589.66	1,125.86
440000-0000-12-000-0	Purch Services-National Healthcare Ma-Security- -	53.36	58.71	71.17	64.05	53.36	53.36	53.36	42.29	57.83	153.47	66.73
440001-0000-08-000-0	Ground Services-Nat. Mgmt.-Maintenance- -	366.53	403.10	488.63	439.78	366.53	366.53	366.53	290.28	397.06	1,053.73	458.14
441000-0000-03-000-0	Computer Expense-National Healthcare-Administr- -	5,676.21	6,242.55	7,567.30	6,811.14	5,676.21	5,676.21	5,676.21	4,494.20	6,148.82	16,319.02	7,094.38
442000-0000-08-000-0	Pest Control-Nat. Mgmt.-Maintenance- -	20.00	21.95	26.65	23.98	20.00	20.00	20.00	15.81	21.62	57.43	24.95
452000-0000-25-000-0	Equipment Rental-National Healthcare-Fiscal Op- -	2,706.81	2,976.72	3,608.72	3,248.36	2,706.81	2,706.81	2,706.81	2,143.04	2,932.26	7,782.25	3,383.22
452100-0000-25-000-0	Equipment Rental - Interes-National -Fiscal Op- -	(1,194.52)	(1,313.70)	(1,592.51)	(1,433.42)	(1,194.52)	(1,194.52)	(1,194.52)	(945.77)	(1,294.02)	(3,434.31)	(1,493.01)
461000-0000-03-000-0	Telephone-National Healthcare Manage-Administr- -	2,712.85	2,983.31	3,616.64	3,255.35	2,712.85	2,712.85	2,712.85	2,147.76	2,938.63	7,799.37	3,390.65
461100-0000-03-000-0	Telephone - Cell-National Healthcare-Administr- -	2,006.26	2,206.37	2,674.65	2,407.48	2,006.26	2,006.26	2,006.26	1,588.40	2,173.30	5,767.96	2,507.54
462000-0000-25-000-0	Electric-National Healthcare Manageme-Property- -	1,529.87	1,682.44	2,039.55	1,835.81	1,529.87	1,529.87	1,529.87	1,211.25	1,657.25	4,398.44	1,912.13
463000-0000-25-000-0	Gas-National Healthcare Management-Property- -	443.34	487.58	591.08	532.03	443.34	443.34	443.34	351.02	480.27	1,274.68	554.15
466000-0000-25-000-0	Water-National Healthcare Management-Property- -	72.43	79.68	96.60	86.95	72.43	72.43	72.43	57.36	78.50	208.30	90.55
471000-0000-25-000-0	Rent-National Healthcare Management-Property- -	6,469.09	7,114.48	8,624.40	7,762.81	6,469.09	6,469.09	6,469.09	5,121.91	7,007.84	18,598.85	8,085.55
472000-0000-25-000-0	Personal Property Taxes-National Hea-Fiscal Op- -	516.53	567.96	688.58	619.75	516.53	516.53	516.53	408.91	559.46	1,484.89	645.51
473000-0000-04-000-0	Real Estate Taxes-National Healthcar-Fiscal Op- -	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
473000-0000-25-000-0	Real Estate Taxes-National Healthcar-Fiscal Op- -	3,426.41	3,768.25	4,568.02	4,111.67	3,426.41	3,426.41	3,426.41	2,712.89	3,711.81	9,851.10	4,282.62
484000-0000-04-000-0	Amort Exp - LHI-National Healthcare -Fiscal Op- -	1,327.68	1,460.13	1,770.03	1,593.23	1,327.68	1,327.68	1,327.68	1,051.22	1,438.25	3,817.12	1,659.43
484100-0000-04-000-0	Amortization Exp- LHI ALL-Nat. Mgmt.-Fiscal Op- -	13.35	14.69	17.82	16.04	13.35	13.35	13.35	10.59	14.51	38.39	16.71
486000-0000-04-000-0	Dep Exp - Moveable Equip-National He-Fiscal Op- -	7,709.31	8,478.48	10,277.90	9,251.17	7,709.31	7,709.31	7,709.31	6,103.96	8,351.46	22,164.73	9,635.76
491000-0000-03-000-0	Dues and Subscriptions-National Heal-Administr- -	257.10	282.74	342.75	308.54	257.10	257.10	257.10	203.56	278.48	739.13	321.30
500000-0000-03-000-0	Licenses and Permits-National Health-Administr- -	21.32	23.43	28.41	25.57	21.32	21.32	21.32	16.88	23.08	61.27	26.63
501000-0000-03-000-0	Advertising Employment-National Heal-Administr- -	8,395.23	9,232.87	11,192.42	10,074.37	8,395.23	8,395.23	8,395.23	6,647.11	9,094.54	24,136.88	10,493.18
501100-0000-03-000-0	Advertising Promotional-National Hea-Administr- -	7,253.58	7,977.65	9,670.79	8,704.30	7,253.58	7,253.58	7,253.58	5,742.94	7,857.89	20,854.26	9,066.65
503000-0000-03-000-0	Interest-National Healthcare Managem-Administr- -	403.92	470.31	570.07	513.28	403.92	403.92	403.92	338.59	463.27	1,229.67	534.49
503500-0000-03-000-0	Penalties-National Healthcare Manage-Administr- -	3.16	133.97	162.47	146.25	3.16	3.16	3.16	96.41	131.87	350.19	152.24
503600-0000-03-000-0	Bank Charges-Nat. Mgmt.-Administration- -	931.40	1,024.35	1,241.72	1,117.67	931.40	931.40	931.40	737.43	1,008.96	2,677.79	1,164.16
504000-0000-03-000-0	Postage-National Healthcare Manageme-Administr- -	984.22	1,082.49	1,312.19	1,181.11	984.22	984.22	984.22	779.28	1,066.23	2,829.69	1,230.12
509000-0000-03-000-0	Seminars-National Healthcare Managem-Administr- -	2,053.89	2,258.79	2,738.16	2,464.68	2,053.89	2,053.89	2,053.89	1,626.20	2,224.99	5,905.05	2,567.16
510000-0000-03-000-0	Liability Insurance-National Healthc-Administr- -	2,748.78	3,022.96	3,664.56	3,298.53	2,748.78	2,748.78	2,748.78	2,176.33	2,977.70	7,902.80	3,435.67
511000-0000-03-000-0	Auto Insurance-National Healthcare M-Administr- -	963.25	1,059.28	1,284.11	1,155.92	963.25	963.25	963.25	762.68	1,043.51	2,769.34	1,203.91
512000-0000-03-000-0	Umbrella Insurance-National Healthca-Administr- -	790.75	869.69	1,054.24	948.94	790.75	790.75	790.75	626.14	856.65	2,273.52	988.38
513000-0000-03-000-0	Crime Insurance-National Healthcare -Administr- -	23.14	25.48	30.93	27.80	23.14	23.14	23.14	18.37	25.12	66.63	28.94
517000-0000-03-000-0	Wor`kmans Comp Insurance-National	391.28	430.37	521.69	469.60	391.28	391.28	391.28	309.82	423.89	1,125.10	489.10
520000-0000-03-000-0	Auto Expense-National Healthcare Man-Administr- -	38.53	42.39	51.40	46.24	38.53	38.53	38.53	30.50	41.81	110.77	48.10
520100-0000-03-000-0	Auto Lease Expense-National Healthca-Administr- -	2,696.65	2,965.51	3,595.01	3,235.78	2,696.65	2,696.65	2,696.65	2,134.84	2,921.04	7,752.31	3,369.97
521000-0000-03-000-0	Travel Expense-National Healthcare M-Administr- -	4,708.93	5,179.26	6,278.29	5,650.74	4,708.93	4,708.93	4,708.93	3,728.03	5,101.27	13,538.39	5,885.96
522000-0000-03-000-0	Hotel Expense-National Healthcare Ma-Administr- -	4,686.54	5,154.73	6,248.54	5,623.81	4,686.54	4,686.54	4,686.54	3,710.28	5,076.90	13,473.77	5,858.17
540000-0000-31-000-0	Donations-National Healthcare Manage-Misc. Exp- -	54.63	60.08	72.83	65.55	54.63	54.63	54.63	43.25	59.18	157.05	68.28
541000-0000-03-000-0	Misc. Expense-Nat. Mgmt.-Administration- -	136.48	150.07	181.96	163.77	136.48	136.48	136.48	108.05	147.83	392.41	170.59
541000-0000-31-000-0	Misc. Expense-National Healthcare Ma-Misc. Exp- -	594.10	653.34	792.13	712.97	594.10	594.10	594.10	470.42	643.67	1,708.20	742.55
541001-0000-03-000-0	Political Contributions-Nat. Mgmt.-Administrat- -	5.46	6.01	7.28	6.56	5.46	5.46	5.46	4.33	5.92	15.71	6.83
542000-0000-31-000-0	Corporate Tax - State-National Healt-Misc. Exp- -	199.40	219.30	265.85	239.31	199.40	199.40	199.40	157.90	216.00	573.31	249.23
543000-0000-31-000-0	Corporate Tax - Federal-National Hea-Misc. Exp- -	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
544000-0000-25-000-0	Sales Tax - Conn.-National Healthcar-Fiscal Op- -	285.82	6,189.53	7,502.39	6,752.24	285.82	285.82	285.82	4,454.53	6,095.81	16,176.78	7,033.01
	Sum	428,982.14	477,834.12	579,240.88	521,357.16	428,982.14	428,982.14	428,982.14	345,388.48	470,655.76	1,249,100.09	543,050.94
	Page 16 line m12 on Cost Report	428,982.00	477,834.00	579,241.00	521,357.00	428,982.00	428,982.00	428,982.00	345,388.00	470,656.00	1,249,100.00	543,051.00
	Variances	0.14	0.12	(0.12)	0.16	0.14	0.14	0.14	0.48	(0.24)	0.09	(0.06)

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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
Marlborough Health Care Center, Inc.	200RH	9/30/2015	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	235,063	235,063		
2. Non-Food Supplies	$	23,877	23,877		
3. Other (*Specify*)_____________________	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	12,069	12,069		
c. Management Services**	$				
d. Other (*Specify*)_________________________	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	271,009	271,009		

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

	Question	Yes	No	
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.
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?	○ 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)

(See Note on Page 5)

Name of Facility	License No.	Report for Year Ended	Page of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	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. $	9,996	9,996		
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)*	$	129,382	129,382		
c. Management Services**	$				
d. Other (*Specify*) Supplies $109; Diapers $40,421	$	40,530	40,530		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	179,908	179,908		

3F. Laundry Questionnaire			
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
Marlborough Health Care Center, Inc.	200RH	9/30/2015	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced					
a. In-House Care	by Personnel					
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	31,383	31,383		
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*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	31,383	31,383		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	299,178	299,178		
b. Medicine Cabinet Drugs		$	20,420	20,420		
c. Medical and Therapeutic Supplies		$	84,961	84,961		
d. Ambulance/Limousine***		$	3,787	3,787		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	23,028	23,028		
f. X-rays and Related Radiological Procedures***		$	26,359	26,359		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	30,501	30,501		
i. Recreation		$	27,924	27,924		
j. Other (Specify)**** See Attached Schedule		$	27,686	27,686		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	543,844	543,844		

* 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)
Purchased Services- Nursing	$ 2,590		
Equipment Rental- Nursing	$ 2,959		
Equipment Rental- Rehabilitation Therapy and Ancilliary	$ 15,499		
Flu Vaccine	$ 6,638		
Total Other Resident Care	$ 27,686	$ -	$ -

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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
Marlborough Health Care Center, Inc.	200RH	9/30/2015	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers: Yes	Related ** to Owners, Operators, Officers: No	Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***: CCNH	RHNS	(Specify)	Pg	Line
Aqua Compliance	290 Buckley Road, Salem, CT 06420	○	⊙		Cesspool Maintenance	34,542			22	6a
MJ Daly LLC	110 Mattatuck Heights, Waterbury, CT, 06705	○	⊙		HVAC	41,539			22	6a
Med-Apparel Service Inc.	Pkwy, Mt. Vernon, NY 10550	○	⊙		Laundry	32,424			19	3b
Unitex Textile Rental	Pkwy, Mt. Vernon, NY 10550	○	⊙		Laundry	96,951			19	3b
All Waste, Inc.	143 Murphy Rd, Hartford, CT 06114	○	⊙		Garbage Pickup	29,975			22	6f
ADP	P.O. Box 842875, Boston, MA	○	⊙		Payroll Service	13,670			16	m13
Kinsley Power Systems	14 Connecticut South Dr East Granby CT 06026	○	⊙		Generator Maintenance	10,310			22	6a
Proline	PO Box 150473, Hartford CT 06145	○	⊙		Dietary Repairs & Maintenance	10,265			18	2b
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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
Marlborough Health Care Center, Inc.	200RH	9/30/2015	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	119,706	119,706		
b. Heat	$	49,897	49,897		
c. Light & Power	$	124,204	124,204		
d. Water	$				
e. Equipment Lease (*Provide detail on page 6*)	$	17,186	17,186		
f. Other (*itemize*)	$	83,016	83,016		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	394,009	394,009		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$				
d. Movable Equipment	$	19,430	19,430		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	19,430	19,430		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	108,671	108,671		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	108,671	108,671		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	360,000	360,000		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	82,054	82,054		
c. Personal property taxes	$	9,057	9,057		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	579,212	579,212		

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

Marlborough Health Care Center, Inc. Attachment Page 22
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Schedule of Other Repairs and Maintenance

Description	**CCNH**	**RHNS**	**(Specify)**
Purchased Services- Security	$ 1,842		
Ground Services- Maintenance	$ 17,670		
Septic Services- Maintenance	$ 26,025		
Pest Control- Maintenance	$ 3,030		
Carting- Maintenance	$ 33,627		
Background Check- Security	$ 48		
Supplies- Security	$ 136		
Short Term Lease - Pitney Bowes Mailing Machine	$ 638		
Total Other Repairs and Maintenance	$ 83,016	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	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								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	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.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					905,366		905,366	838,595	SL	Various	15,197	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					62,235		62,235		SL	Various	4,233	
D-3. Subtotal												19,430
E. ***Total Depreciation***												19,430

Marlborough Health Care Center, Inc.
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Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Land Improvements		$ -		$ -	*
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:					
Total additions for Non-Movable Equipment		$ -		$ -	*
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:					
11/30/2014	DYNO APM with LAL	$ 1,383	5	$ 231	
12/31/2014	DYNO APM with LAL	$ 1,300	5	$ 195	
1/31/2015	76/80" Electric Bed	$ 1,386	15	$ 69	
1/31/2015	Penberry Exhaust	$ 4,291	10	$ 322	
1/31/2015	Furniture	$ 3,084	12	$ 193	
2/28/2015	Desktop	$ 896	5	$ 120	
2/28/2015	3 Desktop	$ 2,788	5	$ 372	
3/31/2015	Kit Blood Pressure/Thermometer	$ 2,045	7	$ 170	
3/31/2015	Bedroom Set	$ 1,930	15	$ 75	
3/31/2015	Fant Variance	$ 2,675	5	$ 312	
3/31/2015	Furniture	$ 24,953	10	$ 1,456	
3/31/2015	Desktop	$ 898	5	$ 105	
4/30/2015	Desktop	$ 898	5	$ 90	
4/30/2015	Series Clocks	$ 2,230	10	$ 112	
4/30/2015	Element Gasket	$ 947	5	$ 95	
4/30/2015	Food Processor	$ 1,426	10	$ 72	
5/31/2015	Small Stationary Hyd	$ 718	10	$ 30	
5/31/2015	Dual Motor Upright V	$ 657	8	$ 34	
7/31/2015	Fujitsu Scanner	$ 914	5	$ 46	
7/31/2015	3 TV's	$ 632	5	$ 32	
7/31/2015	5 Ton Condenser	$ 3,403	15	$ 57	
8/31/2015	80" Electric Bed	$ 1,531	15	$ 17	
9/30/2015	Desktop	$ 826	5	$ 14	
9/30/2015	Vents	$ 615	10	$ 5	
9/30/2015	Rebuild Kit	$ 1,109	10	$ 9	
9/30/2015	H&R Healthcare	$ (1,300)			
Total additions for Movable Equipment		$ 62,235		$ 4,233	*
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:					
11/30/2014	Paint	$ 1,614	5	$ 296	
11/30/2014	Hot Water Storage Tank	$ 5,103	10	$ 468	
11/30/2014	HVAC-Copper Pipe	$ 2,814	10	$ 258	
12/31/2014	Renovations Painting	$ 1,735	10	$ 145	
1/31/2015	Paint	$ 2,551	10	$ 191	
1/31/2015	Carved Sign	$ 4,366	10	$ 327	
1/31/2015	Painting	$ 16,555	10	$ 1,242	
2/28/2015	Lobby Floor Carpet	$ 2,375	5	$ 317	
2/28/2015	Painting	$ 5,791	10	$ 386	
2/28/2015	Hot Water Heater	$ 15,669	20	$ 522	
3/31/2015	Painting	$ 4,227	10	$ 247	
4/30/2015	Painting	$ 2,438	10	$ 122	
4/30/2015	HVAC Tubing	$ 3,945	10	$ 197	
4/30/2015	HVAC Piping	$ 2,552	10	$ 128	
Total additions for Leasehold Improvement		$ 71,735		$ 4,846	*
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
Marlborough Health Care Center, Inc.	200RH	9/30/2015	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.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period				2,285,319	1,395,625	SL		103,825	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				71,735		SL		4,846	
C-4. Subtotal									108,671
D. ***Total Amortization***									108,671

* 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
Marlborough Health Care Center, Inc.	200RH	9/30/2015	25 | 37

11. Property Questionnaire

Part A

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

○ Yes ⊙ No

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

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

Description	Total			
1. Date Land Purchased				
2. Date Structure Completed				
3. If **NOT** Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	120			
6. Square Footage	42,799			
7. Acquisition Cost				
a. Land	186,373			
b. Building	1,480,167			
Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained	08/17/12			
c. Interest Rate for the Cost Year	3.182% + LIBOR			
d. Term of Mortgage (number of years)	18.5			
e. Amount of Principal Borrowed	3,314,802			
f. Principal balance outstanding as of 9/30/2015	3,254,647			
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
Marlborough Health Care Center, Inc	200RH	9/30/2015	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*)

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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
Marlborough Health Care Center, I	200RH	9/30/2015	27 | 37

Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment 1. Automotive Equipment			$				
A. Item	Rate	Amount					
Lender							
Address of Lender							
2. Other (*Specify*)			$				
A. Item	Rate	Amount					
Lender							
Address of Lender							
B. Item	Rate	Amount					
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)			$				
12. D. Other Interest Expense (*Specify*) Interest - Admin: $2,672; Interest - Property: $167			$	2,839	2,839		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)			$	2,839	2,839		
14. Insurance a. Insurance on Property (buildings only)			$	25,378	25,378		
b. Insurance on Automobiles			$	6,773	6,773		
c. Insurance other than Property (as specified above) 1. Umbrella (*Blanket Coverage*)			$	10,688	10,688		
2. Fire and Extended Coverage			$				
3. Other (*Specify*) General Liability Insurance			$	40,213	40,213		
14d. ***Total Insurance Expenditures (14a + b + c)***			$	83,052	83,052		
15. ***Total All Expenditures (A-13 thru C-14)***			$	9,766,409	9,766,409		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	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.	10	12M	Salaries not related to Resident Care	$	12,370	12,370		
3.			Occupational Therapy	$				
4.			Other - See attached Schedule	$	4,636	4,636		
Page 13 - Professional Fees								
5.	13	8c	Resident Care Physicians **	$				
6.	13	10a	Occupational Therapy	$	235,880	235,880		
7.			Other - See attached Schedule	$	67,081	67,081		
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.	15	1c	Bad Debts	$				
10.	15	1c	Accounting & Legal	$	27,285	27,285		
11.			Telephone	$				
12.	15	1h2	Cellular Telephone	$				
13.			Life insurance premiums on the life of Owners, Partners, Operators	$				
14.			Gifts, flowers and coffee shops	$				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	$				
16.			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)	$	1,586	1,586		
18.	16	m3	Unallowable Advertising *	$	27,732	27,732		
19.	15	1j	Income Tax / Corporate Business Tax	$				
20.	16	m10	Fund Raising / Contributions	$				
21.	16	m12	Unallowable Management Fees	$	178,645	178,645		
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	114,009	114,009		
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)	$	669,225	669,225		

* 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)
10	A12o	Director of Respiratory Therapy	$ 790		
10	A2	Administrator Severance	$ 3,846		
Total Other Salaries Adjustment			$ 4,636	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	b2	Dentist	$ 6,315		
13	b12	IV Therapy- Disallow	$ 11,570		
13	b12	Consulting Fees - Rehab Therapy and Ancillary	$ 16,453		
13	b12	Consulting Fees - Nursing	$ 13,706		
13	B8a	Medical Director (over the limit)	$ 19,037		
Total Other Fees Adjustments			$ 67,081	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	L3	Gifts to Staff	5,991		
16	m13	Bank Charges	57,495		
16	m13	Miscellaneous Expenses	13,467		
16	m13	Penalties	18		
16	m13	Crime Insurance	819		
16	M8a	Dues - Chamber of Commerce	1,060		
15	1a43,4,5,7	Benefits on Salaries not Related to Resident Care	2,986		
16	m13	Consulting Fees - Marketing	31,837		
16	m9	Newspaper Subsctiption	336		
Total Other A&G Adjustments			$ 114,009	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
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Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	669,225	669,225		
Page 20 - Resident Care Supplies*								
27.	20	5a2	Prescription Drugs	$	299,178	299,178		
28.	20	5d	Ambulance/Limousine	$	3,787	3,787		
29.	20	5f	X-rays, etc	$	26,359	26,359		
30.	20	5h	Laboratory	$	30,501	30,501		
31.	20	5c	Medical Supplies	$	6,653	6,653		
32.	20	5e2	Oxygen (non emergency)	$	23,028	23,028		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	39,548	39,548		
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$				
36.			Depreciation on Unallowable Motor Vehicles	$				
37.	22	10c	Unallowable Property and Real Estate Taxes	$	762	762		
38.			Rental of Building Space or Rooms	$				
39.			Other - See Attached Schedule	$	12,962	12,962		
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	$	9,216	9,216		
Not For Profit Providers Only								
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	$				
51.			***Total Amount of Decrease (Items 1 - 50)***	$	1,121,219	1,121,219		

*** 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

Marlborough Health Care Center, Inc.
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Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Equipment Rental - Rehabilitation Therapy and Ancilliary	$ 15,499		
20	5j	Equipment Rental - Nursing	$ 2,959		
20	5j	Purchased Services- Nursing	$ 80		
20	5j	Flu Vaccine	$ 6,638		
20	20 / 5a2/b/c	Procare LTC Pharmacy of CT (Disallowance of markups)	$ 731		
20	5c	IV Therapy Supplies	$ 5,153		
20	5i	Cable TV Expense - Resident Rooms	$ 8,488		
Total Other Ancillary Costs			$ 39,548	$ -	$ -

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)
27	14b	Auto Insurance	$ 6,773		
22	6e	Auto Leases	$ 7,031		
23	D2c	Depreciation on Mattresses	$ 458		
23	D2c	Credit on Asset - Not Included in Depreciation Disallowance	$ (1,300)		
Total Other Property Adjustments			$ 12,962	$ -	$ -

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30a	Other Rev	Miscellaneous Other Income	$ 3,171		
30a	Other Rev	SCA Rebate	$ 1,923		
30	IV5	Interest Income	$ 1,485		
27	12D	Interest	$ 2,637		
Total Other Adjustments			$ 9,216	$ -	$ -

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	10,553,016	10,553,016		
b. Medicaid Room and Board Contractual Allowance **	$	(4,951,785)	(4,951,785)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,912,669	1,912,669		
b. Medicare Room and Board Contractual Allowance **	$	452,779	452,779		
4. a. Private-Pay Residents and Other	$	2,354,078	2,354,078		
b. Private-Pay Room and Board Contractual Allowance **	$	(554,350)	(554,350)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	287,882	287,882		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(287,163)	(287,163)		
c. Prescription Drugs - Non-Medicare	$				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$				
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	443,918	443,918		
b. Physical Therapy - Medicare Contractual Allowance **	$	(393,490)	(393,490)		
c. Physical Therapy - Non-Medicare	$	27,862	27,862		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(25,241)	(25,241)		
4. a. Speech Therapy - Medicare	$	108,573	108,573		
b. Speech Therapy - Medicare Contractual Allowance **	$	(103,362)	(103,362)		
c. Speech Therapy - Non-Medicare	$	6,032	6,032		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(7,366)	(7,366)		
5. a. Occupational Therapy - Medicare	$	451,949	451,949		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(373,818)	(373,818)		
c. Occupational Therapy - Non-Medicare	$	18,719	18,719		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(19,897)	(19,897)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	9,901,005	9,901,005		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	1,485	1,485		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	6,065	6,065		
V. Total Other Revenue (1 thru 8)	$	7,550	7,550		
VI. Total All Revenue (III +V)	$	9,908,555	9,908,555		

* *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)
30, Line II6a	Medicare Pt A Lab	$ 30,816		
30, Line II6a	Medicare Pt A X-Ray	$ 30,087		
30, Line II6a	Medicare Pt A IV Therapy	$ 9,527		
30, Line II6a	Medicare Pt A Contra Other	$ (73,403)		
30, Line II6a	Medicare Pt A Ambulance	$ 2,973		
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
30, Line IV5	Interest Income		$ 1,485		
Total Interest Income			$ 1,485	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30, Line IV8	Miscellaneous Other Income	$ 3,171		
30, Line IV8	SCA Rebate	$ 1,923		
30, Line IV8	United Health Care Refund	$ 8,515		
30, Line IV8	Prior Period other	$ (7,540)		
30, Line IV8	General Insurance Recovery - Sales Tax	$ (4)		
Total Other Revenue		$ 6,065	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	31	37

Account			Amount
Assets			
A. Current Assets			
1. Cash (*on hand and in banks*)			$ 659,751
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			$ 1,364,839
3. Other Accounts Receivable (Excluding Owners or Related Parties)			$
4 Inventories			$ 15,841
5. Prepaid Expenses			$ 104,684
a. Insurance		20,028	
b. Taxes (personal property, real estate, corp)		23,289	
c. Management fees		48,267	
d. Other		13,100	
6. Interest Receivable			$
7. Medicare Final Settlement Receivable			$
8. Other Current Assets (*itemize*)			$ 150,319
Patient Funds		42,988	
Due from Related Parties		107,331	
A-9. ***Total Current Assets*** (Lines A1 thru 8)			$ 2,295,434
B. Fixed Assets			
1. Land			$
2. Land Improvements	*Historical Cost		$
	Accum. Depreciation	Net	
3. Buildings	*Historical Cost		$
	Accum. Depreciation	Net	
4. Leasehold Improvements	*Historical Cost	2,357,054	$ 852,758
	Accum. Depreciation	1,504,296 Net	
5. Non-Movable Equipment	*Historical Cost		$
	Accum. Depreciation	Net	
6. Movable Equipment	*Historical Cost	967,601	$ 109,576
	Accum. Depreciation	858,025 Net	
7. Motor Vehicles	*Historical Cost		$
	Accum. Depreciation	Net	
8. Minor Equipment-Not Depreciable			$
9. Other Fixed Assets (*itemize*)			$ (5,592)
Miscellaneous Plug to balance F/S		(5,592)	
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)			$ 956,742

* 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
Marlborough Health Care Center, Inc.	200RH	9/30/2015	32 | 37

Account				Amount
			Total Brought Forward:	$ 3,252,176
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*)				$ 11,500
Security Deposits		11,500		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 11,500
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 3,263,676

* 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
Marlborough Health Care Center, Inc.	200RH	9/30/2015	33 | 37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 1,782,478
2. Notes Payable (*itemize*)	$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

Account	Amount
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)	$ 300,173
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$
7. Medicare Final Settlement Payable	$
8. Medicare Current Financing Payable	$
9. Mortgage Payable (*Current Portion*)	$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)	$
11. Accrued Income Taxes*	$
12. Other Current Liabilities (*itemize*)	$ 1,083,298
Accrued expenses 137,822	
Due to related party 736,283	
Patient personal funds 42,988	
Accrued Resident User Fee 166,205	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 3,165,949

* 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
Marlborough Health Care Center, Inc.	200RH	9/30/2015	34 | 37

Account	Amount
Total Brought Forward:	3,165,949
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

Account	Amount
4. Other Long-Term Liabilities (*itemize*)	$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 3,165,949

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

Name of Facility	License No.	Report for Year Ended	Page of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	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				$	1,000
3. Paid-in Surplus				$	
4. Treasury Stock				$	
5. Cumulated Earnings				$	(45,419)
6. Gain or Loss for Period	10/1/2014	thru	9/30/2015	$	142,146
7. Total Net Worth				$	97,727
C. ***Total Reserves and Net Worth***				$	97,727
D. ***Total Liabilities, Reserves, and Net Worth***				$	3,263,676

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	36	37

	Account		Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2014	$	(49,138)
B.	Total Revenue (*From Statement of Revenue Page 30*)	$	9,908,555
C.	Total Expenditures (*From Statement of Expenditures Page 27*)	$	9,766,409
D.	Net Income or Deficit	$	142,146
E.	Balance	$	93,008
F.	Additions		
	1. Additional Capital Contributed (*itemize*)		
	2. Other (*itemize*)		
	State of Connecticut refund 3,719		
F-3.	Total Additions	$	3,719
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*** 09/30/15	$	96,727

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Marlborough Health Care Center, Inc.	200RH	9/30/2015	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
Blum, Shapiro + Company, P.C.		2/5/16

Printed Name of Preparer	
Blum Shapiro & Co	
Addre: Address	**Phone Number**
29 South Main Street, West Hartford, CT 06127	860-561-4000