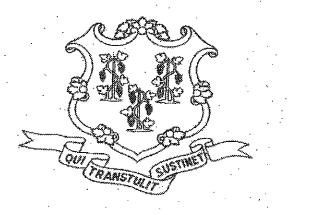
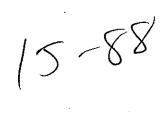
State of Connecticut





Annual Report of Long-Term Care Facility

Cost Year 2015

,						RECEIV			
Name of Facility (as li	icensed)					TEOLIV		1	
Portland Care and Rel		tre, Inc.							
Address (No. & Stree						FEB 18	2016		
333 Main Street, Port						,			
Type of Facility						PT. OF SOCIAL	SERVICE	3	
	_		Rest Home with	n Nursing	OFFICE	OF CON AND F	RATE SET	TINGS	
Chronic and C			Supervision onl	-		(Specify)			
Nursing Home	only (CCNH)	_	(RHNS)	,		11			
Depart for Voor Doors	nina		Report for Year	Ending					
Report for Year Begin 10/1/2014	umig		9/30/2015	Diding					
10/1/2014			2/30/2013						
•		•							
License Numbers:		CCNH	RHNS	((Specify)]	Medicar	e Provid	er
Licondo I (dilicoto)		871-C					07-5	214	
Medicaid Provider N	umbers:	CC	CNH	RH	NS		ICF-III)	
For Department Us							1		
Sequence Number	Signed and	Date	Sequence N		Signed	and Notarize	d Da	te Recei	ved
Assigned	Notarized	Received	Assign	ed					
					7811787		l		
				HEL	JEIVEU				

FEB 23 2016

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Portland Care and Rehabilitation Centre, Inc.	871-C	9/30/2015	_ 1	37
Fortiand Care and Renabilitation Control				

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 Portland Care and Rehabilitation Centre, Inc. [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.

Signed (Administrator)		Date	Signed (Owner)	Date
		2/12/16	9	2/12/16.
Name (Administrator)			Printed Name (Owner)	
. True Yuska			George Yuska	
Subscribed and Sworn	State of	Date	Signed (Notary Public)	Comm. Expires
to before me: Middle Sex	C+	2/12/16	Melvela COAMan	11 130 12019
Address of Notary Public		• .		
	mS+	Manc	hoster Ct 06	042

State of Connecticut **Department of Social Services**

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	tm	ent		Page	of
				1A	37
Name of Facility		Period Cove	ered:	From	То
Portland Care and Rehabilitation Centre, Inc.				10/1/2014	9/30/2015
Address of Facility					
333 Main Street, Portland CT 06480		,			
Report Prepared By		Phone Num		Date	
Ryan Turko		860-342 - 03	70	1/12/2016	
				-	
Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$	221,497	221,497		
2. Laundry wages paid	\$	61,796	61,796		
3. Housekeeping wages paid	\$	82,803	82,803		
4. Nursing wages paid	\$	2,029,438	2,029,438		
5. All other wages paid	\$	1,465,492	1,465,492		
6. Total Wages Paid	\$	3,861,026	3,861,026		
7. Total salaries paid	\$				
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$	3,861,026	3,861,026		

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire Type of Facility - Organization Structure

	Phone No. of Fa	- 1	Report for Yea	ar Ended	Page	of	
	(860) 342-0370		9/30/2015		2	37	
Name of Facility (as shown on license)			treet, City, Sta				
Portland Care and Rehabilitation Centre, Inc.		street, I	Portland CT 0	5480			
CCNH	RHNS		(Specify)			Provider No),
License Numbers: 871-C		<u> </u>			07-5214		
Type of Facility (Check appropriate box(es))							
Chronic and Convalescent	Rest Home with			(Specify)			
Nursing Home only (CCNH)	Supervision only	'(RHN	IS) —				
Type of Ownership (Check appropriate box)							
O Proprietorship O LLC O Partnership	Profit Corp.	0	Non-Profit Cor	р. О	Government	O Trust	t
		Date	Opened	Date Clo	sed		
If this facility opened or closed during report year provid	le:	-					
	M - 10 - 1						
Has there been any change in ownership	.	_	~ ~	Y 0 11 T 11	1 . 0 11		
or operation during this report year?	O Yes	<u> </u>	No	If "Yes,"	explain full	<u>y.</u>	
Administrator				•			
Name of Administrator			Nursing Ho				
George Yuska			Administrat	or's	001892		
			License l	No.:		·	
Other Operators/Owners who are assistant administrator	rs (full or part time)	of this					
Name			License 1	No.:			
	14		atar				
,							
							

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Annual Report of Long-Term Care Facility

CSP-3 Rev. 10/2005

General Information and Questionnaire Partners/Members

Name of Facility Portland Care and Rehabilitation	Centre, Inc.	License No. 871-C	Report for Y 9/30/2015	ear Ended	Page of 3 37
Legal Name of Partm		Business	Address		or Town(s) in Registered
			Ţ,		
Name of Partners/Members	Business A	ddress		Title	% Owned

State of Connecticut

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CSP-3A Rev. 10/2005

General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year En	ded	Page of
Portland Care and Rehabilitation Centre, Inc.	871-C	9/30/2015		3A 37
If this facility is owned or operated as a corpo	ration, provide the	following information	n:	
Legal Name of Corporation		ss Address		ch Incorporated
Portland Care and Rehabilitation	333 Main Street,	Portland CT 06480	CT	
Centre, Inc.				i
·				
				NI GI
Name of Directors, Officers	Busine	ss Address	Title	No. Shares
				Held by Each
George Yuska	103 South Pond J	Rd, Glastonbury CT	Vice President	87
000.50 1		•		
	24 C - 4 C4 T	Describe Designs	President	87
Gerald Yuska	34 South Stony E Marlborough CT		Fresident	67
	Iviarioorough C1	V0447		
Constance Yuska	34 South Stony E	Brook Drive,	Secretary	
	Marlborough CT			
				,
		,		
-				
Names of Stockholders Owning at Least 10%				
of Shares				
·				
			-	
·				

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General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended 9/30/2015	Page of 3B 37
Portland Care and Rehabilitation Centre, Inc.	871-C	19/30/2013	
If this facility is owned or operated as an individu	iai proprietorship,	provide the following infoli	iauon.
Ov	vner(s) of Facility		
			_
	-		
			·
			

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General Information and Questionnaire Related Parties*

Name of Facility Portland Care and Rehabilitation Centre, Inc.		License No. 871	No 871-C	Report for Year Ended 9/30/2015		Page 4	of 37
The state of the s							
Are any individuals receiment and individuals receiment and individuals ability to contra	Are any individuals receiving compensation from the facility related through marriage ability to control, ownership, family or business association?	cility rela ss associ	ong	o Yes © No	If "Yes," provide the Name/Address and complete the information on Page 11 of the report.	e Name/Add nation on Pag	ress and ge 11 of the report.
of Course (agreement	, ,						
Are any individuals or co	Are any individuals or companies which provide goods or services,	or servic	es,				
including the rental of prelated through family as	including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business	o unis ra control,	culty, or business	O Yes © No			
association to any of the	association to any of the owners, operators, or officials of this facility?	of this fa	cility?		If "Yes," provide the following information:	e following i	nformation:
		Goods	Also Provides Goods/Services to		Indicate Where Costs are Included		
Name of Related	Business	Non-R	Non-Related Parties	Description	in Annual Report	Cost	Actual Cost to the
Individual or Company	Address	Yes	No %**	Provided	Page # / Line #	Reported	Kelated Party
George Yuska	333 Main Street, Portland CT 06480	0	0		Page 10 Line 4		
Gerald Yuska	333 Main Street, Portland CT 06480	0	O		Page 10 Line 2		
Constance Yuska	333 Main Street, Portland CT 06480	0	•		Page 10 Line h/m		
		0	0				
		0	0				
		0	0				
		0	0				
		0	0				
		0	0				
4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4							

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

State of Connecticut Annual Report of Long-Term Care Facility CSP-5 Rev. 9/2002

General Information and Questionnaire Basis for Allocation of Costs

Name of Facility	License No		Report for Year Ended	Page of
Portland Care and Rehabilitation Centre, Inc.	871-C		9/30/2015	5 37
If the facility is licensed as CDH and/or RCH or	r provides A	IDS or TBI	services with special Medica	d rates, costs
must be allocated to CCNH and RHNS as follo	ws:			
Item			Method of Allocation	n
Dietary		Number of	meals served to residents	
Laundry		Number of	pounds processed	
Housekeeping			square feet serviced	
Nursing		employee c Registered Attendants	hours of routine care provide lassification, i.e., Director (or Nurses, Licensed Practical N	Charge Nurse), urses, Aides and
Direct Resident Care Consultants			hours of resident care provid (See listing page 13)	ed by EACH
Maintenance and operation of plant		Square fee		
Property costs (depreciation)		Square fee		
Employee health and welfare		Gross sala		
Management services	·		e cost center involved	
All other General Administrative expenses			rect and Allocated Costs	
The preparer of this report must answer the following	lowing quest	ions applica	ble to the cost information pr	ovided.
1. In the preparation of this Report, were all costs allocated as required?	• Yes	O No	If "No," explain fully why so not made.	ach allocation was
2. Explain the allocation of related company ex	xpenses and	attach copy	of appropriate supporting dat	a
3. Did the Facility appropriately allocate and s (e.g., Assisted Living, Home Health, Outpa	self-disallow tient Service	direct and i	y Care Services, etc.)	
	• Yes	O No	If "No," explain fully why s not made.	uch allocation wa

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-6 Rev. 9/2002

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.

should not be included in these amounts.					,		
Name of Facility			License No.	Report for Year Ended	ear Ended		-
Portland Care and Rehabilitation Centre, Inc.			871-C	9/30/2015		A CONTRACTOR OF THE CONTRACTOR	6 37
* * * * * * * * * * * * * * * * * * *	Related * to	d * to					
	Owners,	ers,				-	
	Operators,	itors,		ţ	E	Annual	A A
	Officers	cers		Date of	lerm of	Amount	Amount
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	of Lease	Claimed
N/A	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
T. a Milana I or Book Maintained for All Leased Vehicles?	eased Ve	hicles ?	O Yes		O No	Total ***	

Is a Mileage Log Book Maintained for All Leased Vehicles?

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

** Attach copies of newly acquired leases.

*** Amount should agree to Page 22, Line 6e.

General Information and Questionnaire Accounting Basis

ame of Facility Lie	cense No.	Report for Year Ended		P	-, I	37
ortland Care and Rehabilitation C	871-C	9/30/2015			7	31
e records of this facility for the peri-	od covered by this re	eport were maintained on the following	basis:			
Accrual O Cash O Mo	odified Cash					,,-
the accounting basis for this						
eriod the same as for the • Ye	es	If "No," explain.				
revious period? O No	0					
landa Assauting Firm	· · · · · · · · · · · · · · · · · · ·					
ndependent Accounting Firm Jame of Accounting Firm		Address (No. & Street, City, State	e, Zip Code)		-	_
Marcum Accounting & Advisors		555 Long Wharf Drive, New	Haven, CT 06511			
		Florida				
KPMG HR Block		Various				
Blum Shapiro		29 South Main St, West Har	tford CT			
ervices Provided by This Firm (desc	ribe fully)					
	• • • •			\$	15,531	
Consulting and Auditing				\$	526	
Cost Report Software				\$	217	
Tax Software				\$		
			Chare	e for Se	rvices P	rovide
are These Charges Reflected in the Expenditu	ere Portion of This Report	t? If Yes, Specify Expense Classification and Lin		se for Se	rvices P 16,274	rovide
Are These Charges Reflected in the Expenditu O Yes O No C Legal Services Information)g 15 Line 9	t? If Yes, Specify Expense Classification and Lin	e No.	\$ hone Nu	16,274 umber	rovide
● Yes O No C Legal Services Information Name of Legal Firm or Independent)g 15 Line 9	t? If Yes, Specify Expense Classification and Lin	e No. Telep	\$ hone Nu	16,274 umber 0	rovide
Arc These Charges Reflected in the Expenditu O Yes O No C Legal Services Information Name of Legal Firm or Independent A Murtha Cullin)g 15 Line 9	t? If Yes, Specify Expense Classification and Lin	Telep 860-2 860-5	hone Nu 40-6006	16,274 amber 0	rovide
Are These Charges Reflected in the Expenditu O Yes O No C Legal Services Information Name of Legal Firm or Independent A Murtha Cullin O'Connell Flathery Attmore)g 15 Line 9	t? If Yes, Specify Expense Classification and Lin	Telep 860-2 860-5	\$ hone Nu	16,274 amber 0	rovide
Are These Charges Reflected in the Expenditu O Yes O No C Legal Services Information Name of Legal Firm or Independent A Murtha Cullin O'Connell Flathery Attmore Gordon & Rees LLP)g 15 Line 9	t? If Yes, Specify Expense Classification and Lin	Telep 860-2 860)	hone Nu 40-6006 548-130 278-74	16,274 umber 0 0 48	rovid
Are These Charges Reflected in the Expenditu O Yes O No C Legal Services Information Name of Legal Firm or Independent A Murtha Cullin O'Connell Flathery Attmore Gordon & Rees LLP Haile, Shaw & Pfaffenberger O'Connell Flathery Attmore	Og 15 Line 9 Attorney	t? If Yes, Specify Expense Classification and Lin	Telep 860-2 860)	hone Nu 40-6006	16,274 umber 0 0 48	rovide
Are These Charges Reflected in the Expenditu O Yes O No C Legal Services Information Name of Legal Firm or Independent A 1 Murtha Cullin 2 O'Connell Flathery Attmore 3 Gordon & Rees LLP 4 Haile, Shaw & Pfaffenberger 5 O'Connell Flathery Attmore Address (No. & Street, City, State, Z	Attorney Age Code	t? If Yes, Specify Expense Classification and Lin	Telep 860-2 860)	hone Nu 40-6006 548-130 278-74	16,274 umber 0 0 48	rovide
Are These Charges Reflected in the Expenditure Yes O No Chegal Services Information Name of Legal Firm or Independent A Murtha Cullin O'Connell Flathery Attmore Gordon & Rees LLP Haile, Shaw & Pfaffenberger O'Connell Flathery Attmore Address (No. & Street, City, State, Z City Place 1, Hartford CT 06103	Attorney Gip Code)	t? If Yes, Specify Expense Classification and Lin	Telep 860-2 860)	hone Nu 40-6006 548-130 278-74	16,274 amber 0 0 48	rovide
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egal Services Information Name of Legal Firm or Independent A Murtha Cullin O'Connell Flathery Attmore Gordon & Rees LLP Haile, Shaw & Pfaffenberger O'Connell Flathery Attmore Address (No. & Street, City, State, Z City Place 1, Hartford CT 06103 2 260 Trumbull Street, Hartford CT North Palm, FL 33408 5 260 Trumbull Street, Hartford CT	Attorney Attorney Tip Code) To 06103 TO 06103	t? If Yes, Specify Expense Classification and Lin	Telep 860-2 860)	hone Nu 40-6006 48-130 278-74	16,274 umber 0 0 48	
O Yes O No Concernation Jame of Legal Firm or Independent A Murtha Cullin O'Connell Flathery Attmore Gordon & Rees LLP Haile, Shaw & Pfaffenberger O'Connell Flathery Attmore Address (No. & Street, City, State, Z City Place 1, Hartford CT 06103 City Plac	Attorney Attorney Tip Code) To 06103 TO 06103	t? If Yes, Specify Expense Classification and Lin	Telep 860-2 860)	\$ hone No. 40-6000 448-1300 278-74	16,274 Lumber 0 0 48	
O Yes O No Congal Services Information Name of Legal Firm or Independent A Murtha Cullin O'Connell Flathery Attmore Gordon & Rees LLP Haile, Shaw & Pfaffenberger O'Connell Flathery Attmore Address (No. & Street, City, State, Z) City Place 1, Hartford CT 06103 2 260 Trumbull Street, Hartford C3 95 Glastonbury Blvd, G	Attorney Attorney Tip Code) To 06103 TO 06103	t? If Yes, Specify Expense Classification and Lin	Telep 860-2 860)	\$ hone No. 40-6006 48-1300 278-74	16,274 number 0 0 48 0	
egal Services Information Jame of Legal Firm or Independent A Murtha Cullin O'Connell Flathery Attmore Gordon & Rees LLP Haile, Shaw & Pfaffenberger O'Connell Flathery Attmore Address (No. & Street, City, State, Z City Place 1, Hartford CT 06103 2 260 Trumbull Street, Hartford C3 3 95 Glastonbury Blvd, Glastonbury North Palm, FL 33408 5 260 Trumbull Street, Hartford C5 Services Provided by This Firm (des	Attorney Attorney Tip Code) To 06103 TO 06103	t? If Yes, Specify Expense Classification and Lin	Telep 860-2 860)	\$ hone Nu.40-6006 48-1300 278-74 548-1300	16,274 number 0 0 48 0 (22,417 3,963 21,852	
Are These Charges Reflected in the Expenditure O Yes O No Chegal Services Information Name of Legal Firm or Independent A Murtha Cullin O'Connell Flathery Attmore Gordon & Rees LLP Haile, Shaw & Pfaffenberger O'Connell Flathery Attmore Address (No. & Street, City, State, Z City Place 1, Hartford CT 06103 2 260 Trumbull Street, Hartford C3 95 Glastonbury Blvd, Glastonbury North Palm, FL 33408 5 260 Trumbull Street, Hartford C5 Services Provided by This Firm (des.) Legal, Collections 2 Collections, Legal	Attorney Attorney Tip Code) To 06103 TO 06103	t? If Yes, Specify Expense Classification and Lin	Telep 860-2 860)	\$ hone No. 40-6006 648-1300 278-74 548-1300 \$ \$ \$ \$ \$ \$ \$	16,274 Limber 0 0 48 0 (22,417 3,963 21,852 5,587	
Are These Charges Reflected in the Expenditure O Yes O No Chegal Services Information Name of Legal Firm or Independent A Murtha Cullin O'Connell Flathery Attmore Gordon & Rees LLP Haile, Shaw & Pfaffenberger O'Connell Flathery Attmore Address (No. & Street, City, State, Z City Place 1, Hartford CT 06103 2 260 Trumbull Street, Hartford C 3 95 Glastonbury Blvd, Glastonbury North Palm, FL 33408 5 260 Trumbull Street, Hartford C Services Provided by This Firm (dess Legal, Collections Collections, Legal Legal	Attorney Attorney Tip Code) To 06103 TO 06103	t? If Yes, Specify Expense Classification and Lin	Telep 860-2 860-5 (860)	\$ hone No. 40-6006 648-1300 278-74 548-1300 \$ \$ \$ \$ \$ \$ \$ \$ \$	16,274 Tamber 0 0 48 0 (22,417 3,963 21,852 5,587 (14,418)
egal Services Information Name of Legal Firm or Independent A Murtha Cullin O'Connell Flathery Attmore Gordon & Rees LLP Haile, Shaw & Pfaffenberger O'Connell Flathery Attmore Address (No. & Street, City, State, Z City Place 1, Hartford CT 06103 2 260 Trumbull Street, Hartford C3 3 95 Glastonbury Blvd, Glastonbury North Palm, FL 33408 5 260 Trumbull Street, Hartford CS Services Provided by This Firm (desservices Provided by This Firm (desservices Collections) Collections, Legal Legal	Attorney Attorney Tip Code) To 06103 TO 06103	t? If Yes, Specify Expense Classification and Lin	Telep 860-2 860-5 (860)	\$ hone No. 40-6006 648-1300 278-74 548-1300 \$ \$ \$ \$ \$ \$ \$ \$ \$	16,274 Limber 0 0 48 0 (22,417 3,963 21,852 5,587) Providence

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Annual Report of Long-Term Care Facility
CSP-8 Rev. 9/2002

Schedule of Resident Statistics

THE PARTY AND PA			oN earen: I				Report for	Report for Year Ended	Ę		Page	of
Name of Facility			ricelise iv	871-C			9/30/2015				8	37
Portiand Care and Rehabilitation Centre, Inc.						Period 10/1 Thru 6/30	1 Thru 6/:	30		Period 7/1 Thru 9/30	Thru 9/30	
	Total All	Total CCNH	Total RHNS	Total	Total	CCNH	RHMS	(Specify)	Total	CCNH	RHINS	(Specify)
Certified Bed Capacity	Levels	Tevel	revei	(choose)					1	Š		
On last day of PREVIOUS report period	65	65			65	65			65	6		
On last day of THIS report period	65	65			65	65			65	65		
Number of Residents	09	9				99		and the state of t	09	09		
of minimum of the vice of the	3,5	98			09	09			56	56		
B. As of midnight of 11415 report period Total Number of Days Care Provided During Period										•		
A Medicare	3,582	3,582			2,502	2,502			1,080	1,080		
Medicaid (Conn.)	12,591	12,591		i de la companya de l	9,498	9,498			3,093	3,093		
Medicaid (other states)												
Private Pay	5,061	5,061			3,986	3,986			1,075	1,075		
State SSI for RCH												
Other (Specify)												
Total Care Days During Period (3A thru F)	21,234	21,234			15,986	15,986			5,248	5,248		
Total Number of Days Not Included in Figures in 3G												
for Which Revenue Was Received for Reserved Beds A. Medicaid Bed Reserve Days	19	19			19	19						
Other Bed Reserve Days				20,000						╧		
Tree of David Same (3C + AA + AB)	21.253	21,253			16,005	16,005			5,248	5,248		

Annual Report of Long-Term Care Facility

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Schedule of Resident Statistics (Cont'd)

Name of Facil	lity		<u> </u>	Licer	ise No.				Report	for Year	Ended		Page	of
	•	habilitat	ion Centre, Inc.	8	71-C					9/30/201	5		9	37
7 Orthand Care	, une rec													
4. Were the	ere any o	hanges	in the certified b	ed ca	pacity du	ring t	he repo	rt yea	t?	0	Yes	⊙	No	
If "YES"	, provid	e the fol	lowing informat	ion:	,									
			Change		Cl	nange	in Bed	S		Ca	pacity After	r Change		
Date of		RHNS	(Specify)		Lost			Gaine	đ					
Date of	CCIVII	KTTIAD	(Specify)		10031		<u> </u>							İ
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	Reason fo	or Change
	 (,)	(2)	. (5)	(*)		3-7	(-/	× /.						
	1													
			1.1 1		4 . 4	. 41			a manart	ad in itan	a A aboue) r	arowide the nun	her of	
			in certified bed			tne r	eport y	ear (a	s report	ea m nen	1 4 above) 1	Movide the num		
RESIDI	ENT DA	YS for	90 days followii	ng the	change.					T				
1													/0	-:0>
			Change in R	esider	nt Days					CC	NH	RHNS	(Spe	cify)
1 st chan	ge													
2nd cha														
3rd char														
4th char	ige				,	1.37				l	1			
6. Number	of Resi	dents an	d Rates on Sept	ember			ar	T		Ç.	elf-Pay		Other Sta	te Assisted
			Medicare	├-	Med	Caid		 		<u></u>	on-ray		Outer Bu	T ISSISTED
				1										
				1 .		_	-		an Tr		TO TO	(2:2)	D C II	ICF-MR
	Item		CCNH	_	CONH	R	HNS	0	CNH	Kı	INS	(Specify)	R.C.H.	ICF-IVIR
No. of R		s				0.0000000								
Per Dier									206.00					
a. One			Various	-	223.00		-	╁	396,00 355-376	 				
b. Two			Various	┨	223.00	+		1-	333-370	 				
c. Thre		re		ŀ				1		i				
bed	rms.		N/A		N/A			.1	N/A	 				
		CDI:	. 1 Tl T-00	ton out	~					TC	TAL	CCNH	RHNS	(Specify)
		are - Pa	al Therapy Trea	шене	8					 	203	203	1 2 2 1 2	(3)
A	Modic	aid (Ev	clusive of Part B	3										
P			ce Treatments	9										
			Treatments							\top				
C	Other										45	45		
			l Therapy Trea	tment	S						248	248		
			h Therapy Treat											
		care - Pa									50	50		
В	. Medic	caid (Ex	clusive of Part E	3)										
	1. Ma	aintenan	ce Treatments							<u> </u>				
	2. Re	storativ	Treatments											
	C. Other										11	11		
			Therapy Treati								61	61		
			pational Therapy	Treat	tments									
A	A. Medi	care - Pa	rt B								203	203		
E			clusive of Part I	3)										
			ce Treatments							-				
			e Treatments							+	20	20		
	C. Other			T	dana maad-					1	223	223		
l I). Total	Оссир	itional Therapy	rea	iments					_1		223	· 1	

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Report of Expenditures - Salaries & Wages

Report of Ex	• • • • • • • • • • • • • • • • • • • •	- Darain	Report for Year		Page	of
Name of Facility	License No.		9/30/2015	Diffee	10	37
Portland Care and Rehabilitation Centre, Inc.	871-C		9/30/2013		<u> </u>	37
Are time records maintained by all individuals receiving cor	npensation?	•	Yes	0	No	
			Total Cost ar	nd Hours		
					1	
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I						
of Schedule AI)						
2. Administrator(s) (Complete also Sec. III	243,193	2,080		192191111111111111111111111111111111111		
of Schedule A1) 3. Assistant Administrator (Complete also Sec. IV	243,193	1,000				
of Schedule A1) 4. Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)	386,804	8,114				
5. Dietary Service						
a. Head Dietitian	1		<u> </u>		 	ļ
b. Food Service Supervisor	001 407	16,135			1	
c. Dietary Workers	221,497	10,133	7			
6. Housekeeping Service a. Head Housekeeper				Village in the second		
b. Other Housekeeping Workers	82,803	7,184	1			
7. Repairs & Maintenance Services						
a Engineer or Chief of Maintenance		5.01	, , , , , , , , , , , , , , , , , , , ,		1	
b. Other Maintenance Workers	126,008	5,910	0			
8. Laundry Service						
a. Supervisor b. Other Laundry Workers	61,796	5,993	3			
b. Other Laundry Workers 9. Barber and Beautician Services						
10. Protective Services				siarimenna kidik		
11. Accounting Services						
a. Head Accountant		<u> </u>	 	<u> </u>		
b. Other Accountants						
12. Professional Care of Residents	119,135	2,09	n l	, and and and and		
a. Directors and Assistant Director of Nurses	119,13	2,07	V			
b. RN 1. Direct Care	683,101	19,13	ol		ms-vermenamana	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
2. Administrative**	74,838					
c. LPN						
1. Direct Care	317,500	10,14	.5			
2. Administrative**	924.05	59,23			 	+
d. Aides and Attendants	834,851 272,710			 	-	
e. Physical Therapists f. Speech Therapists	212,110	3,72				
g. Occupational Therapists	225,37	8 6,52	3			
h. Recreation Workers	147,14		7			
i. Physicians						
Medical Director			 	 		-
2. Utilization Review		-	 	+		
3. Resident Care*** 4. Other (Specify)						
4. Office (opecity)				pressuatainiiii		
j. Dentists						1
k. Pharmacists						
1. Podiatrists		21 21		-		-
m. Social Workers/Case Management	55,41	3 2,10	70	 	-	
n. Marketing o. Other (Specify)						
o. Other (Specify) See Attached Schedule	8,84	6			ana innervitation	
A-13. Total Salary Expenditures	3,861,02		36			

^{*} 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)

	CC	NH	RE	INS	(Spe	cify)
Position	\$	Hours	\$	Hours	\$	Hours
Paid Time Off	\$ 8,846					
					10000	
200						
			ļ.,		Δ.	
Total	\$ 8,846		S -	<u> </u>	\$ -	-

Schedule of Other Fees (Page 13)

	C	CNH	·R	HNS	(Spe	ecify)
Service	\$	Hours	\$	Hours	\$	Hours
	6.000				100	
	500					
	100					
200 m						
100 miles						
10.0 m					0.00	
100						
Fotal	· S -	-	\$ -	-	8	-

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-11 Rev. 10/2005

Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties*

		7	ווואטופופפע	arm crommerring thingsect					2,2,0	J
Name of Facility				License No.		Report for	Report for Year Ended		Lage	
Portland Care and Rehabilitation Centre, Inc.	Centre, Inc.			871-C		9/30/2015			11	/ C
			-							
		Salary Faid		Fringe Benetits					1	
	1	pHMG	(Spacify)	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**	Hours Worked	Compensation Received
Name	IN O	CATTO	(Shearty)	(francorran)						
Section I - Operators/Owners										
Canada Vieles	243.193				Administrator	2,080	A2		2,080	-
מכסולה בי השאת										
Section II - Other related										
parties of Operators/Owners	-				-					
employed in and paid by										
facility (EXCEP'I those who						_				
may be the Administrator or										
are identified on Page 12).										
	.,,									
										,

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

^{**} Include all employment worked during the cost year.

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Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties*

		J	YSSIStair.	n northing 7	Assistant thinness and the care at the care	500707				
Name of Facility (as licensed)				License No.		Report for Year Ended	ear Ended		, Page	ŢO.
Portland Care and Rehabilitation Centre, Inc.	entre, Inc.			871-C		9/30/2015			12	37
		Colons Doid	π							<u>-</u> .
		Salary 1 an		France Menetite						
				and/or Other	Total Description of	Total Hours	Line Where	Name and Address of All	Total	Compensation
Name	CCNH	RHINS	(Specify)	rayments (describe fully)	Services Rendered	Worked	Page 10	Other Employment**	Worked	Received
Section III - Administrators***										
George Viiska	243.193				Administrator	2,080 A2	A2		2,080	
			1							
Section IV - Assistant										
Administrators	•									
		-								

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

 $[\]ast\ast$ Include $\underline{\mathbf{all}}$ 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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No. 871-		Report for Y 9/30/2015	ear Ended	Page 13	of 37
Portland Care and Rehabilitation Centre, Inc.	0/1-	-0	Total Cost	and Hours	1 . 13	1
			10tai Cost	and noms	<u> </u>	ļ
¥4	CCNH	Hours	RHNS	Hours	(Specify)	Hours
Item	CCNH	1100115	KHAD	Hours	(Bpcchy)	Hoars
B. Direct care consultants paid on a fee						
for service basis in lieu of salary (For all such services complete Schedule B1)						
	17,614	314			**************************************	0.000.000.0000.000000000000000000000000
1. Dietitian 2. Dentist	500	6				
3. Pharmacist	300					
4. Podiatrist					1	
5. Physical Therapy						
a. Resident Care		14545511111111111111111111111111111111				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	21,600	444				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting	625					
c. Resident Care**	,,,,					
d. Administrative Services facility						
1. Infection Control Committee						
(Quarterly meetings)						ļ
2. Pharmaceutical Committee						
(Quarterly meetings) 3. Staff Development Committee		,		1	-	
(Once annually)						
e. Other (Specify)						
· · · · · · · · · · · · · · · · · · ·						
9. Speech Therapist						
a. Resident Care						<u> </u>
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care			<u> </u>			
2. Administrative***						
b. LPN						
1. Direct Care			<u> </u>	 		
2. Administrative***	ļ	ļ		1		
c. Aides			<u> </u>	_		
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	40,339	772				1

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

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

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

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

Name of Facility	License No.		Report for Ye	ar Ended	Page	of 37
Portland Care and Rehabilitation Centre, l	nc. 871-C	Dalatades	9/30/2015 * to Owners,		14	3/
Name & Address of Individual	Full Explanation of Service		rs, Officers	Explai	nation of Rel	lationship
Name & Addless of Individual	, an Explanation of porvious	Yes	No	1		.,.
Debra Weeks Jameson, Middlefield CT	Dietician	0	•			
Joseph Lantos, Portland CT	Dental Consultant	0	•			
Dr. Matthew Raider, Portland CT	Medical Director	0	•			
Dr. Otto Weis, Portland CT	Utilization Review	0	•			
		0	0		A	
		0	0			
		0	0			
		0	0	—		
		. 0	0			
		0	0			
		0	0		1, 10, -11	
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		0	0		<u></u>	
		0	0			Limes
		0	0			
		0	0			
		0	0			

^{*} Use additional sheets if necessary.

^{**} Refer to Page 4 for definition of related.

Annual Report of Long-Term Care Facility

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility Portland Care and Rehabilitation Centre, Inc. License No. 871-C		Report for Ye 9/30/2015	ar Ended	Page 15	of 37
1 of third Care and Testabilitation Centre, inc.					
,					
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
Workmen's Compensation	\$	101,231	101,231		
Disability Insurance	\$				
Unemployment Insurance	\$	110,519	110,519		
4. Social Security (F.I.C.A.)	\$	269,924	269,924		
5. Health Insurance	\$	231,169	231,169		
6. Life Insurance (employees only)					
(not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory)	\$				
(not-owners and not-operators)					
8. Uniform Allowance	\$				
9. Other (Specify)	\$	(6,398)	(6,398)		***************************************
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and	\$		····		
Profit Sharing Plans for Owners and					
Operators (Discriminatory)*					
<u> </u>					
c. Bad Debts*	\$				
d. Accounting and Auditing	\$	16,275	16,275		
e. Legal (Services should be fully described on Page 7)	\$	(5,520)	(5,520)		
f. Insurance on Lives of Owners and	\$	3,745	3,745	***************************************	
Operators (Specify)*					
g. Office Supplies	\$	22,378	22,378		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	20,575	20,575		
2. Cellular Phones	\$				
i. Appraisal (Specify purpose and	\$[
attach copy)*				0.00	
j. Corporation Business Taxes (franchise tax)	\$	250	250		emmerin insulainann
k. Other Taxes (Not related to property - See Page 22)					
1. Income*	\$				
2. Other (Specify)	-\$	generalistika propositiva propositiva propositiva propositiva propositiva propositiva propositiva propositiva p	THANKATI SALIMAN AND AND AND AND AND AND AND AND AND A	0 000000/100000000000000000000000000000	
See Attached Schedule					
3. Resident Day User Fee	\$	298,230	298,230		
Subtotal	\$	1,062,378	1,062,378		

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

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

Portland Care and Rehabilitation Centre, Inc. 9/30/2015

Attachment Page 15

Schedule of Other Employee Benefits

Description		CC	CNH	RHNS	(Specify)
Pre Employment Physical		\$	799		
Delete	1112	\$	(7,272)		
Manual Payroll Checks		\$	150		
Payroll to Allocate		\$	(73)		
Bk Rec Difference		\$	(2)		
	200 1 1				
the state of the s					
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
				6 (03/6) (E.)	
				8 6 600	
				(1) (1)	
					2.2
Appell Color	100	m	6.000	0	di di
Total		\$	(6,398)	3 -	\$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
		6 950 %	65 (64 (54 (54 (54 (54 (54 (54 (54 (54 (54 (5
		900	
	No. 2 6		
Total	\$ -	\$ -	\$ -

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

Name of Facility	License No.		Report for Y	ear Ended	Page	of
Portland Care and Rehabilitation Centre, Inc.	871-C		9/30/2015	4	16	37
Item			Total	CCNH	RHNS	(Specify)
Subtota	ls Brought Forwar	d:	1,062,378	1,062,378		
Travel and Entertainment						
Resident Travel and Entertainment		\$				
2. Holiday Parties for Staff		\$	8,336	8,336		
3. Gifts to Staff and Residents		\$	199	199		
4. Employee Travel		\$				
5. Education Expenses Related to Seminars an	d Conventions	\$	3,636	3,636		
6. Automobile Expense (not purchase or depr	eciation)	\$	1,918	1,918		
7. Other (Specify)		\$		*************	****	: :
See Attached Schedule						
m. Other Administrative and General Expenses						
1. Advertising Help Wanted (all such expense.		\$				
2. Advertising Telephone Directory (all such e	xpenses)***	\$				
3. Advertising Other (Specify)***		\$	399	399		
See Attached Schedule						
4. Fund-Raising***		\$				
5. Medical Records		\$				
6. Barber and Beauty Supplies (if this service		\$				
directly and not by contract or fee for service	e)***					
7. Postage		\$	2,595	2,595		
* 8. Dues and Membership Fees to Professional		\$				
Associations (Specify)						
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other Non-	Allowable Org.***	\$				
9. Subscriptions		\$	2,653	2,653		
10. Contributions***		\$	360	360		
See Attached Schedule						
11. Services Provided by Contract (Specify and	-	\$	36,781	36,781		
Schedule C-2, Page 21 for each firm or inc	lividual)					
12. Administrative Management Services**		\$	···			
13. Other (Specify)		\$	97,600	97,600		
See Attached Schedule						
C-14 Total Administrative & General Expenditures		\$	1,216,855	1,216,855		<u> </u>

^{*} 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	\$	S	\$

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Facility Advertising	s 399		
Total Other Advertising	\$ 399	3	5

Schedule of Dues

Description	CCNH	RHNS	(Specify)
23310.232	I		
-			
Fotal Dues	S	s -	\$

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Donation:	360		
Total Contributions	360 \$		\$ -

Schedule of Other Administrative and General

Description		 	CCNH	RHNS	(Specify)
Bank Service Charges		\$	381		
Computer Services		3	22,031		
Gas		S	3,342		
Marketing		8	1,861		
Licenses and Permits		s	1,623		
VERG		8	- 0		
ayróll Services		\$	11,917		
² enaities		5	32,461		
Other Travel and Entertainme	at	S	23,984		
Total Other Administrative	and General	Ş	97,600	<u> </u>	\$

Schedule C-1 - Management Services*

Name of Facility Portland Care and Rehabilitation Centre, I	License No. 871-C	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 #

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

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

				rage 5)	_			т=	
Nan	ne of Facility	[]	License			ear Ended	Page 18	of	
Port	land Care and Rehabilitation Centre, Inc.		**************************************	871-C	9,	9/30/2015			37
	Item			Total	(CNH	RHNS	(Sp	ecify)
2.	Dietary								
	a. In-House Preparation & Service								
	1. Raw Food		\$	202,988		202,988			
<u></u>	2. Non-Food Supplies		\$			18,148			
<u> </u>	3. Other (Specify)		\$						
	C. (4 - 3)								
	b. Purchased Services (by contract other		\$						
	than through Management Services)								
	(Complete Schedule C-2 att. Page 21)								
	c. Management Services**		9						
	d. Other (Specify)		9						
	() () () () () () () () () ()								
2E.	Total Dietary Expenditures (2a+b+c+d)		9	221,136		221,136			
=					Ī				
	District On the saint			Total	(CCNH	RHNS	(St	ecify)
2F.	Dietary Questionnaire			Total	 `	CIVII	Runs	(5)	,,,,,
G.	Resident Meals: Total no. of meals served per				<u> </u>			<u> </u>	
H.	Is cost of employee meals included in 2E?	0	Yes	•	No				
		$\overline{}$	T 7		NT		If yes, specify		
I.	Did you receive revenue from employees?	O	Yes	•	No		amt.		
J.	Where is the revenue received reported in the	Cost	Repor	t? (Page/Line l	tem)		-		•
=	Is cost of meals provided to persons other		t.				×0 .0		
K.	than employees or residents (i.e., Board	0	Yes	•	No		If yes, specify		
12.	Members, Guests) included in 2E?	_	1			•	cost.		
	Wiemoers, Odests) metaded in 22:					417	If yes, specify		
L.	Is any revenue collected from these people?	0	Yes	•	No		amt.		
		<u> </u>	D	to (Decolline)	[tom)				
<u>M.</u>	Where is the revenue received reported in the	Cost	repor	i: (rage/Line	пеш)			•	
	Is cost of food (other than meals, e.g., snacks						If yes, specify		
N.	at monthly staff meetings, board meetings)	0	Yes	•	No		· · - ·		
ļ- ''	provided to employees included in 2E?						cost.		
<u> </u>	F						TC 'C		
O.	Is any revenue collected from employees?	0	Yes	•	No		If yes, specify		
<u>U</u> .	is any revenue concessed from empreyees.			1201			amt.	•	
Р.	Where is the revenue received reported in the	Cost	Repor	t? (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)

	of Facility]]	License	No. 371-C		Report for Y 9/30/2015	ear Ended	Page 19	of 37
Portla	nd Care and Rehabilitation Centre, Inc.			5/1-C		9/30/2013		12	37
	Item			Total	1	CCNH	RHNS	(Sp	ecify)
1	aundry In-House Processing* Bed linens, cubicle curtains, draperies,		Lbs.						
	gowns and other resident care items washed, ironed, and/or processed.***	-	Amt. \$						
	Employee items including uniforms, gowns, etc. washed, ironed and/or		Lbs.						
	processed.***		Amt. \$						
	3. Personal clothing of residents	-	Lbs.						
	washed, ironed, and/or processed.***	\downarrow	Amt. \$						
	4. Repair and/or purchase of linens.***		Lbs.						
		_	Amt. \$		204	7.001			
l t	o. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	1	,901	7,901			1856 1863 1863
	. Management Services**		\$						
	1. Other (Specify)		\$						
3E. 3	Total Laundry Expenditures $(3a+b+c+d)$		\$	7	,901	7,901			
3F. I	Laundry Questionnaire						T.C		
G. I	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 Cos	st F	Report?			(Page/Line	e Item)		
,]	Is Cost of laundry provided to persons other		Yes		•	No	If yes, specify cost.		
K	Did you receive revenue from these people?	0	Yes	15.00	•	No	If yes, specify amt.		
L.	Where is the revenue received reported in the Co	st F	Report?			(Page/Line	e 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)

Nan	ne of Facility	i	Repo	rt for Year Er	nded	Page	of
Portland Care and Rehabilitation Centre, Inc. 871-C				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,	Amt.	\$	14,973	14,973		
	pails, brooms, etc.)						
	b. Purchased Services (by contract other	Sq. Ft. Serviced		Į.			
	than through Management Services)	by Personnel					
	(Complete Schedule C-2 att.	Amt.	\$				
	Page 21)						
	c. Management Services*		\$				
	d. Other (Specify)		\$	~~~			
4E.	Total Housekeeping Expenditures (4a +	b+c+d)	\$	14,973	14,973		
5.	Resident Care (Supplies)**						
	a. Prescription Drugs***						
	1. Own Pharmacy		\$				
	2. Purchased from		\$	140,142	140,142		
	CAP Pharmacy						
	b. Medicine Cabinet Drugs		\$	18,687	18,687		
	c. Medical and Therapeutic Supplies		\$	90,420	90,420		
	d. Ambulance/Limousine***		\$	1,558	1,558		
	e. Oxygen						
	1. For Emergency Use		\$	29,374	29,374		
	2. Other***		\$				
	f. X-rays and Related Radiological		\$	11,174	11,174		
	Procedures***						
	g. Dental (Not dentists who should be inc	cluded under	\$		30/// <i>4/30//////////////////////////////</i>		
	salaries or fees)						
	h. Laboratory***		\$	(33,210)	(33,210)		
	i. Recreation		\$	3,684	3,684		
	j. Other (Specify)****		\$	10,353	10,353		
.	See Attached Schedule						
5K	. Total Resident Care Expenditures (5a -	5j)	\$	272,182	272,182		

^{*} 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)
PT Supplies	\$ 6,314		
Social Services Supplies	\$ 41		
Medical Supplies T19 imallowable	\$ 3,998		
			2.0
			100
	F84.2		
			100
	200		
		10.00 10.00	
Total Other Resident Care	\$ 10,353	\$ -	\$ -

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CSP-21 Rev. 10/2001

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

of 37			Line														
Page 21			Pg														
		Total Cost/Page Ref.***	(Specify)								4				•		
		Total Cost/	RHNS														
ņ			CCNH											3			
Report for Year Ended 9/30/2015	The same of the sa		Full Explanation of Service Provided*					And the second s								a de la companya de l	
License No. 871-C			Explanation of Relationship		all desiration and de												
	o Owners.	Officers	No	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Related ** to Owners.	Operators, Officers	Yes	0	0	0	0	0	0	0	0	0	0	0	0	0	0
n Centre, Inc.	A CONTRACTOR OF THE PROPERTY O		Address				And the state of t		The state of the s	Als an annual bloggroups .	***************************************	AND THE PROPERTY OF THE PROPER	description of the control of the co	wake an	THE STATE WALL	THE THE PROPERTY OF THE PROPER	
Name of Facility Portland Care and Rehabilitation Centre, Inc.			Name of Individual or Company						And the second s	Annual	The state of the s	- Company and the company and	- monday		- And Annual results (Apply)	Transmission of the control of the c	

^{*} List all contracted services over \$10,000. Use additional sheets if necessary.

^{**} Refer to Page 4 for definition of related.

^{***} Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility License No.).	Report for Ye	ear Ended		Page	of
Portland Care and Rehabilitation Centre, Inc. 871-C		9/30/2015			22	37
Item .		Total	CCNH	RHNS	(Sp	ecify)
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	174,691	174,691			
b. Heat	\$	14,672	14,672			
c. Light & Power	\$	114,622	114,622			
d. Water	\$	35,679	35,679			
e. Equipment Lease (Provide detail on page 6)	\$					
f. Other (itemize)	\$	25,725	25,725			
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	365,389	365,389			
7. Depreciation (complete schedule page 23*)			-			
a. Land Improvements	\$	27,198	27,198			
b. Building & Building Improvements	\$	69,704	69,704			
c. Non-Movable Equipment	\$	13,155	13,155			
d. Movable Equipment	\$	43,822	43,822			·
*7e. Total Depreciation Costs (7a+b+c+d)	\$	153,879	153,879			
8. Amortization (Complete att. Schedule Page 24*)						
a. Organization Expense	\$					
b. Mortgage Expense	\$	4,173	4,173			
c. Leasehold Improvements	\$					
d. Other (Specify)	\$					
*8e. Total Amortization Costs (8a+b+c+d)	\$	4,173	4,173			
9. Rental payments on leased real property less		:				
real estate taxes included in item 10b	\$					
10. Property Taxes						
a. Real estate taxes paid by owner	\$	65,257	65,257			
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$	14,542	14,542			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	237,851	237,851			

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Exterminating	\$ 590		
Hazardous Waste Disposal	\$ 3,803		
Elevator Services	\$ 5,672		
Rubbish Removal	\$ 9,674	40.00	
Snow Removal	\$ 1,000		
Plant Repair- Other	\$ 4,270	0.00	
Oil San	\$ 716	55.	100
		2000	
and the second s			
	80		
The state of the s			
			6
Total Other Repairs and Maintenance	\$ 25,725	3 :	S -

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			Depreci	Depreciation Schedule	nedule			•		
Name of Facility			License No.			Report for Year Ended	nded		Page	Jo
Portland Care and Rehabilitation Centre, Inc.			871-C	Ü		9/30/2015		***************************************	23	37
100.000.000.000.000.000.000.000.000.000			Historical	1		Accumulated				
			Cost Exclusive of	Less	Cost to Be	Depreciation to Beginning of	Method of Computing	Useful	Depreciation	
Property Item			Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
A. Land Improvements							,			
1. Acquired prior to this report period			666,455		666,455	362,067	Straight Line	Various	27,198	
2. Disposals (attach schedule)				-						
3. Acquired during this report period (attach schedule)	ı schedule)									
A-4. Subtotal										27,198
B. Building and Building Improvements				•						
 Acquired prior to this report period 			3,527,394		3,530,053	1,516,600	Straight Line Various	Various	69,549	
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	ı schedule)		2,659		2,659		Straight Line	15	155	
B-4. Subtotal										69,704
C. Non-Movable Equipment						-				
 Acquired prior to this report period 			161,872		161,873	47,558	Straight Line Various	Various	13,155	
2. Disposals (attach schedule)				A			A Libertina Control			
 Acquired during this report period (attach schedule) 	schedule)									
C-4. Subtotal										13,155
1	Is a mileage					***				
ti	logbook maintained? A	Date of Acquisition	Cost	Less		Depreciation to	Method of			
			Exclusive of	Salvage	Cost to Be	Beginning of	Computing	Useful	Depreciation	
	Yes No Month	nth Year	Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
D. Movable Equipment										
1. Motor Vehicles (Specify name, model										
and year of each vehicle)	YES May	, 2010	30,360		30,360	30,360	Straight line	5	6,718	
									(100)0	
C. C.										
d.										
2. Movable Equipment										
a. Acquired prior to this report period			374,794		374,794	290,051	Straight Line Various	Various	36,234	
b. Disposals (attach schedule)										
c. Acquired during this report period										
(attach schedule)			16,919						870	
6										43,822
E. Total Depreciation										153,879

Portland Care and Rehabilitation Centre, Inc. 9/30/2015

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of		Cost	Useful Life	Depreciation
Additions:					
		40.00			
	3.45				
Total additions for Land I	mprovements		S -		8 -
Deletions:					
	70.00				
Total deletions for Land I	mprovements		s -		S -

^{*}Ties to Page 23, Line A3

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Light Posts	Light Post in Parking Lot from Electrical Wholesalers	\$ 2,659	15	\$ 155
	and the second s			
Total additions fo	r Building Improvements	\$ 2,659		\$ 155 *
Deletions:				
		100		
Total deletions to	r: Building Improvements	\$ -		š - *

^{*}Ties to Page 23, Line B3

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:	Jesot Peton Or Item			
				0.00
	0.000			
	14.			
	100			
otal additions for Non-Movabl	e Equipment	\$ -		\$ -
Deletions:				
	200			
100				
Cotal deletions for Non-Movable	Equipment	\$ -		\$ -

^{*}Ties to Page 23, Line C3

^{**}Ties to Page 23, Line A2

^{**}Ties to Page 23, Line B2

^{**}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:				
T Equipment	Nu-Step Bike	\$ 5,345	5	
T Equipment	Hi Lo Stand Table	\$ 3,732		\$ 249
tmazori	Triple Door Fing	2754	10	143
Lmazon	3 Door:Freezer	2563	10	110
Amazon	2 Door Freezer	2525	10	101
	2.0			
otal additions fo	or Movable Equipment	\$ 16,919.		\$ 870
Deletions:				
		and the second s		
	200	50.00		
				. 2
l'otal deletions fe	ir Movalile Equipment	\$ -		3

^{*}Ties to Page 23, Line D2c

*Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

	•		Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
	2.00			
			9	
Total additions for Leasehold Improvement	and the second second second second	ζ		\$ -
Deletions:				
Deteons				
200	E 10 10 10 10 10 10 10 10 10 10 10 10 10			
Total délétions for Leasehold Triprovement.		8 - 1		§ -
Talful deletions into respending multiple accurate			800) <u>///////////////////////////////////</u>	

^{*}Ties to Page 24, Line C3

^{**}Ties to Page 24, Line C2

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Amortization Schedule*

Name of Facility			License No. 871-C		Report for Year Ended 9/30/2015	ır Ended		Page 24	of 37
FOI Hallu Care and Avadaomicanon Control					Accumulated				
	Date of	Jt			Amort. to				
	Acquisition	tion			Beginning of			•	
			Length of	Cost to Be	Year's			Amortization	,
Item	Month	Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
A. Organization Expense									
2.									
Ú									
A-4. Subtotal									
B. Mortgage Expense		7000	243	166 941		Straight Line	25	4.173	
Capitalized Financing Costs	2	0007	40 yis	100,771		a company and a			
2.									
3,									7172
B-4. Subtotal									4,1/3
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	p.								
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)									
C-4. Subtotal									4 172
D. Total Amortization									4,1/2
* Straight-line method must be used.									

* 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 End	ded		Page	of
Portland Care and Rehabilitation Cents 871-C	9/30/2015			25	37
11. Property Questionnaire				.,,,,,	
Part A		_		If "Yes," comp	lete Part B.
Is the property either owned by the Facility or leased from a Related Party?*	Yes	0	No	If "No," comple	
*If any owner or operator of this facility is related by family, ma	rriage ownershin ability	to control or		, 1	
business association to any person or organization from whom b	uildings are leased, then i	t is considered a			
related party transaction.		·			
Description	Total				
Date Land Purchased	01/01/69				
Date Structure Completed	09/30/71				
3. If NOT Original Owner, Date of Purchase				100000 1000000 10000000000000000000000	
4. Date of Initial Licensure	01/01/71				
5. Total Licensed Bed Capacity	65				
6. Square Footage	40,000				
7. Acquisition Cost	181,505				
a. Land	946,061				
b. Building	1st Mortgage		3rd Mortgage	4th Mo	rtgage
Part B - Owner and Related Parties	13t Mortgage	Zhu wortgage	Sta Woregage		-8-8-
 Financing Type of Financing (e.g., fixed, variable) 	Fixed				
b. Date Mortgage Obtained	06/23/05				
c. Interest Rate for the Cost Year	575.00%	 			
d. Term of Mortgage (number of years)	40				
e. Amount of Principal Borrowed	3,518,398				
f. Principal balance outstanding as of 09/30/1	5 3,778,650				in and an
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)				<u> </u>	
k. Amount of Principal Borrowed		 			
Principal Outstanding on Note Paid-Off	<u> </u>	<u> </u>			
Part C - Arms-Length Leases for Real Property	Improvements On	D-tfloors	Torm of I and	e Annual Amo	unt of Lease
Name and Address of Lessor Pr	operty Leased	Date of Lease	e Term or Leas	Ailluai Aillu	unt of Lease
					
	·				
		1			
		1	 		.==,

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

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

Name of Facility License No.		Report for Year Ended			Page	of
Portland Care and Rehabilitation Centry 871-C		9/30/2015			26	37
Item		Total	CCNH	RHNS	(Spe	ecify)
12. Interest						
A. Building, Land Improvement & Non-Movable						
Equipment		210.602	010.000			
1. First Mortgage	\$	218,602	218,602			
Name of Lender	Rate 5.75%					
Berkadia Commercial Mortgage Address of Lender	3.1370					
118 Welsh RoadHorsham, PA 19044-2207						
2. Second Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
3. Third Mortgage	\$		***************************************			
Name of Lender	Rate					
Address of Lender						
4. Fourth Mortgage	\$		(0)884726566844476447644			
Name of Lender	Rate					
Address of Lender		24 25 25 25 25 25 25 25 25 25 25 25 25 25		(10) (10)		3000 10000 10000
B. CHEFA Loan Information						
Original Loan Amount	\$	4,073,111				
2. Loan Origination Date		06/23/05				
3. Interest Rate %		5.75%				
4. Term		40				
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)	\$		218,602			

(Carry Subtotals forward to next page)

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

Name of Facility Portland Care and Rehabilitation C	License No. 871-C		Report for Year Ended 9/30/2015			Page of 27 37
Portland Care and Renabilitation C	d 9/1-C		9/30/2013			2, 31
Ite	****		Total	CCNH	RHNS	(Specify)
160		ught Forward:	218,602	218,602	TGII (B	(Specify
12. C. Movable Equipment	Bublout Die	agair i oi mara.				
1. Automotive Equipme	nt	\$				
A. Item	Rate	Amount				
Lender						60 C C C C C C C C C C C C C C C C C C C
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender		<u> </u>				
Lender						
Address of Lender				65 (5) (5) (5) (6)	2000 2000 2000	
B. Item	Rate	Amount				
Lender					9996 9596 9596 9597	
						55555
Address of Lender						
12. C. 3. Total Movable Equip	oment Interest					
Expense (C1 + 2)	(G · C)	<u> </u>				
12. D. Other Interest Expense (<i>ъресіју</i>)	1				
13. Total All Interest Expense (12B7 + 12C3 + 12E) \$	218,602	218,602		
14. Insurance	91 1	d	8,032	8,032		,
a. Insurance on Property (b. Insurance on Automobil	ouildings only)	9		2,180	<u></u>	
- 1 1 7			2,100	2,100		
c. Insurance other than Pro 1. Umbrella (Blanket C		(3			
2. Fire and Extended C		9				
3. Other (Specify)	· · · · · · · · · · · · · · · · · · ·	(86,590		
General Liability=64	1980 PMI=21610					
14d. Total Insurance Expenditu	res(14a+b+c)	(96,802	96,802		
15. Total All Expenditures (A			6,553,057	6,553,057		
15. 10th The Important Co (12-			1 / / / / / / / / / / / / / / / / / / /			

D. Adjustments to Statement of Expenditures

	of Fa		d Rehabilitation Centre, Inc.	Lic	ense No. 871-C	Report for Yea 9/30/2015	ır Ended	Page of 28 37
0171	ina Ot	are carr		•	Total			
tom	Page	Lina			Amount of			
			Item Description		Decrease	CCNH	RHNS	(Specify)
No.	No.	No.	es and Wages		Decrease	COLLI	Idire	(SPESIL))
	10 - 2	aiari	Outpatient Service Costs	\$				
1.			Salaries not related to Resident Care	<u></u> \$,. <u>.</u>			
2.	10			\$	225,378	225,378		
3.	10	g	Occupational Therapy	<u> </u>	223,376	223,316		
4.	10 1		Other - See attached Schedule	Ф				
	13 - 1	rofes	sional Fees	ተ				
5.			Resident Care Physicians **	\$				
6.			Occupational Therapy	\$				
7.			Other - See attached Schedule	\$				
	s 15 8	216 -	Administrative and General	_				
8.			Discriminatory Benefits	\$				
9.			Bad Debts	\$				
10.			Accounting & Legal	\$				
11.			Telephone	\$	18,145	18,145		
12.			Cellular Telephone	\$				
13.			Life insurance premiums on the life					
			of Owners, Partners, Operators	\$				
14.			Gifts, flowers and coffee shops	\$				
15.			Education expenditures to colleges or					
			universities for tuition and related costs					
	ļ		for owners and employees	\$				
16.	16	m13	Travel for purposes of attending					
			conferences or seminars outside the					
			continental U.S. Other out-of-state					2000 2000 2000 2000 2000 2000 2000 200
			travel in excess of one representative	\$	23,984	23,984		
17.	1		Automobile Expense (e.g. personal use)	\$				
18.	16	m3	Unallowable Advertising *	\$		399		
19.	15	i	Income Tax / Corporate Business Tax	\$	4	250		
20.	1.5)	Fund Raising / Contributions	\$				
21.			Unallowable Management Fees	\$				
22.	 	+	Barber and Beauty	\$				
23.	 	1	Other - See attached Schedule	\$		399,756		
		Dieta	ry Expenditures	Ψ	377,736	577,700		
		риени,	Meals to employees, guests and others					
24.			who are not residents	\$				
70	10	<u> </u>		Ψ	1			
<u> </u>	•	Laun	dry Expenditures					
25.			Laundry services to employees, guests	ď				
	1	<u> </u>	and others who are not residents	\$				
	r	Hous	ekeeping Expenditures					
26			Housekeeping services to employees, guests					
	<u> </u>		and others who are not residents	\$		667.012		-
			Subtotal (Items 1 - 26) \$		667,912 arry Subtotal 1	<u> </u>	

^{*} 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)
			100		
		20 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1			100
Total Othe	r Salaries 2	Adjustment	-	\$ -	\$ -
L					

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
		200 (100 (100 (100 (100 (100 (100 (100 (
Total Othe	r Fees Adj	ustments \$	-	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10 /	4 2	Administrator Cap	\$ 171,602		
10 /	44	Administrator Cap	\$ 171,602		
10)	1	Related Party Cap	\$ 56,552		
					10.7
Total Other	· A&G Ad	justments	\$ 399,756		\$ -
tour comer		Control Cont			

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

Name	e of Fa	cility	D. Adjustments to Stateme		ense No.	Report for Y		Page	of
		•	l Rehabilitation Centre, Inc.	"	871-C		29	37	
Ortio	anu Ca	ne an	1 Kenaphration Cente, inc.	<u> </u>	Total	9/30/2015			
itam	Page	Tina			Amount of				
		No.	Item Description	-	Decrease	CCNH	RHNS	(Spe	ecify)
140.	1110.	140.	Subtotals Brought Forward	\$	667,912	667,912			
Dage	20 - I	Rosido	nt Care Supplies***	-					
27.	20-1		Prescription Drugs	\$	140,142	140,142			
28.			Ambulance/Limousine	\$	1,559	1,559			
29.	<u> </u>		X-rays, etc	\$	11,174	11,174			
30.	 	 	Laboratory	\$	(33,210)	(33,210)			
31.			Medical Supplies	\$	3,998	3,998			
32.	-		Oxygen (non emergency)	\$	29,374	29,374			
33.	 		Occupational Therapy	\$	6,314	6,314	1 111		
34.	 	 	Other - See Attached Schedule	\$					
	22 - 1	Mainte	enance and Property						
35.	1		Excess Movable Equipment Depreciation				7.7	7.5	
	1		See Attached Schedule	\$					
36.	<u> </u>		Depreciation on Unallowable						
500			Motor Vehicles	\$					
37.			Unallowable Property and Real						
- • •			Estate Taxes	\$					
38.		 	Rental of Building Space or Rooms	\$					
39.	-		Other - See Attached Schedule	\$					
	27-1	Insura	ince						
40.		T	Mortgage Insurance	\$					
41.		\dagger	Property Insurance	\$					
Othe	er - Mi	scella	neous						
42.	.]		Research or Experimental Activities	\$					
43.			Radio and Television Revenue	\$					
44.		1	Vending Machine Revenue	\$					
45			Purchase Discounts and Allowances	\$					
46			Duplications of functions or services	\$					
47		1	Expenditures made for the protection,						
			enhancement or promotion of the						
			providers interest	\$				ļ	
48			Interest Income on Accounts Rec	\$	}				
49			Other (include personnel and other					1.25	
			costs unrelated to resident care) - See						
			Attached Schedule	\$					
Not	For P	rofit l	Providers Only		(4) (5) (5) (5) (6) (6)				
50).		Building/Non Movable Eq. Depreciation						
			Unallowable Building Interest -						
			See Attached Schedule	5					
51	. Tota	il Amo	ount of Decrease (Items 1 - 50)	4	827,263	827,263			

^{***} 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.

Portland Care and Rehabilitation Centre, Inc. 9/30/2015

Schedule of Other Ancillary Costs

Page Ref Line Ref	f Description			CCNH	RHNS	(Specify)
		0.00				
	100		100			
						5.0
Total Other Ancilla	ry Costs			\$ -	\$	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description		CCNH	RHNS	(Specify)
			100			
		100				
Total Exce	ss Moyabl	e Equipment Depreciation		\$	S -	8 -

Schedule of Other Property Adjustments

Page Ref	Line Ref Description	CCNH	RHNS	(Specify)
<u> </u>	Fee22			
			100	
Total Oth	r Property Adjustments	S - j	\$ -	\$ -

Page Ref Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Adjustn	ents S		\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Tuge Itel					
	_				
Total Unal	lowable B	uilding Interest	- \$	- 3	

F. Statement of Revenue

Name of Facility License No.		Report for Yo	Page			
Portland Care and Rehabilitation Centre, 871-C	9	9/30/2015			30	37
Item	100	Total	CCNH	RHNS	(Sp	ecify)
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (CT only)	\$	2,815,798	2,815,798		ļ	
b. Medicaid Room and Board Contractual Allowance **	\$					
2. a. Medicaid (All other states)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (all inclusive)	\$	1,389,094	1,389,094			
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$	2,194,780	2,194,780			
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
a. Prescription Drugs - Medicare	\$				<u>.</u>	
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
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	\$	61,103	61,103	· · · · · · · · · · · · · · · · · · ·		
b. Physical Therapy - Medicare Contractual Allowance **	\$		1			
c. Physical Therapy - Non-Medicare	\$					
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$			· · · · · · · · · · · · · · · · · · ·		
4. a. Speech Therapy - Medicare	\$					
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$					
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$					
b. Occupational Therapy - Medicare Contractual Allowance **	\$				1	
c. Occupational Therapy - Non-Medicare	\$					
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (Specify) - Medicare	\$					
b. Other (Specify) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)	\$	6,460,775	6,460,775		 	
IV. Other Revenue*		0,100,773	0,100,710			
<u> </u>	\$					
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$				-	
3. Telephone	\$				<u> </u>	
4. Rental of Television and Cable Services	\$	220	220		+	
5. Interest Income (Specify)		229	229		 	
6. Private Duty Nurses' Fees	\$			1	+	
7. Barber, Coffee, Beauty and Gift shops	\$	140.004	140.000		+	
8. Other (Specify)	\$	149,026	149,026	-	+	
V. Total Other Revenue (1 thru 8)	\$	149,255	149,255		+	
VI. Total All Revenue (III+V)	\$	6,610,030	6,610,030			

^{*} 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)
100			
Total Other Resident Revenue - Medicare.	\$.	s -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref Description	CCNH	RHNS	(Specify)
Total Other Resident Revenue	\$ -	S -	2 -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Rockville Bank Interest		\$ 229		
Total Inter	rest Income		\$ 229 \$	-	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Dividend Income	\$ 42		
	Lafe Institance Proceeds	\$ 207,411		
	CSV of Life Insurance	\$ (58,427)		
		100000		
Total Othe	r:Révenue	\$ 149,026	à -	ð -

G. Balance Sheet

Name of	f Facility	License No.	Report for Year Ended	Page	of
Portland	Care and Rehabilitation Cent	re 871-C	9/30/2015	31	37
		Account		A	mount
Assets					
A. Cu	urrent Assets				
1.	Cash (on hand and in banks)		\$	220,665
2.	Resident Accounts Receivab	le (Less Allowance fo	r Bad Debts)	\$	312,821
3.	Other Accounts Receivable	Excluding Owners or	Related Parties)	\$	
4	Inventories			\$	
5.	Prepaid Expenses			\$	97,400
	a. Prepaid Property Tax		15,355		
	b. Prepaid Building Insurance	ce	64,037		
	c. Prepaid Mortgage Insura	nce	18,008		
	d.				
6,	Interest Receivable			\$	
7.	Medicare Final Settlement R	eceivable		\$	
8.	Other Current Assets (itemiz	e)		\$	183,107
	Undeposited Funds		166,740		
	State Audit		425 15,942		60.0000 60.0000
	Resident Funds		1,0,742		
A-9 To	otal Current Assets (Lines Al	thru 8)		\$	813,993
	xed Assets				
	Land			\$	181,505
	Land Improvements	*Historical Cost	666,455	\$	277,190
. سے	Date Improvement	Accum. Depreciation			•
3	Buildings	*Historical Cost	3,530,053	\$	1,943,749
J,		Accum. Depreciation			, ,
	Leasehold Improvements	*Historical Cost	-yy	\$	
-1.	Doubertold Milproversion	Accum. Depreciation	on Net		
5	Non-Movable Equipment	*Historical Cost	161,872	\$	101,159
٥,	Tion ino table Equipment	Accum. Depreciation			•
6	Movable Equipment	*Historical Cost	391,713	\$	64,558
0.	1410 tuoto Equipitotti	Accum. Depreciation			ĺ
7.	Motor Vehicles	*Historical Cost	30,360	\$	(6,718
,.	Wictor Volicios	Accum. Depreciation			
8.	Minor Equipment-Not Depr			\$	
9.	Other Fixed Assets (itemize)		\$	261,974
	HUD Replacement Reser	-	133,989		•
	Financing Costs		127,985		
B-10.	Total Fixed Assets (Lines 1	31 thru 9)		\$	2,823,417

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

G. Balance Sheet (cont'd)

		Facility	License No.	Report for Year Ended		Page	ı	of
Portl	and	Care and Rehabilitation Centre	e, 871-C	9/30/2015		32	<u> </u>	37
			Account			Amo		
				Total Brought Forward:	\$		3,63′	7,410
C.	Lea	asehold or like property record	led for Equity Purposes.					
		Land			\$		• • • •	
	2.	Land Improvements	*Historical Cost	<u> </u>	_			
			Accum. Depreciation	Net	\$	<u></u>		
	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	\$			
		Minor Equipment-Not Depre			\$			
C-8		tal Leasehold or Like Proper	ties (C1 thru 7)		\$			
D.		vestment and Other Assets						
	1.	Deferred Deposits			\$			
<u></u>		Escrow Deposits			\$			
ļ	3.	Organization Expense	*Historical Cost					
<u> </u>			Accum. Depreciation	Net Net	\$			
<u></u>		Goodwill (Purchased Only)			\$_			
	5.	Investments Related to Resid	lent Care (itemize)		\$			
	6.				\$			
		Name and Address	Amount	Loan Date	-			
Ì	7.	Other Assets (itemize)			\$			
					-			
					-			
D-8		otal Investments and Other A			\$		0.65	
D-9	$T\epsilon$	otal All Assets (Lines A9 + B	10 + C8 + D8)		\$		3,63	7,410

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

G. Balance Sheet (cont'd)

Name of Facility		License No.		Report for Year En	ded	Page	of	
Portland Car	e and	Rehabilitation Centre, Inc.	871-C		9/30/2015		33	37
Account						Am	ount	
Liabilities								
A.	Cu	rrent Liabilities					*	
	1.	Trade Accounts Payable					\$	252,505
	2.	Notes Payable (itemize)				ļ	\$	193
		Capital One Credit Card			193			
			 					
							rh	
	3.	Loans Payable for Equipm				,	\$	
		Name of Lender	Purpose		Amount	Date Due		
					÷			
	2.				,			
			•					
•			i					
		•			,			
·					•			
	4.	Accrued Payroll (Exclusiv	e of Owners and/	or Stoc	kholders only)	I	\$	110,942
	5.	Accrued Payroll (Owners					\$	
	6.	Accrued Payroll Taxes Pa					\$	9,270
<u> </u>	7.	Medicare Final Settlemen					\$	
	8.	Medicare Current Financi		****			\$	
	9.	Mortgage Payable (Curre					\$	44,831
		. Interest Payable (Exclusiv		r Relat	ed Parties)		\$	
		. Accrued Income Taxes*					\$	
		. Other Current Liabilities	(itemize)				\$	340,400
		Employee 401k	,	186	Property Tax accrual	2,952		
		Unum Insurance Liability			Accrued Bonus Tax	55,269		
		Acrrued User Fee Penalty		11,815	Paid Time Off	107,306		
		User Fee Payable		146,837	Resident Fund Account	15,942		
A-13	3. To	otal Current Liabilities (Li	nes A1 thru 12)				\$	758,141

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

G. Balance Sheet (cont'd)

Name of Facility License No. Report for Year Ended			Ended	Page	of
Portland Care and Rehabilitation Centre, Inc	871-C	9/30/2015		34	37
	Account			A	mount
		Total Broug	ht Forward:		758,141
Liabilities (cont'd)					
B. Long-Term Liabilities	· ·				•
1. Loans Payable-Equipment	(itemize)		\$		
Name of Lender	Purpose	Amount	Date Due		0.00000
					5 (5)(5)
,					
					0.700.010
2. Mortgages Payable	15 / /		\$		3,733,819
Loans from Owners or Relation			\$		
Name and Address of Lender	Amount	Loan D	Pate		
Wells Fargo Bank					
		·			
		ļ			
4. Other Long-Term Liabilitie	\$				
_	-				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)		\$		3,733,819
C. Total All Liabilities (Lines A-	13 + B-5)		\$		4,491,960

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

	ne of Facility License No. Report for Year Ended	Pag	
Port	land Care and Rehabilitation Centre 871-C 9/30/2015 Account	35	Amount 37
A.	Reserves		Amount
	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	-	•
<u> </u>	Owner's Capital	\$	
	2. Capital Stock	\$	39,000
	3. Paid-in Surplus	\$	631,000
	4. Treasury Stock	\$	
	5. Cumulated Earnings	\$	(1,581,623)
	6. Gain or Loss for Period 10/1/2014 thru 9/30/2015	\$	57,073
	7. Total Net Worth	\$	(854,550)
C.	Total Reserves and Net Worth	\$	(854,550)
D.	Total Liabilities, Reserves, and Net Worth	\$	3,637,410

H. Changes in Total Net Worth

	e of Facility	License No.	Report for Year E	nded		•	of
Portl	and Care and Rehabilitation Centre,		9/30/2015			36 31	7
		Account			ļ	Amount	
<u>A.</u>	Balance at End of Prior Period as s	*	/30/2014		\$	(736,54	
В.	Total Revenue (From Statement of	<u> </u>			\$	6,610,12	
C.	Total Expenditures (From Statemen	nt of Expenditures Pa	ge 27)		\$	6,553,05	
<u>D.</u>	Net Income or Deficit				\$	57,07	_
E	Balance				\$	(679,47	<i>l</i> 6)
F.	Additions						
	1. Additional Capital Contributed	(itemize)				50 cm 50 cm 50 cm	
						355	
	2. Other (itemize)						
	•						
						335	
F-3.	Total Additions				\$		
G.	Deductions						
	1. Drawings of Owners/Operators				\$	172,85	54
	Name and Address (No., City,	State, Zip)	Title	Amount		0.000	
Gera	ld Yuska		Owner/President	87,203			
Geor	ge Yuska		wner/Adminstrate	85,651			
	2. Other Withdrawings (Specify)				\$		
	Purpose		Amour	nt ·			
			•			5.00	
						\$1000 GE	
	3. Total Deductions		_l		\$	172,85	### 54
H.	Balance at End of Period	09/30/1	5		\$	(852,33	

I. Preparer's/Reviewer's Certification

Name	of Facility	License No.	Report for Year Ended	Page	of
Portland Care and Rehabilitation Centre,		871-C	9/30/2015	37	37
		Check appropriate category			
M	Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)	□ (Specify)		
		Preparer/Reviewer Certific	cation		
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.					
Signat	ure of Preparer	Title Comptroller	Date Signed		
Printe	Name of Preparer		,		
	Ryen Torko				
Addres Address		•	Phone Number		
	333 Mus (7)	Vert RHL) (I a	B480 1860)342-	-03-	7 <i>U</i>