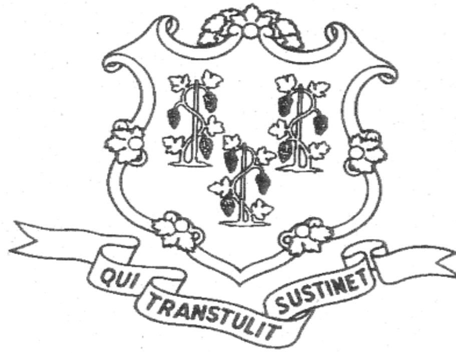
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2017

Name of Facility (as licensed) Riverside Health Care Center, Inc.	
Address (No. & Street, City, State, Zip Code) 745 Main St., East Hartford, CT 06108	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	1000c			075257

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	10009		

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2017	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Riverside Health Care Center, Inc. [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Karen Chadderton			Printed Name (Owner) Marvin J. Ostreicher	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment		Page 1A	of 37
Name of Facility Riverside Health Care Center, Inc.	Period Covered:	From 10/1/2016	To 9/30/2017
Address of Facility 745 Main St., East Hartford, CT 06108			
Report Prepared By Blum Shapiro & Co.	Phone Number 203-944-2100	Date 2/1/2018	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$				
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$				
5. All other wages paid	$				
6. ***Total Wages Paid***	$				
7. Total salaries paid	$				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
(860) 289-2791	9/30/2017	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Riverside Health Care Center, Inc.	745 Main St., East Hartford, CT 06108

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	1000c			075257

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.:
Karen Chadderton	001221

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2017	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
Riverside Health Care Center, Inc.	1000c	9/30/2017	3A	37

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

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Riverside Health Care Center, Inc	745 Main St, East Hartford, CT 06108	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Dorris Laufer	1402 59th Street Brooklyn, NY 11219	President	50
Marvin Ostreicher	184 Wildacre Avenue Lawrence, NY 11559	Secretary	200
Michael Pollack	2441 Beachwood Road Beachwood, OH 44122	Director	100
Agnes Zitter	9 Dogwood Lane Lawrence, NY 11559	Director	50
Izak Keller	9 Dogwood Lane Lawrence, NY 11559	Director	150
Names of Stockholders Owning at Least 10% of Shares			
Michael Pollack	2441 Beachwood Road Beachwood, OH 44122	Director	100
Marvin Ostreicher	184 Wildacre Avenue Lawrence, NY 11559	Secretary	200
Izak Keller	2417 Beachwood Blvd. Beachwood, OH 44122	Director	150
H. Ostreicher	1 Lakeside Drive East Lawrence, NY 11559	Director	166

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2017	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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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2017	4	37

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
See attachment		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					

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

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.	1000-C	9/30/2017	4	37

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report		Cost Reported	Actual Cost to the Related Party
		Yes	No	%**		Page #	Line #		
Preferred Therapy Solutions	850 Silas Deane Highway, Wethersfield, Ct 06109	☑	☐	37%	PT,OT,ST Services/Consulting	13	5a,9a,10a,12	1,519,217	1,500,758
NOA Diagnostics	6851 Jericho Turnpike, Suite 150 Syosset, NY 11791	☑	☐	82%	Radiology	20	5f	27,173	25,093
National Health Care Associates - Aetna	850 Silas Deane Highway, Wethersfield, Ct 06109	☐	☑		Health Insurance Trust***	15	1a5	2,345,902	2,345,902
National Health Care Associates	20 Sunrise Hwy, Valley Stream, NY 11581	☐	☑		Banking Transactions	16	13	23,518	23,518
Water's Edge Center for Health & Rehab	11 Church St Middletown CT 06457	☐	☑		Consulting - Marketing	16	m13	69,840	69,840
Riverside Realty	745 Main Street, East Hartford, CT 06108	☐	☑		Rent	22	9	1,261,427	1,261,427
National Health Care Associates	20 Sunrise Hwy, Valley Stream, NY 11581	☐	☑		Shared Expenses	16	12/ 13	1,461,416	1,461,416
850 Silas Deane Realty	850 Silas Deane Highway, Wethersfield, Ct 06109	☐	☑		Shared Expenses	16	12	5,004	5,004
VK Newburyport, LLC	180 Low St, Newburyport MA 01950	☐	☑		Shared Expenses	16	12	684	684
20Sunrise	20 Sunrise Highway, Valley Stream NY 11581	☐	☑		Shared Expenses	16	12	27,500	27,500
Procare LTC Pharmacy Of MA LLC	155 Northboro Rd STE 4 Southborough MA 01772	☑	☐	92%	Drugs	20	5a2	7,886	7,054
Procare LTC Pharmacy of CT	1492 Highland Ave Cheshire CT 06410	☑	☐	92%	Drugs/OTC's/Supplies/Consulting/Fees	20/12	5a2,b,j/b3,11	706,521	631,951

* 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
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.	1000-C	9/30/2017	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ☐ Yes ☑ No — If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties: Yes	No	%**	Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page #	Line #	Cost Reported	Actual Cost to the Related Party
Marlborough Health Care Center, Inc.	85 Stage Harbor Rd., Marlborough, CT 06447	☐	☑		Due from Related	31	A8	149,813	149,813
National Health Care Associates - Aetna	850 Silas Deane Highway, Wethersfield, CT 06109	☐	☑		Accounts payable	33	A1	1,790,320	1,790,320
Preferred Therapy Solutions	850 Silas Deane Highway, Wethersfield, CT 06109	☑	☐	37%	Due to Related	33	A12	315,973	315,973
NOA Diagnostics	6851 Jericho Turnpike, Suite 150 Syosset, NY 11791	☑	☐	82%	Due to Related	33	A12	5,404	5,404
Riverside Realty	745 Main Street, East Hartford, CT 06108	☐	☑		Due to Related	33	A12	89,889	89,889
National Health Care Associates	20 East Sunrise Highway, Valley Stream, NY 11581	☐	☑		Due to Related	33	A12	3,540	3,540
National Health Care Associates	20 East Sunrise Highway, Valley Stream, NY 11581	☐	☑		Due to Related (Debt)	33	A12	209,274	209,274
Cold Spring Hills Center for Nursing & Rehabilitation	378 Syosset-Woodbury Rd, Woodbury, NY 11797	☐	☑		Due to Related	33	A12	50,110	50,110
Harbor Hill Care Center, Inc.	11 Church Street, Middletown, CT 06457	☐	☑		Due to Related	33	A12	430,340	430,340
Milford Health Care Center, Inc.	195 Platt St Milford CT 06460	☐	☑		Due to Related	33	A12	21,945	21,945
Procare LTC Pharmacy of CT	1492 Highland Ave Cheshire CT 06410	☑	☐	92%	Due to Related	33	A12	435,799	435,799
Procare LTC Pharmacy of MA	155 Northboro Rd STE 4 Southborough MA 01772	☑	☐	92%	Due to Related	33	A12	6,032	6,032

* 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
Riverside Health Care Center, Inc.	1000c	9/30/2017	5	37

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

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

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

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

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

Shared expenses, allocated by bed size or geographic territory. 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
Riverside Health Care Center, Inc.	1000c	9/30/2017	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers: Yes	No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Reliable Health Systems, Nostrand Ave, Brooklyn, NY 11230	○	⊙	Computer Equipment	10/01/08	60 / ongoing	2,930	2,930
Wescom Solutions, PO Box 674802, Detroit, MI 48267	○	⊙	Software	Ongoing	Ongoing	44,260	44,260
Leaf 1720A Crete Street, Moberly, MO 65270	○	⊙	Copier	01/01/16	39 months	12,120	12,117
Leaf 1720A Crete Street, Moberly, MO 65270	○	⊙	Copier	10/01/16	39 months	7,494	7,422
Toyota Financial Services	○	⊙	Car	03/16/15	36 months	4,644	4,644
Nissan Motor Acceptance Corp, PO Box 371447, Pittsburgh PA 15250	○	⊙	Car	08/05/16	35 months	4,500	4,500
Wells Fargo, PO Box 7777, San Francisco, CA 94120	○	⊙	Copier	08/01/16	39 months	1,613	1,602
	○	⊙					
	○	○					
	○	○					

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

Total *** 77,475

* 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.

THE OFFICE WORKS

SALES ORDER

The Office Works, Inc.
45 Corporate Avenue
Plainville, CT 06062
1-800-634-4810 1-860-793-9994

DATE: 10-6-16

BILL TO:
Riverside Health and Rehabilitation Center, Inc.
745 Main Street
East Hartford, CT 06108

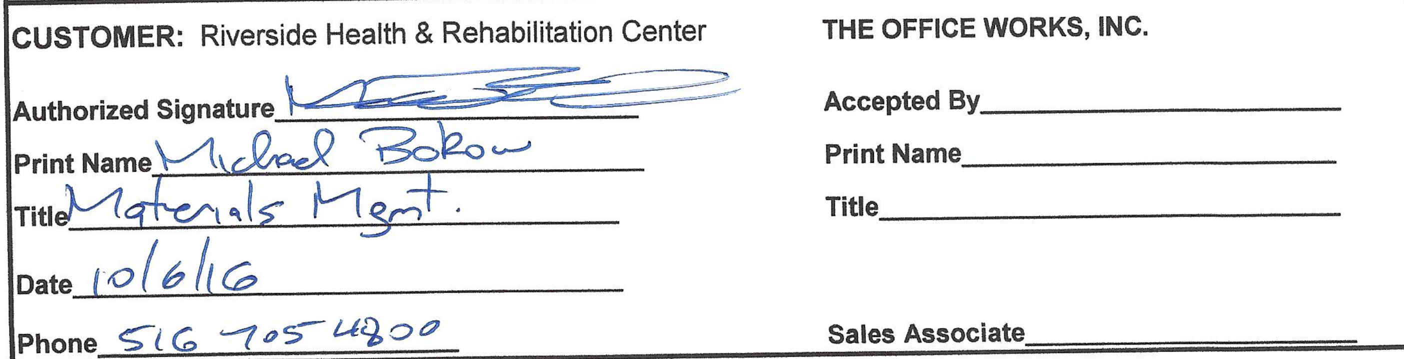
SHIP TO:
Same

ITEM	DESCRIPTION	QTY	UNIT PRICE	EXTENDED PRICE
e-Studio 3008A	Toshiba ~~color~~ multifinctional copier	6		
e-Studio 3508A	Toshiba ~~color~~ multifinctional copier	1		39-Month Lease
MR3031	Automatic document handler	7		564.78 per month
Stand 5005	Large capacity paper feed pedestal	7		
GD1370	Fax kit	1		

TOTAL SALE	Lease
DELIVERY CHARGE	N/C
SALES TAX	6.35% of mo. payment
TOTAL DUE	N/A

Notes / Provisions

- Lease cost includes delivery, installation and training.
- The seven new copying systems will be added to the current maintenance agreement.



CUSTOMER: Riverside Health & Rehabilitation Center

Authorized Signature [signature]

Print Name Michael Bokow

Title Materials Mgmt.

Date 10/6/16

Phone 516 705 4800

THE OFFICE WORKS, INC.

Accepted By__________

Print Name__________

Title__________

Sales Associate__________

LEASE AGREEMENT

1720A Crete Street, Moberly, MO 65270
Phone: 800-662-3759, Fax: 800-426-2626

LESSEE LEGAL NAME:	Tax ID#:	Telephone No:
Riverside Health & Rehabilitation Center Inc dba RIVERSIDE HEALTH & REHABILITAT		8602892791

Billing Address:	Equipment Location (if other than Billing Address):
745 MAIN ST, EAST HARTFORD, CT 06108	745 MAIN STREET, EAST HARTFORD, CT 06108

EQUIPMENT DESCRIPTION: (indicate quantity, new or used and include make, model, serial # and all attachments – see below and/or attached Schedule A)

Unit Quantity	Description of Equipment Leased	Make and Type	Model Number	Serial Number
	* PLEASE REFER TO SCHEDULE A			

BASE TERM IN MONTHS	TOTAL NUMBER OF LEASE PAYMENTS	END OF LEASE PURCHASE OPTION		
39	39 @ $564.78 (plus taxes)	X Fair market value, plus taxes ___ 10% of Equipment cost, plus taxes ___ $1.00, plus taxes (FMV unless another option is selected. You may not exercise a purchase option if you are in default. If you exercise a purchase option we will convey all of our right, title and interest in such Equipment to you on an AS-IS WHERE IS without warranty.)	(a) Advance Payment: (b) Security Deposit: (c) Documentation Fee: Total due a + b + c =:	$0.00 $0.00 $95.00 $95.00

**If more than one lease payment is required as an Advance Payment, the balance will be applied to lease payments in inverse order, starting with the last lease payment.
Your obligation to pay all amounts and perform all other obligations is non-cancellable, absolute, unconditional and not subject to abatement, set-off or defense.

TERMS AND CONDITIONS

In this agreement ("Lease"), "we," "our," and "us" refers to **LEAF Capital Funding, LLC** as Lessor and "you" and "your" refer to the Lessee. You agree to lease the Equipment upon the following terms and conditions:

1. LEASE PAYMENTS AND TERM: The Lease is enforceable on you upon your execution. The term of the Lease shall commence on the date the Equipment is delivered to you ("Lease Commencement Date"). The first Lease Payment shall be due on the date we specify in the month following the Lease Commencement Date as set forth in our invoice, and the remaining Lease Payments will be due on the same day of each subsequent month (each, a "Payment Date") until paid in full. The Base Term shall commence on the date one month prior to the first Payment Date. We may charge you a portion of one Lease Payment for the period from the Lease Commencement Date until the first day of the Base Term ("Interim Rent"). The Interim Rent shall be due as invoiced. We may adjust the Lease Payments up to 15% if the actual costs are different than the estimate used to calculate the Lease Payments.

2. DELIVERY, ACCEPTANCE, USE AND REPAIR: You are responsible for Equipment delivery and installation. You unconditionally accept the Equipment upon the earlier of (a) your oral or written acceptance of the Equipment, or (b) 10 days after delivery of the Equipment. You authorize us to fill in the Lease Commencement Date, serial numbers and other information. **You will not move the Equipment from the above location without our written consent and are responsible for maintaining the Equipment in good repair.** We are not responsible for Equipment or vendor failures.

3. INDEMNIFICATION: You agree to indemnify, defend and hold us harmless from and against any losses, damages, penalties, claims and suits, including attorneys' fees and expenses related to the ordering, manufacture, installation, ownership, condition, use, lease, possession, delivery or return of Equipment.

4. LEASE EXPIRATION, RENEWAL: Unless you notify us at least 90 days prior to the expiration of the Lease of your election to return or purchase the Equipment, this Lease will renew on a month-to-month basis at the same monthly Lease Payment until you either exercise the purchase option or provide us with at least 90 days notice and return the Equipment. If you return the Equipment, (i) it must be to the location we designate and you are responsible for all return costs and we may charge a Restocking Fee equal to one Lease Payment, and (ii) you must securely remove all data from any and all disk drives or magnetic media prior to returning the Equipment (and you are solely responsible for selecting an appropriate removal standard that meets your business needs and complies with applicable laws). You will pay us for any loss in value resulting from failure to maintain the Equipment in accordance with this Lease or for damages incurred in shipping and handling. If you exercise a purchase option we will convey all of our interest in such Equipment to you on an AS-IS WHERE IS basis without representation or warranty.

5. LATE FEES AND CHARGES: If any amount is not paid within five (5) days of when due, you agree to pay us a late charge equal to the lesser of 10% of the amount past due or the maximum legal amount. Amounts which are not paid within 30 days of when due shall accrue interest at 1.5% per month (or if less, the maximum legal rate) until paid. You agree to pay $25 for each pay by phone and $35 for each returned payment.

6. NO WARRANTY: We do not manufacture the Equipment and you have selected the Equipment and the supplier. **WE MAKE NO EXPRESS OR IMPLIED WARRANTIES, INCLUDING THOSE OF MERCHANTABILITY OR FITNESS FOR A PURPOSE AND ARE NOT RESPONSIBLE FOR CONSEQUENTIAL OR INCIDENTAL DAMAGES.**

7. INSURANCE, RISK OF LOSS: You bear all risk of loss or damage to the Equipment from its order until it is returned in the required condition or purchased by you ("Risk Period"). During the Risk Period you will maintain property and liability insurance on the Equipment acceptable to us, naming us loss payee and additional insured. If you do not provide us with proof of such insurance, we may secure insurance on the Equipment to cover our interests (and only our interests). If we obtain such insurance, you will pay us an additional amount for the cost of such insurance and an administrative fee, the cost of which may be more than the cost to obtain your own insurance and on which we may make a profit.

8. OWNERSHIP AND TAXES: We own the Equipment (excluding licensed software). If you are deemed to own it, you grant us a security interest in the Equipment. You authorize us to file UCC financing statements to confirm our interest. You will pay, when due, all taxes, fines and penalties relating to the purchase, use, leasing and/or ownership of the Equipment. If we pay any taxes, (including property tax), fees or penalties on your behalf, you will pay us the amount we paid plus an administrative fee. You agree to pay us the documentation fee specified above or if not so specified, the greater of either $125 or 0.5% of the Equipment cost. If we require an Equipment site inspection, or you request administrative services, you agree to reimburse our costs.

9. DEFAULT: If you or any guarantor do not pay us any amount within ten (10) days of its due date, or breach any terms of this Lease, any guaranty or any license relating to the Equipment, you will be in default. If you default, we may require you to do any combination of the following: (a) immediately pay all amounts then due, plus the present value of the remaining Lease Payments, Interim Rent and residual value of the Equipment, as determined by us, discounted at an annual rate of 3%; (b) return all of the Equipment; (c) allow us to repossess the Equipment; or (d) use any and all remedies available to us under applicable law. If you default, you agree to pay the cost of repossession and our attorney's fees and costs. In addition to all other charges and as reimbursement for expenses incurred and not as a penalty, we may require you to reimburse us for the phone calls, letters, and any additional expense incurred in the collection or servicing of this Lease for you. If we take possession of the Equipment, we may sell or otherwise dispose of it with or without notice, at a public or private sale, and apply the net proceeds (after we have deducted all costs related to the sale or disposition of the Equipment) to the amounts that you owe us. You agree that if notice of sale is required by law, **10** days' notice shall constitute reasonable notice. You remain responsible for any amounts that are due after we have applied such net proceeds. We may apply any security deposits to your obligations and if you do not default, the balance will be refunded without interest.

10. ASSIGNMENT: You have no right to sell or assign the Equipment or Lease. We may sell or assign our rights in the Lease and/or Equipment and the new owner will have all our rights but will not be subject to any claim or defense you have against us.

11. ARTICLE 2A: You agree this Lease is a "finance lease" as defined in Article 2A of the Uniform Commercial Code. **You waive all rights and remedies conferred upon a lessee by Article 2A (508-522) of the UCC.** You have received a copy of the Supply Contract or been informed of the identity of the Supplier and you may have rights under the Supply Contract and may contact the Supplier for a description of those rights.

12. CREDIT INFORMATION: You authorize us or any of our affiliates to obtain credit bureau reports, and make other credit inquiries that we deem necessary.

13. CHOICE OF LAW: THIS LEASE WILL BE GOVERNED BY PENNSYLVANIA LAW. YOU CONSENT TO JURISDICTION IN THE STATE OR FEDERAL COURTS IN PENNSYLVANIA AND WAIVE ANY RIGHT TO A TRIAL BY JURY.

14. MISCELLANEOUS: This Lease is the parties' entire agreement and can be amended only in writing signed by both parties. This Lease may be executed in counterparts (manually or by electronic means) and, when transmitted to us shall be binding upon you for all purposes. This Lease is not binding on us until we sign it. You agree not to raise as a defense to the enforcement of this Lease that it was executed or transmitted to us by electronic means. You will use the Equipment only for business purposes and not for personal, family or household use.

ACCEPTED BY LESSEE: Riverside Health & Rehabilitation Center Inc dba RIVERSIDE HEALTH & REHABILITAT
X [signature] Lessee Authorized Signature
Print Name: Michael Bokow
Title: Materials Mgmt
E-Mail Address: ______
Date: 10/6/16

PERSONAL GUARANTY: Undersigned guarantees that Lessee will make all payments and perform all other obligations under the Lease when due. Undersigned agrees that this is a guaranty of payment and not of collection, and that we can proceed directly against undersigned without first proceeding against Lessee or the Equipment. Undersigned also waives all suretyship defenses and notification if the Lessee is in default and consents to any extensions or modifications granted to Lessee. Undersigned will pay us all expenses (including attorneys' fees) we incur in enforcing our rights against undersigned or Lessee. If more than one person signs this guaranty, each agrees that his/her liability is joint and several. Undersigned authorizes us and our affiliates to obtain credit bureau reports and make inquiries regarding undersigned's personal credit. You consent to jurisdiction in the State or Federal courts in Pennsylvania and expressly waive any right to a trial by jury.

SIGNED X ______ Print Name: ______ E-Mail Address: ______

Accepted by:
LEAF Capital Funding, LLC By: ______ **Title:** ______ **Date:** ______

SCHEDULE A TO LEASE AGREEMENT
(EQUIPMENT DESCRIPTION)

Lease Application No.: **376027**

QNT	Equipment Description	New/Used	Make	Model	Serial Number
Location: 745 MAIN ST, EAST HARTFORD, CT 06108					
1	Toshiba E-STUDIO 3508A	New		E-STUDIO 3508A	
Location: 745 MAIN STREET, EAST HARTFORD, CT 06108					
6	Toshiba E-STUDIO 3008A	New		E-STUDIO 3008A	

LESSEE: Riverside Health & Rehabilitation Center Inc dba RIVERSIDE HEALTH & REHABILITAT

BY: ______

PRINT NAME: Michael Boskow

TITLE: Materials Mgmt.

DATE: 10/6/16

LEAF CAPITAL FUNDING, LLC

BY: ______

PRINT NAME: ______

TITLE: ______

DATE: ______

Equipment Lease Agreement

Wells Fargo Financial Leasing, Inc. | 800 Walnut, 4th floor | Des Moines, Iowa 50309 | Phone: 800-247-5083

Customer Information: Customer's Full Legal Name ("You" and "Your"): RIVERSIDE HEALTHCARE CENTER, INC.		**Supplier Information:** Supplier Name ("Supplier"): THE OFFICE WORKS, INC
Address: 745 MAIN STREET		Address: 45 CORPORATE AVENUE
City/State/Zip Code: EAST HARTFORD, CT 06804		City/State/Zip Code: PLAINVILLE, CT 06062
Telephone Number: 860-289-2791	Federal Tax ID#:	County:

Equipment Information: ☐ See Attached Equipment Schedule		Equipment Location (If different than address shown above):	
Quantity	Equipment Make, Model & Serial Number	Quantity	Equipment Make, Model & Serial Number
1	E-STUDIO 457		

Term And Payment Information: Initial Term: 39 months Payment*: $115.38 (*plus applicable taxes)

Payment Period is "Monthly" unless otherwise noted here: Security Deposit: $ Documentation/Processing Fee: $75.00

Advance Payment: $ applied to: ☐ 1st Payment ☐ Last Payment ☐ 1st and Last Payments

Purchase Option (shall be Fair Market Value unless another option is checked): ☒ Fair Market Value ☐ $1.00 ☐ Other

You acknowledge and agree that this agreement (as amended from time to time, the "Lease") represents the complete and exclusive agreement between You and Us regarding the subject matter herein and supersedes any other oral or written agreements between You and Us regarding such matters. This Lease can be changed only by a written agreement between You and Us. Other agreements not stated herein (including, without limitation, those contained in any purchase order or service agreement between You and the Supplier) are not part of this Lease. To help the government fight the funding of terrorism and money laundering activities, U.S. Federal law requires financial institutions to obtain, verify and record information that identifies each person (individuals or businesses) who opens an account. What this means for You: When You open an account or add any additional service, We will ask You for Your name, address, federal employer identification number and other information that will allow Us to identify You. We may also ask to see other identifying documents.

1. **LEASE OF EQUIPMENT.** You agree to lease from Us the personal property listed above (together with all existing and future accessories, attachments, replacements and embedded software, the "Equipment") upon the terms stated herein. This Lease is binding on You as of the date You sign it. You agree that after You sign, We may insert or correct any information missing on this Lease, including Your proper legal name, serial numbers and any other information describing the Equipment, and change the Payment by up to 15% due to a change in the Equipment or its cost or a tax or payment adjustment.

2. **TERM; AUTOMATIC RENEWAL.** The term of this Lease will begin on the date that it is accepted by Us or any later date that We designate (the "Commencement Date") and will continue for the number of months shown above (the "Initial Term"). As used herein, "Term" means the term presently in effect at any time, whether it is the Initial Term or a Renewal Term (defined below). **Unless You have a $1.00 Purchase Option, You shall notify Us in writing at least 60 days but not more than 120 days before the end of the Term (the "Notice Period") that You intend to purchase or return the Equipment at the end of such Term or: (a) this Lease will automatically renew for an additional one-year period** (a "Renewal Term"), and (b) all terms of this Lease will continue to apply. If You do notify Us in writing within the Notice Period that You intend to purchase or return the Equipment at the end of the Term, then You shall (i) purchase the Equipment by paying the purchase option amount (and all other amounts due hereunder) within 10 days after the end of the Term, or (ii) return the Equipment pursuant to Section 12. For any "Fair Market Value" Purchase Option, the fair market value shall be determined by Us in Our sole but commercially reasonable judgment. **This Lease is non-cancelable for the full Term.**

3. **UNCONDITIONAL OBLIGATION.** You agree that: (i) We are a separate and independent company from the Supplier, manufacturer and any other vendor (collectively, "Vendors"), and the Vendors are NOT Our agents; (ii) No representation or warranty by any Vendor is binding on Us, and no Vendor has authority to waive or alter any term of this Lease; (iii) You, not We, selected the Equipment and the Vendors based on Your own judgment; (iv) Your obligations hereunder are absolute and unconditional and are not subject to cancellation, reduction or setoff for any reason whatsoever; (v) If You are a party to any maintenance, supplies or other contract with any Vendor, We are NOT a party thereto, such contract is NOT part of this Lease (even though We may, as a convenience to You and a Vendor, bill and collect monies owed by You to such Vendor), and no breach by any Vendor will excuse You from performing Your obligations to Us hereunder; and (vi) If the Equipment is unsatisfactory or if any Vendor fails to provide any service or fulfill any other obligation to You, You shall not make any claim against Us and shall continue to fully perform under this Lease.

4. **PAYMENTS.** You agree to pay Us an interim rent charge as reasonably calculated by Us for the period from the date the Equipment is delivered to You until the Commencement Date. The payment for this interim period will be based on the Payment prorated on a 30-day calendar month and will be added to Your first invoice. Each Payment Period, You agree to pay Us, by the due date set forth on Our invoice to You (i) the Payment, and (ii) applicable taxes and other charges provided for herein. Restrictive endorsements on checks will not be binding on Us. All payments received will be applied to past due amounts and to the current amount due in such order as We determine. Any security deposit that You pay is non-interest bearing, may be commingled with Our funds, may be applied by Us at any time to cure any default by You, and the unused portion will be returned to You after You have satisfied all of Your obligations hereunder. If We do not receive a payment in full on or before its due date, You shall pay a fee equal to the greater of 10% of the amount that is late or $29.00 (or the maximum amount permitted by applicable law if less). You shall pay Us a returned check or non-sufficient funds charge of $20.00 for any returned or dishonored check or draft.

5. **INDEMNIFICATION.** You shall indemnify and hold Us harmless from and against, any and all claims, actions, damages, liabilities, losses and costs (including but not limited to reasonable attorneys' fees) made against Us, or suffered or incurred by Us, arising directly or indirectly out of, or otherwise relating to, the delivery, installation, possession, ownership, use, loss of use, defect in or malfunction of the Equipment. This obligation shall survive the termination of this Lease. We shall not be liable to You for any damages of any kind, including any liability for consequential damages, arising out of the use of or the inability to use the Equipment.

6. **NO WARRANTIES. WE ARE LEASING THE EQUIPMENT TO YOU "AS IS". WE HAVE NOT MADE AND HEREBY DISCLAIM ANY AND ALL WARRANTIES, EXPRESS OR IMPLIED, ARISING BY APPLICABLE LAW OR OTHERWISE, INCLUDING WITHOUT LIMITATION, THE IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE.** The parties hereto agree that this Lease is, or shall be treated as, a "finance lease" under Article 2A of the Uniform Commercial Code (the "UCC"). You hereby waive any and all rights and remedies conferred upon You by Article 2A of the UCC. If this Lease is deemed to be a secured transaction, You hereby grant to Us a security interest in the Equipment and all proceeds thereof. You authorize Us to record UCC financing statements to protect Our interests in the Equipment. You may be entitled under Article 2A of the UCC to the promises and warranties (if any) provided to Us by the Supplier(s) in connection with or as part of the contract (if any) by which We acquire the Equipment, which warranty rights We assign to You for the Term (provided You are not in default). You acknowledge that You are aware of the name of the Supplier of each item of Equipment and You may contact the Supplier(s) for an accurate and complete statement of those promises and warranties (if any), including any disclaimers and limitations of them or of remedies.

7. **DELIVERY; LOCATION; OWNERSHIP; USE AND MAINTENANCE.** We are not responsible for delivery or installation of the Equipment. You are responsible for Equipment maintenance. You will not remove the Equipment from the Equipment Location unless You first get Our permission. You shall give Us reasonable access to the Equipment Location so that We may inspect the Equipment, and You agree to pay Our costs in connection therewith. We will own and have title to the Equipment (excluding

BY SIGNING BELOW, CUSTOMER ACKNOWLEDGES RECEIPT OF PAGE 2 OF THIS AGREEMENT AND AGREES TO THE TERMS ON BOTH PAGES 1 & 2

Customer: (identified above) RIVERSIDE HEALTHCARE CENTER, INC.	Wells Fargo Financial Leasing, Inc. ("We," "Us," "Our" and "Lessor")
By: [signature] Date: 6/23/16	By: [signature] Date: 8/2/16
Print name: MICHAEL BOKOW Title: Materials Mgmt Coordinator	Print name: Joe Countryman Title: EFTC
	Agreement Number: 603-0156050-000

any software) during the Lease. If the Equipment includes any software: (i) We don't own the software, (ii) You are responsible for entering into any necessary software license agreements with the owners or licensors of such software, (iii) You shall comply with the terms of all such agreements, if any, and (iv) any default by You under any such agreements shall also constitute a default by You under this Lease. You agree that the Equipment is and shall remain personal property and without Our prior written consent, You shall not permit it to become (i) attached to real property or (ii) subject to liens or encumbrances of any kind. You represent that the Equipment will be used solely for commercial purposes and not for personal, family or household purposes. You shall use the Equipment in accordance with all laws, operation manuals, service contracts (if any) and insurance requirements, and shall not make any permanent alterations to it. At Your own cost, You shall keep the Equipment in good working order and warrantable condition, ordinary wear and tear excepted ("Good Condition").

8. **LOSS; DAMAGE; INSURANCE.** You shall, at all times during this Lease, (i) bear the risk of loss and damage to the Equipment and shall continue performing all Your obligations to Us even if it becomes damaged or suffers a loss, (ii) keep the Equipment insured against all risks of damage and loss ("Property Insurance") in an amount equal to its replacement cost, with Us named as sole "loss payee" (with a lender's loss payable endorsement if required by Lessor or an Assignee), and (iii) carry public liability insurance covering bodily injury and property damage ("Liability Insurance") in an amount acceptable to Us, with Us named as an additional insured thereunder. You have the choice of satisfying these insurance requirements by providing Us with satisfactory evidence of Property and Liability Insurance ("Insurance Proof"), within 30 days of the Commencement Date. Such Insurance Proof must provide for at least 30 days prior written notice to Us before it may be cancelled or terminated and must contain other terms satisfactory to Us. If you do not provide Us with Insurance Proof within 30 days of the Commencement Date, or if such insurance terminates for any reason, then (a) You agree that We have the right, but not the obligation, to obtain such Property Insurance and/or Liability Insurance in such forms and amounts from an insurer of Our choosing in order to protect Our interests ("Other Insurance"), and (b) You agree that We may charge you a periodic charge for such Other Insurance. This periodic charge will include reimbursement for premiums advanced by Us to purchase Other Insurance, billing and tracking fees, charges for Our processing and related fees associated with the Other Insurance, and a finance charge of up to 18% per annum (or the maximum rate allowed by law if less) on any advances We make for premiums (collectively, the "Insurance Charge"). We and/or one or more of our affiliates and/or agents may receive a portion of the Insurance Charge, which may include a profit. We are not obligated to obtain, and may cancel, Other Insurance at any time without notice to You. Any Other Insurance need not name You as an insured or protect Your interests. The Insurance Charge may be higher than if You obtained Property and Liability Insurance on Your own.

9. **ASSIGNMENT.** You shall not sell, transfer, assign or otherwise encumber (collectively, "Transfer") this Lease, or Transfer or sublease any Equipment, in whole or in part, without Our prior written consent. We may, without notice to You, Transfer Our interests in the Equipment and/or this Lease, in whole or in part, to a third party (an "Assignee"), in which case the Assignee will, to the extent of such Transfer, have all of Our rights and benefits but will not have to perform Our obligations (if any). Any Transfer by Us will not relieve Us of Our obligations hereunder. You agree not to assert against the Assignee any claim, defense or offset You may have against Us.

10. **TAXES AND OTHER FEES.** You are responsible for all taxes (including, without limitation, sales, use and personal property taxes, excluding only taxes based on Our income), assessments, license and registration fees and other governmental charges relating to this Lease or the Equipment (collectively "Governmental Charges"). Sales or use taxes due upfront will be payable over the Initial Term, with a finance charge. You authorize Us to pay any Governmental Charges as they become due, and You agree to reimburse Us promptly upon demand for the full amount. You agree to pay Us a fee for Our administration of taxes related to the Equipment. You also agree to pay Us upon demand (i) for all costs of filing, amending and releasing UCC financing statements, and (ii) a documentation/processing fee in the amount set forth on Page 1 (or as otherwise agreed to). You also agree to pay Us a fee for additional services We may provide to You at Your request during this Lease. If You so request, and We permit the early termination of this Lease, You acknowledge that there may be a cost or charge to You for such privilege. In connection with the expiration or earlier termination of this Lease, You agree to pay Us any Governmental Charges accrued or assessed but not yet due and payable, or Our estimate of such amounts. You agree that the fees and other amounts payable under this Lease may include a profit to Us and/or the Supplier.

11. **DEFAULT; REMEDIES.** You will be in default hereunder if: (1) You fail to pay any amount due hereunder within 15 days of the due date; (2) You breach or attempt to breach any other term, representation or covenant herein or in any other agreement now existing or hereafter entered into with Us or any Assignee; (3) an event of default occurs under any obligation You may now or hereafter owe to any affiliate of Us or any Assignee; and/or (4) You and/or any guarantors or sureties of Your obligations hereunder (i) die, (ii) go out of business, (iii) commence dissolution proceedings, (iv) merge or consolidate into another entity, (v) sell all or substantially all of Your or their assets, or there is a change of control with respect to Your or their ownership, (vi) become insolvent, admit Your or their inability to pay Your or their debts, (vii) make an assignment for the benefit of Your or their creditors (or enter into a similar arrangement), (viii) file, or there is filed against You or them, a bankruptcy, reorganization or similar proceeding or a proceeding for the appointment of a receiver, trustee or liquidator, or (ix) suffer a material adverse change in Your or their financial condition. If You default, We may do any or all of the following: (A) cancel this Lease, (B) require You to promptly return the Equipment pursuant to Section 12, (C) take possession of and/or render the Equipment (including any software) unusable (and for such purposes You hereby authorize Us and Our designees to enter Your premises, with or without prior notice or other process of law), and sell, lease or otherwise dispose of the Equipment on such terms and in such manner as We may in Our sole discretion determine, (D) require You to pay to Us, on demand, liquidated damages in an amount equal to the sum of (i) all Payments and other amounts then due and past due, (ii) all remaining Payments for the remainder of the Term discounted at a rate of 6% per annum, (iii) the residual value of the Equipment estimated by Us at the inception of this Lease (as shown in Our books and records), discounted at a rate of 6% per annum, (iv) interest on the amounts specified in clauses "i", "ii" and "iii" above from the date of demand to the date paid at the rate of 1.5% per month (or the maximum amount permitted by law if less), and (v) all other amounts that may thereafter become due hereunder to the extent that We will be obligated to collect and pay such amounts to a third party (such amounts specified in sub-clauses "i" through "v" referred to below as the "Balance Due"), and/or (E) exercise any other remedy available to Us under law. You also agree to reimburse Us on demand for all reasonable expenses of enforcement (including, without limitation, reasonable attorneys' fees and other legal costs) and reasonable expenses of repossessing, holding, preparing for disposition, and disposition ("Remarketing") of the Equipment, plus interest at the rate in sub-clause (iv) on the foregoing amounts from the date of demand to the date paid. In the event We are successful in Remarketing the Equipment, We shall give You a credit against the Balance Due in an amount equal to the present value of the proceeds received and to be received from Remarketing minus the above-mentioned costs (the "Net Proceeds"). If the Net Proceeds are less than the Balance Due, You shall be liable for such deficiency. Any delay or failure to enforce Our rights hereunder shall not constitute a waiver thereof. The remedies set forth herein are cumulative and may be exercised concurrently or separately.

12. **RETURN OF EQUIPMENT.** If You are required to return the Equipment under this Lease, You shall, at Your expense, send the Equipment to any location(s) that We may designate and pay Us a handling fee of $250.00. The Equipment must be properly packed for shipment, freight prepaid and fully insured, and must be received in Good Condition (defined in Section 7). All terms of this Lease, including Your obligation to make Payments and pay all other amounts due hereunder shall continue to apply until the Equipment is received by Us in accordance with the terms of this Lease. You are solely responsible for removing all data from any digital storage device, hard drive or other electronic medium prior to returning the Equipment or otherwise removing or allowing the removal of the Equipment from Your premises for any reason (and You are solely responsible for selecting an appropriate removal standard that meets Your business needs and complies with applicable laws). We shall not be liable for any losses, directly or indirectly arising out of, or by reason of the presence and/or use of any information, images or content retained by or resident in any Equipment returned to Us or repossessed by Us.

13. **APPLICABLE LAW; VENUE; JURISDICTION; SEVERABILITY.** This Lease shall be deemed fully executed and performed in the state of Iowa and shall be governed and construed in accordance with the laws of the state of Iowa. If Lessor or its Assignee shall bring any judicial proceeding in relation to any matter arising under this Lease, You hereby irrevocably agree that any such matter may be adjudged or determined in any court or courts in the state of Iowa or the state of Lessor's or its Assignee's principal place of business, or in any other court or courts having jurisdiction over You or Your assets, all at the sole election of Lessor or its Assignee. You hereby irrevocably submit generally and unconditionally to the jurisdiction of any such court so elected by Lessor or its Assignee in relation to such matters and irrevocably waive any defense of an inconvenient forum to the maintenance of any such action or proceeding. **YOU AND WE HEREBY WAIVE YOUR AND OUR RESPECTIVE RIGHTS TO A TRIAL BY JURY IN ANY LEGAL ACTION.** If any amount charged or collected under this Lease is greater than the amount allowed by law (an "Excess Amount"), then (i) any Excess Amount charged but not yet paid will be waived by Us and (ii) any Excess Amount collected will be refunded to You or applied to any other amount then due hereunder. Each provision hereof shall be interpreted to the maximum extent possible to be enforceable under applicable law. If any provision is construed to be unenforceable, such provision shall be ineffective only to the extent of such unenforceability without invalidating the remainder hereof.

14. **DOLLAR PURCHASE.** This Section only applies if You have a $1.00 Purchase Option. At the end of the Initial Term, You shall purchase the Equipment "AS IS, WHERE IS" for one dollar ($1.00); provided, however, We shall not be required to transfer Our interest in the Equipment to You until You have paid to Us all amounts then owing hereunder, if any. You agree that prior to entering into this Lease, You could have purchased the Equipment from the Supplier for a specific cash amount, but instead You hereby choose and agree to pay a higher amount (the "Time Price") to Us in installments over the Initial Term. The Time Price equals the Payment amount shown above multiplied by the total number of Payments to be paid over the Initial Term, plus $1.00. You agree that the Time Price represents only a higher purchase price and does not include an interest component or finance charge. However, if the Time Price should be determined or adjudicated to include an interest component or finance charge, then you agree that (i) each Payment shall be deemed to include an amount of pre-computed interest, (ii) the total pre-computed interest scheduled to be paid over the Initial Term is to be calculated by subtracting the amount We pay the Supplier ("Our Investment") from the Time Price, (iii) the annual interest rate deemed applicable to this transaction is the rate that will amortize Our Investment down to $1.00 by applying all periodic Payments as payments (and this rate calculation method assumes that each periodic Payment is received by Us on the due date), and (iv) none of the other fees or costs We may charge You pursuant to this Lease (including but not limited to UCC filing fees, late fees, documentation or processing fees) shall be considered interest or a finance charge.

15. **MISCELLANEOUS.** You shall furnish Us or an Assignee with current financial statements upon request by Us or an Assignee. You authorize Us or an Assignee to (a) obtain credit reports or make credit inquiries in connection with this Lease, and (b) provide Your credit application, information regarding Your Lease account to credit reporting agencies, potential Assignees, Vendors and parties having an economic interest in this Lease and/or the Equipment. This Lease may be executed in counterparts, each of which shall be deemed an original, but all of which together shall constitute the same document; provided, however, only the counterpart which is marked "Original" and is in Our possession shall constitute chattel paper under the UCC. You acknowledge that You have received a copy of this Lease and agree that a facsimile or other copy containing Your faxed, copied or electronically transmitted signature may be treated as an original and will be admissible as evidence of this Lease. You waive notice of receipt of a copy of this Lease with Our original signature. You hereby represent to Us that this Lease is legally binding and enforceable against You in accordance with its terms.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 6/95

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2017	7	37

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

⦿ Accrual ○ Cash ○ Modified Cash

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

If "No," explain.

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Blum Shapiro	2 Enterprise Drive, Shelton, CT, 06484
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1 Compilation, preparation of Medicare and Medicaid cost reports, HUD audit, and year end tax services	$ 30,855
2	$
3	$
4	$
Charge for Services Provided	$ 30,855

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

⦿ Yes ○ No Page 15, Line 1D

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 See attachment	
2	
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)
1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1 See attachment	$ 59,783
2	$
3	$
4	$
5	$
Charge for Services Provided	$ 59,783

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

⦿ Yes ○ No Page 15, Line 1E

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 6/95

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2017	7	37

Legal Services Information

	Name of Legal Firm or Independent Attorney	Telephone Number
1	Russ Hodgson	(716) 856-4000
2	Jackson Lewis	914-872-8069
3	Rogin Nassau	(860) 256-6300
4	Walker Dunlop	
5	Goldman, Gruder & Wood	(203) 899-8900
6	Treasurer, State of Connecticut	
7	Statewide Process Serving	

	Address (*No. & Street, City, State, Zip Code*)
1	140 Pearl Street, Suite 100 Buffalo, NY 14202-4040
2	44 South Broadway, White Plains NY 10601
3	185 Asylum Street -22nd Floor, Hartford CT 06103-3460
4	PO Box 90498, Chicago, IL 60696-0498
5	200 Connecticut Avenue Norwalk, CT. 06854
6	Hartford, CT, 06106
7	34 Connecticut Boulevard Suite #9 East Hartford, CT. 06108

	Services Provided by This Firm (*describe fully*)	
1	Labor	$ 1,073
2	Labor	$ 378
3	Labor	$ 1,242
4	Labor	$ 1,000
5	Collections - Disallow	$ 48,420
6	Conservator - Disallow	$ 6,590
7	Conservator - Disallow	$ 1,080
		Charge for Services Provided $ 59,783

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

⊙ Yes ○ No Page 15 line 1e

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

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				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	345	345			345	345			345	345		
B. On last day of THIS report period	345	345			345	345			345	345		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	310	310			310	310			310	310		
B. As of midnight of THIS report period	321	321			329	329			321	321		
3. Total Number of Days Care Provided During Period												
A. Medicare	9,289	9,289			6,562	6,562			2,727	2,727		
B. Medicaid (Conn.)	101,469	101,469			75,516	75,516			25,953	25,953		
C. Medicaid (other states)												
D. Private Pay	3,369	3,369			2,655	2,655			714	714		
E. State SSI for RCH												
F. Other (Specify) Managed Care	1,336	1,336			1,003	1,003			333	333		
G. Total Care Days During Period (3A thru F)	115,463	115,463			85,736	85,736			29,727	29,727		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	1	1							1	1		
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	115,464	115,464			85,736	85,736			29,728	29,728		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	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 CCNH	Medicaid CCNH	Medicaid RHNS	Self-Pay CCNH	Self-Pay RHNS	Self-Pay (Specify)	Other State Assisted R.C.H.	Other State Assisted ICF-MR
No. of Residents	24	282		15				
Per Diem Rate								
a. One bed rm.	PPS	243.16		446/540				
b. Two bed rms.	PPS	243.16		426/475				
c. Three or more bed rms.	PPS	243.16						

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	3,842	3,842		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	4,985	4,985		
C. Other	15,310	15,310		
D. ***Total Physical Therapy Treatments***	24,137	24,137		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	767	767		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	427	427		
C. Other	1,348	1,348		
D. ***Total Speech Therapy Treatments***	2,542	2,542		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	6,865	6,865		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	5,777	5,777		
C. Other	9,350	9,350		
D. ***Total Occupational Therapy Treatments***	21,992	21,992		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2017	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)	47,633	50				
2. Administrator(s) (Complete also Sec. III of Schedule A1)	174,615	2,312				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	138,638	2,080				
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	538,729	22,641				
5. Dietary Service						
a. Head Dietitian	133,697	4,430				
b. Food Service Supervisor	193,280	8,515				
c. Dietary Workers	842,312	53,047				
6. Housekeeping Service						
a. Head Housekeeper	119,174	4,430				
b. Other Housekeeping Workers	1,153,453	66,275				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	77,812	2,080				
b. Other Maintenance Workers	181,514	7,522				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	448,155	25,254				
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	254,737	4,492				
b. RN						
1. Direct Care	1,417,963	39,110				
2. Administrative**	242,496	6,278				
c. LPN						
1. Direct Care	3,391,990	120,852				
2. Administrative**						
d. Aides and Attendants	5,575,963	309,624				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	400,434	17,000				
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	439,530	14,855				
n. Marketing						
o. Other (Specify) See Attached Schedule	152,726	Disallowed				
A-13. Total Salary Expenditures	15,924,851	710,847				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Salary - Director Respiratory	$ 87,738	Disallowed				
Salary - Respiratory	$ 64,988	Disallowed				
Total	$ 152,726	Disallowed	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Consulting Fees - Rehabilitation, Therapy and Ancillary	$ 31,815	Disallowed				
Total	$ 31,815	Disallowed	$ -	-	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2017	11	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 I - Operators/Owners										
Marvin J. Ostreicher, 184 Wildacre Ave, Lawrence, NY 11559	47,633			Similar to Other Employees	Supervises operations, deals with DNS & other patient care,	50	Pg 16 line m1	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 - OWNER
TIME STUDY
YEAR END SEPTEMBER 30, 2017

Name	Beds	Total w/ Bnft
Augusta	72	53.82
Belair	102	52.61
Bethel	161	76.49
Bloomfield	120	55.03
Brattleboro	80	58.96
Brentwood	78	36.58
Brewer	111	67.73
Bristol	132	64.40
Cambridge	160	45.65
Catskill	136	51.40
Cold Spring Hills	-	-
Colony	92	44.44
Country	111	43.24
Dover	112	61.98
Eastside	69	48.07
Eliot	114	68.33
Glen Falls	120	48.68
Hudson	-	-
Huntington	320	54.42
Kennebunk	78	55.63
Hebrew Home	257	60.77
Ludlowe	144	65.00
Maple View	120	59.26
Marlborough	120	60.47
Maywood	120	47.47
Milford	120	52.00
Newton Wellseley	110	54.42
Norway	70	53.51
Poughkeepsie	200	63.19
Regency	130	48.68
Reservoir	144	53.51
Riverside	345	50.19
Ross	135	-
Rutland	125	55.93
Sachem	111	59.56
Sands Point	180	67.42
Utica	117	54.42
Village Crest	95	48.38
Water's Edge	150	57.75
Westgate	104	52.00
Winship	72	51.10
Total	5,137	2,102.50
Vacation		
Sick		
Personal		
Holiday		
Total Hours		

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2017	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Karen Chadderton (10/1/16-9/30/17)	152,307			Similar to Other Employees	Management & supervision of healthcare facility	2,080	a2			
Robert J. Baranello (10/28/16-11/4/16) - Disallowed	22,308			Similar to Other Employees	Management & supervision of healthcare facility	232	a2			
Section IV - Assistant Administrators										
Michael Bernardi	138,638			Supervises operations, deals with DNS &	Assists in management and supervision of a	2,080	a3			

*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.
** Include **all** other employment worked during the cost year.
*** If more than one Administrator is reported, include dates of employment for each.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.		Report for Year Ended		Page	of
Riverside Health Care Center, Inc.	1000c		9/30/2017		13	37
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	9,403	Disallowed				
3. Pharmacist	19,940	Disallowed				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	559,794	10,953				
b. Other						
6. Social Worker	4,350	174				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	114,292	136				
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)						
Psychiatrist	2,725	Disallowed				
9. Speech Therapist						
a. Resident Care	148,984	2,530				
b. Other						
10. Occupational Therapist						
a. Resident Care	789,769	14,619				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	31,815	Disallowed				
B-13 Total Fees Paid in Lieu of Salaries	1,681,072	28,412				

* 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 Year Ended	Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2017	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Gerident Solutions, PO Box 290539 Weathersfield, CT	Dentist	○	⊙	
Procare LTC of CT, 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist / Consulting Fees - Rehab Therapy & Ancillary	⊙	○	Common Ownership
Preferred Therapy Solutions, 850 Silas Deane Hwy Wethersfield, CT 06109	PT/OT/ST / Consulting Fees - Rehab Therapy & Ancillary	⊙	○	Common Ownership
Dr. David Grise, 27 Sycamore St, Glastonbury, CT 06033	Medical Director	○	⊙	
Family Medicine Center, 893 Main St., East Hartford, CT 06108	Medical Director	○	⊙	
Mouli Associates, 43 Wood St., Hartford, CT 06105	Medical Director	○	⊙	
University Physicians, P.O. Box 300611 Hartford, CT 06106	Medical Director	○	⊙	
Hira Jain, 153 Main St., Manchester, CT 06040	Psychiatrist	○	⊙	
Dr. Peter Radasch, 846 Farmington Ave West Hartford, CT 06127	Psychiatrist	○	⊙	
Swallowing Diagnostics, PO Box 848 Manchester, CT 06040	ST	○	⊙	
Amy Horvath 150 Westerly Terrace E Hartford CT 06118	Social Worker	○	⊙	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2017	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	646,859	646,859		
2. Disability Insurance	$				
3. Unemployment Insurance	$	195,885	195,885		
4. Social Security (F.I.C.A.)	$	1,178,262	1,178,262		
5. Health Insurance	$	2,345,902	2,345,902		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	61,843	61,843		
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	$	30,855	30,855		
e. Legal (*Services should be fully described on Page 7)*	$	59,783	59,783		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	44,552	44,552		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	26,920	26,920		
2. Cellular Phones	$	5,265	5,265		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$	250	250		
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*) See Attached Schedule	$				
3. Resident Day User Fee	$	1,717,876	1,717,876		
Subtotal	$	6,314,252	6,314,252		

* 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**

Riverside Health Care Center, Inc. Attachment Page 15
9/30/2017

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2017	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		6,314,252	6,314,252		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	7,463	7,463		
3. Gifts to Staff and Residents	$	42,671	42,671		
4. Employee Travel	$	12,315	12,315		
5. Education Expenses Related to Seminars and Conventions	$	5,198	5,198		
6. Automobile Expense (*not purchase or depreciation*)	$	3,786	3,786		
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	$	99,641	99,641		
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	$	7,309	7,309		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	23,467	23,467		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	750	750		
9. Subscriptions	$	1,646	1,646		
10. Contributions*** See Attached Schedule	$	1,500	1,500		
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$	1,463,850	1,463,850		
13. Other (*Specify*) See Attached Schedule	$	342,779	342,779		
C-14 Total Administrative & General Expenditures	$	8,326,627	8,326,627		

* 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 - Marketing	$ 87,785		
Advertising Promotional - Administration	$ 11,856		
Total Other Advertising	$ 99,641	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 23,077		
Karen Chadderton - Disallowed	$ 310		
Devika Singh - Disallowed	$ 80		
Total Dues	$ 23,467	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Political Contributions-Administration - Disallowed	$ 1,500		
Total Contributions	$ 1,500	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Consulting Fees - Fiscal Operations	$ 17,882		
Consulting Fees - Adminstration - Disallowed via management fee	$ 30,754		
Consulting Fees - Marketing - Disallowed	$ 69,840		
IT Services-Administration	$ 72,494		
Purchased Services - Administration	$ 2,200		
Purchased Services - Fiscal Operations	$ 49,933		
Licenses and Permits - Administration	$ 2,537		
Penalties - Administration - Disallowed	$ 7,849		
Bank Charges - Administration - Disallowed	$ 54,627		
Background Check - Administration	$ 3,491		
Crime Insurance - Administration - Disallowed	$ 6,098		
Miscellaneous Expense - Administration - Disallowed	$ 25,074		
Total Other Administrative and General	$ 342,779	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Riverside Health Care Center, Inc.	License No. 1000c	Report for Year Ended 9/30/2017	Page of 17 | 37
Name & Address of Individual or Company Supplying Service	**Cost of Management Service**	**Full Description of Mgmt. Service Provided**	**Indicate Where Costs are Included in Annual Report Page #/Line #**
National Healthcare	1,463,850	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.**

National Health Care
Profit and Loss Allocated by GL Account

Start Date: 10/1/2016
End Date: 9/30/2017

Account	Description	0101 Bloomfield	0102 Bristol	0103 Cambridge	0104 Ludlowe	0105 Maple View Manor	0106 Marlborough	0107 Milford	0108 New Milford	0109 Regency	0110 Riverside	0112 Water's Edge	0113 Bethel Health and Rehabilitation Center	0114 HEBREW HOME
300001-0000-00-000-0	TROY Shared Cost	(3,082.11)	(3,390.21)	(4,109.29)	(3,698.60)	(3,082.11)	(3,082.11)	(3,082.11)	(2,439.75)	(3,338.75)	(8,861.25)	(3,852.66)	(5,214.41)	(4,920.43)
391500-0000-00-000-0	Misc. Other Income-Nat. Mgmt.- - -	(230.77)	(253.85)	(307.69)	(276.93)	(230.77)	(230.77)	(230.77)	(182.66)	(249.96)	(663.47)	(288.48)	(390.42)	(494.21)
400000-0000-00-000-0	Salary-National Healthcare Management- - -	315,626.39	347,189.87	416,571.18	378,754.68	315,626.39	315,626.39	315,626.39	251,580.28	344,284.39	907,444.85	394,532.95	539,945.39	510,738.73
401000-0000-04-000-0	FICA-National Healthcare Management-Fiscal Ope- -	20,604.17	22,664.72	27,084.42	24,725.44	20,604.17	20,604.17	20,604.17	16,511.41	22,595.70	59,238.55	25,755.42	35,585.87	35,056.66
401100-0000-04-000-0	FUI-National Healthcare Management-Fiscal Oper- -	91.21	100.31	120.44	109.45	91.21	91.21	91.21	72.19	98.81	262.25	114.01	156.06	184.12
401200-0000-04-000-0	SUI-National Healthcare Management-Fiscal Oper- -	1,334.59	1,468.09	1,754.79	1,601.56	1,334.59	1,334.59	1,334.59	1,055.97	1,445.10	3,837.06	1,668.31	2,274.74	2,740.85
401201-0000-00-000-0	SUI - NY-National Healthcare Management- - -	(102.24)	(112.46)	(136.33)	(122.72)	(102.24)	(102.24)	(102.24)	(80.96)	(110.78)	(293.99)	(127.83)	(172.98)	(109.49)
401250-0000-00-000-0	NY MTA Tax-Nat. Mgmt.- - -	596.40	656.05	779.98	715.79	596.40	596.40	596.40	480.35	657.42	1,714.83	745.53	1,039.96	964.66
401300-0000-04-000-0	Health Insurance-National Healthcare-Fiscal Op- -	33,107.00	36,417.24	44,141.92	39,730.92	33,107.00	33,107.00	33,107.00	26,207.09	35,864.31	95,186.98	41,386.05	56,027.91	57,068.30
401400-0000-04-000-0	Workers Compensation-National Health-Fiscal Op- -	2,355.62	2,591.29	3,140.82	2,826.94	2,355.62	2,355.62	2,355.62	1,864.50	2,551.68	6,772.78	2,944.77	3,985.43	5,044.92
401500-0000-04-000-0	Medical Benefits-National Healthcare-Fiscal Op- -	(7.67)	(8.44)	(10.23)	(9.20)	(7.67)	(7.67)	(7.67)	(6.07)	(8.31)	(22.05)	(9.59)	(12.98)	(16.43)
401600-0000-04-000-0	Disability Expense-National Healthca-Fiscal Op- -	(91.06)	(100.12)	(121.39)	(109.29)	(91.06)	(91.06)	(91.06)	(72.05)	(98.64)	(261.82)	(113.84)	(154.04)	(133.07)
401700-0000-04-000-0	Pension-National Healthcare Manageme-Fiscal Op- -	6,418.84	7,060.44	8,558.00	7,702.73	6,418.84	6,418.84	6,418.84	5,081.06	6,953.32	18,454.51	8,023.53	10,859.59	10,007.07
401800-0000-04-000-0	Employee Benefits - Other-National H-Fiscal Op- -	708.47	779.27	944.60	850.19	708.47	708.47	708.47	560.82	767.42	2,036.84	885.57	1,198.07	1,118.67
402000-0000-04-000-0	Holiday Expense-National Healthcare -Fiscal Op- -	106.86	117.55	142.46	128.21	106.86	106.86	106.86	84.59	115.76	307.20	133.55	180.77	74.55
410000-0000-04-000-0	Supplies-National Healthcare Managem-Fiscal Op- -	2,856.68	3,142.36	3,808.96	3,428.12	2,856.68	2,856.68	2,856.68	2,261.43	3,094.65	8,213.37	3,570.94	4,791.09	5,014.89
410000-0000-08-000-0	Supplies-National Healthcare Managem-Maintenan- -	10.69	11.75	14.25	12.82	10.69	10.69	10.69	8.47	11.60	30.73	13.35	18.09	0.70
410000-0000-09-000-0	Supplies-National Healthcare Managem-Housekeep- -	22.52	24.76	30.00	27.01	22.52	22.52	22.52	17.84	24.36	64.72	28.15	40.42	42.47
411000-0000-04-000-0	Food-National Healthcare Management-Fiscal Ope- -	27.76	30.52	37.01	33.33	27.76	27.76	27.76	21.96	30.08	79.83	34.69	46.97	35.88
431000-0000-03-000-0	Consulting Fees-National Healthcare -Administr- -	18.03	19.84	24.04	21.64	18.03	18.03	18.03	14.27	19.53	51.84	22.54	30.51	38.62
431000-0000-04-000-0	Consulting Fees-National Healthcare -Fiscal Op- -	8,620.19	9,481.77	11,493.28	10,344.69	8,620.19	8,620.19	8,620.19	6,823.93	9,338.21	24,783.91	10,775.60	14,401.14	12,800.60
432000-0000-03-000-0	Accounting Fees-National Healthcare -Administr- -	541.16	595.30	721.49	649.41	541.16	541.16	541.16	428.36	586.30	1,555.96	676.47	915.53	749.23
433000-0000-03-000-0	Legal Fees-National Healthcare Manag-Administr- -	8,472.34	9,319.49	11,296.21	10,167.38	8,472.34	8,472.34	8,472.34	6,706.49	9,177.86	24,359.05	10,590.96	14,331.19	14,974.30
440000-0000-03-000-0	Purch Services-National Healthcare M-Administr- -	11,050.58	12,155.52	14,733.60	13,261.53	11,050.58	11,050.58	11,050.58	8,747.49	11,970.89	31,771.33	13,813.66	18,696.03	18,753.34
440000-0000-08-000-0	Purch Services-National Healthcare M-Maintenan- -	4,060.58	4,466.78	5,414.06	4,872.98	4,060.58	4,060.58	4,060.58	3,214.16	4,398.65	11,674.64	5,076.06	6,869.97	7,797.89
440000-0000-09-000-0	Purch Services-National Healthcare M-Housekeep- -	1,489.60	1,638.50	1,986.19	1,787.73	1,489.60	1,489.60	1,489.60	1,179.29	1,613.64	4,282.82	1,862.18	2,520.33	2,368.28
440000-0000-12-000-0	Purch Services-National Healthcare Ma-Security- -	3.49	3.83	4.65	4.18	3.49	3.49	3.49	2.76	3.78	10.03	4.36	5.90	7.47
440001-0000-08-000-0	Ground Services-Nat. Mgmt.-Maintenance- -	18.25	20.07	24.33	21.89	18.25	18.25	18.25	14.42	19.77	52.43	22.81	30.84	27.68
441000-0000-03-000-0	Computer Expense-National Healthcare-Administr- -	12,976.69	14,274.04	17,301.36	15,572.95	12,976.69	12,976.69	12,976.69	10,272.48	14,057.75	37,308.86	16,221.30	21,685.61	18,439.19
442000-0000-08-000-0	Pest Control-Nat. Mgmt.-Maintenance- -	8.17	8.98	10.89	9.80	8.17	8.17	8.17	6.47	8.85	23.49	10.21	13.82	
452000-0000-25-000-0	Equipment Rental-National Healthcare-Fiscal Op- -	2,879.22	3,166.92	3,838.70	3,455.18	2,879.22	2,879.22	2,879.22	2,279.21	3,119.01	8,277.99	3,599.21	4,871.10	4,482.71
461000-0000-03-000-0	Telephone-National Healthcare Manage-Administr- -	3,831.96	4,215.02	5,109.25	4,598.59	3,831.96	3,831.96	3,831.96	3,033.57	4,151.25	11,017.47	4,790.27	6,483.10	5,691.40
461100-0000-03-000-0	Telephone - Cell-National Healthcare-Administr- -	1,779.85	1,957.75	2,373.00	2,135.85	1,779.85	1,779.85	1,779.85	1,408.86	1,928.03	5,117.10	2,224.80	3,004.55	2,866.05
462000-0000-25-000-0	Electric-National Healthcare Manageme-Property- -	2,842.62	3,126.81	3,790.05	3,411.30	2,842.62	2,842.62	2,842.62	2,250.29	3,079.44	8,172.84	3,553.35	4,809.26	4,075.05
463000-0000-25-000-0	Gas-National Healthcare Management-Property- -	286.27	314.91	381.68	343.56	286.27	286.27	286.27	226.63	310.10	823.08	357.86	484.34	512.52
466000-0000-25-000-0	Water-National Healthcare Management-Property- -	125.39	137.94	167.19	150.50	125.39	125.39	125.39	99.25	135.83	360.51	156.75	212.16	197.85
471000-0000-25-000-0	Rent-National Healthcare Management-Property- -	11,904.14	13,093.27	15,871.29	14,285.51	11,904.14	11,904.14	11,904.14	9,424.58	12,896.53	34,225.14	14,880.11	20,139.49	12,476.79
472000-0000-25-000-0	Personal Property Taxes-National Hea-Fiscal Op- -	1,061.56	1,167.79	1,415.52	1,273.89	1,061.56	1,061.56	1,061.56	840.35	1,150.01	3,052.09	1,326.90	1,795.85	2,207.16
473000-0000-25-000-0	Real Estate Taxes-National Healthcar-Fiscal Op- -	3,443.49	3,788.25	4,591.57	4,132.72	3,443.49	3,443.49	3,443.49	2,725.32	3,729.98	9,900.97	4,305.09	5,826.20	9,261.26
484000-0000-04-000-0	Amort Exp - LHI-National Healthcare -Fiscal Op- -	2,516.86	2,768.45	3,355.70	3,020.36	2,516.86	2,516.86	2,516.86	1,992.36	2,726.52	7,236.24	3,146.16	4,258.13	3,941.29
486000-0000-04-000-0	Dep Exp - Moveable Equip-National He-Fiscal Op- -	11,227.34	12,349.82	14,969.42	13,473.47	11,227.34	11,227.34	11,227.34	8,887.35	12,162.26	32,279.85	14,034.76	18,994.98	19,585.47
491000-0000-03-000-0	Dues and Subscriptions-National Heal-Administr- -	923.05	1,015.35	1,230.71	1,107.72	923.05	923.05	923.05	730.65	999.93	2,653.89	1,153.87	1,561.71	1,636.89
500000-0000-03-000-0	Licenses and Permits-National Health-Administr- -	581.40	639.59	775.21	697.74	581.40	581.40	581.40	460.20	629.82	1,671.67	726.81	983.64	1,079.59
501000-0000-03-000-0	Advertising Employment-National Heal-Administr- -	5,904.90	6,494.59	7,872.45	7,085.66	5,904.90	5,904.90	5,904.90	4,674.72	6,396.87	16,976.31	7,380.55	9,989.70	5,795.97
501100-0000-03-000-0	Advertising Promotional-National Hea-Administr- -	6,751.42	7,426.73	9,002.04	8,102.13	6,751.42	6,751.42	6,751.42	5,344.56	7,313.87	19,411.29	8,439.87	11,380.63	10,816.81
503000-0000-03-000-0	Interest-National Healthcare Managem-Administr- -	2,273.15	2,500.56	3,030.81	2,728.05	2,273.15	2,273.15	2,273.15	1,799.44	2,462.54	6,535.70	2,841.61	3,846.98	3,787.91
503500-0000-03-000-0	Penalties-National Healthcare Manage-Administr- -													
503600-0000-03-000-0	Bank Charges-Nat. Mgmt.-Administration- -	1,390.29	1,529.34	1,853.69	1,668.44	1,390.29	1,390.29	1,390.29	1,100.51	1,506.09	3,997.26	1,737.92	2,352.16	2,304.72
504000-0000-03-000-0	Postage-National Healthcare Manageme-Administr- -	1,028.24	1,131.09	1,370.92	1,233.97	1,028.24	1,028.24	1,028.24	813.92	1,113.82	2,956.35	1,285.36	1,739.60	1,917.74
509000-0000-03-000-0	Seminars-National Healthcare Managem-Administr- -	580.46	638.51	773.95	696.66	580.46	580.46	580.46	459.55	628.81	1,668.93	725.66	981.20	904.13
510000-0000-03-000-0	Liability Insurance-National Healthc-Administr- -	2,222.62	2,444.82	2,963.43	2,667.30	2,222.62	2,222.62	2,222.62	1,759.39	2,407.73	6,390.26	2,778.40	3,760.36	3,648.18
511000-0000-03-000-0	Auto Insurance-National Healthcare M-Administr- -	1,464.24	1,610.68	1,952.30	1,757.20	1,464.24	1,464.24	1,464.24	1,159.11	1,586.22	4,209.98	1,830.43	2,477.33	2,517.47
512000-0000-03-000-0	Umbrella Insurance-National Healthca-Administr- -	1,199.48	1,319.43	1,599.27	1,439.48	1,199.48	1,199.48	1,199.48	949.48	1,299.36	3,448.64	1,499.41	2,029.36	2,047.90
513000-0000-03-000-0	Crime Insurance-National Healthcare -Administr- -	67.24	73.99	89.66	80.71	67.24	67.24	67.24	53.23	72.86	193.35	84.07	113.74	125.48
517000-0000-03-000-0	Wor`kmans Comp Insurance-National	1,245.82	1,370.25	1,660.94	1,494.91	1,245.82	1,245.82	1,245.82	986.23	1,349.58	3,581.65	1,557.19	2,107.67	1,318.23
520000-0000-03-000-0	Auto Expense-National Healthcare Man-Administr- -	1,940.32	2,134.10	2,586.87	2,328.27	1,940.32	1,940.32	1,940.32	1,536.21	2,102.07	5,578.30	2,425.16	3,282.49	1,300.95
520100-0000-03-000-0	Auto Lease Expense-National Healthca-Administr- -	3,326.39	3,658.73	4,434.78	3,991.57	3,326.39	3,326.39	3,326.39	2,633.34	3,603.08	9,563.31	4,157.82	5,641.63	4,606.91
521000-0000-00-000-0	Travel Expense-Nat. Mgmt.- - -	11.04	12.14	14.72	13.24	11.04	11.04	11.04	8.74	11.95	31.74	13.79	18.67	23.63
521000-0000-03-000-0	Travel Expense-National Healthcare M-Administr- -	7,274.81	8,002.45	9,699.71	8,730.06	7,274.81	7,274.81	7,274.81	5,758.52	7,880.71	20,915.97	9,093.90	12,267.84	12,259.94
522000-0000-03-000-0	Hotel Expense-National Healthcare Ma-Administr- -	6,265.22	6,891.68	8,353.42	7,518.61	6,265.22	6,265.22	6,265.22	4,959.41	6,786.92	18,013.18	7,831.80	10,599.82	10,784.74
541000-0000-03-000-0	Misc. Expense-Nat. Mgmt.-Administration- -	117.75	129.52	157.02	141.31	117.75	117.75	117.75	93.18	127.51	338.47	147.19	199.22	370.50
541000-0000-31-000-0	Misc. Expense-National Healthcare Ma-Misc. Exp- -	(973.14)	(1,070.55)	(1,297.65)	(1,167.88)	(973.14)	(973.14)	(973.14)	(770.27)	(1,054.09)	(2,798.09)	(1,216.71)	(1,643.72)	(2,586.93)
541001-0000-03-000-0	Political Contributions-Nat. Mgmt.-Administrat- -	12.21	13.43	16.28	14.65	12.21	12.21	12.21	9.67	13.23	35.10	15.26	20.65	13.07
542000-0000-31-000-0	Corporate Tax - State-National Healt-Misc. Exp- -	169.94	186.94	226.59	203.94	169.94	169.94	169.94	134.52	184.10	488.59	212.44	287.51	233.36
544000-0000-25-000-0	Sales Tax - Conn.-National Healthcar-Fiscal Op- -	0.00	7,216.97	8,747.91	7,873.27	0.00	0.00	0.00	5,194.14	7,108.03	18,862.83	8,201.33	11,099.29	7,905.23
	Misc. variance	(2,449.44)	(3,807.40)	(2,941.05)	(4,154.98)	(2,449.44)	(2,449.44)	(2,449.44)	(3,092.88)	(7,341.25)		(4,327.62)	(8,341.42)	2,407.09
Total														
		510,838.54	568,023.13	685,491.35	619,677.59	510,838.54	510,838.54	510,838.54	410,359.93	558,462.11	1,494,604.24	645,491.34	877,341.62	838,892.50
	Page 16 line M12	502,649.00	560,296.00	672,061.00	607,612.00	501,141.00	503,724.00	500,784.00	397,514.00	544,850.00	1,463,850.55	633,369.00	852,211.00	823,994.00
	Page 16 line M13	8,189.30	7,727.20	13,430.55	12,065.44	9,697.91	7,114.31	10,054.26	12,845.97	13,612.08	30,753.35	12,122.80	25,120.51	14,898.12

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
Riverside Health Care Center, Inc.	1000c	9/30/2017	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	888,329	888,329		
2. Non-Food Supplies	$	92,049	92,049		
3. Other (*Specify*)____________________	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	80	80		
c. Management Services**	$				
d. Other (*Specify*)________________________	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	980,458	980,458		

2F. Dietary Questionnaire				Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*							
H. Is cost of employee meals included in 2E?	○ 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)

Name of Facility	License No.	Report for Year Ended	Page of
Riverside Health Care Center, Inc.	1000c	9/30/2017	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	29,676	29,676		
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)*	$	744	744		
c. Management Services**	$				
d. Other (*Specify*) Supplies $26,083; Diapers $168,740	$	194,823	194,823		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	225,243	225,243		

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.

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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
Riverside Health Care Center, Inc.	1000c	9/30/2017	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping a. In-House Care	Sq. Ft. Serviced by Personnel					
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	90,596	90,596		
b. Purchased Services (*by contract other than through Management Services*)	Sq. Ft. Serviced by Personnel					
(*Complete Schedule C-2 att. Page 21*)	Amt.	$	(276)	(276)		
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	90,320	90,320		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from PCA		$	625,447	625,447		
b. Medicine Cabinet Drugs		$	44,521	44,521		
c. Medical and Therapeutic Supplies		$	380,533	380,533		
d. Ambulance/Limousine***		$	6,941	6,941		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	55,508	55,508		
f. X-rays and Related Radiological Procedures***		$	27,283	27,283		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***		$	35,335	35,335		
i. Recreation		$	59,996	59,996		
j. Other (Specify)**** See Attached Schedule		$	105,771	105,771		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	1,341,335	1,341,335		

* 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)
Flu Vaccine - Medical Services	$ 11,610		
IV Therapy Supplies - Rehabilitation Therapy and Ancillary	$ 46,035		
Purchased Services - Nursing	$ 7,445		
Equipment Rental - Nursing	$ 21,488		
Equipment Rental - Rehabilitation Therapy and Ancillary	$ 19,193		
Total Other Resident Care	$ 105,771	$ -	$ -

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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
Riverside Health Care Center, Inc.				1000c	9/30/2017				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
MJ Daly	110 Mattatuck Heights, Waterbury, CT, 06705	○	⊙		HVAC and Boiler service	74,443			22	6A
Otis Elevator	PO Box 13716 Newark, NJ 07188	○	⊙		Elevator Service	30,580			22	6A
Fire Protection Testing	1701 Highland Ave #4, Cheshire, CT 06410	○	⊙		Alarm Maintenance and Monitoring	13,391			22	6A
Kone Inc.	47-36 36th Street, Long Island City, NY 11101	○	⊙		Elevator Maintenance	11,648			22	6A
Junga Electric, LLC	19 CandleWood RD, Milford, CT 06461	○	⊙		Electrical Services	15,245			22	6A
ADM Environmental	1317 Coney Island Ave, Brooklyn, NY 11230	○	⊙		Removal/Recycling Services	45,887			22	6F
ADP	Philadelphia, PA 19170-0372	○	⊙		Payroll Processing	28,367			16	M13
Integrated Health Systems	PO Box 23072 Overland Park, KS 66283	○	⊙		Computer Maintenance Systems	18,429			16	M13
Smartlinx	333 Thornall St. 4th Floor Edison, NJ 08837	○	⊙		Time & Attendance	19,529			16	M13
The Office Works	45 Corp Ave, Plainville, CT, 06062	○	⊙		Copier Maintenance	10,438			16	M13
Beacon Plowing	PO Box 380270, East Hartford CT, 06138	○	⊙		Snow Removal	11,220			22	6F
Ecolab Equipment Care	24673 Network Place Chicago IL 60673	○	⊙		Dietary Equipment Maintenance	34,888			22	6A
		○	○							
		○	○							

* 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
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Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	292,213	292,213		
b. Heat	$	132,061	132,061		
c. Light & Power	$	406,449	406,449		
d. Water	$	124,213	124,213		
e. Equipment Lease (*Provide detail on page 6*)	$	77,475	77,475		
f. Other (*itemize*)	$	73,746	73,746		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	1,106,157	1,106,157		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$				
d. Movable Equipment	$	138,077	138,077		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	138,077	138,077		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	210,403	210,403		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	210,403	210,403		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	1,261,427	1,261,427		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	379,037	379,037		
c. Personal property taxes	$	39,286	39,286		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	2,028,230	2,028,230		

* 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)
Ground Services - Maintenance	$ 11,220		
Ground Supplies - Maintenance	$ 2,805		
Pest Control - Maintenance	$ 5,509		
Carting - Maintenance	$ 50,350		
Background Check - Security	$ 48		
Purch Services-Security	$ 1,022		
Short Term Lease - Pitney Bowes Mailing Machine	$ 2,792		
Total Other Repairs and Maintenance	$ 73,746	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2017	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
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	20,614,833		20,614,833	(equity purposes)				
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	1,048,608		1,048,608	(equity purposes)				
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. Ford Van			4	2002	14,137		14,137	14,137	SL	10		
b. 1998 Van			4	2004	7,974		7,974	7,974	SL	10		
c. 2005 Ford Van			4	2005	29,250		29,250	29,250	SL	10		
d. Other-See attached Schedule					55,590		55,590	55,590	SL	10		
2. Movable Equipment												
a. Acquired prior to this report period					1,655,919		1,655,919	1,028,117	SL	Various	112,159	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					313,723		313,723		SL	Various	25,918	
D-3. Subtotal												138,077
E. ***Total Depreciation***												138,077

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Depreciation Schedule

Name of Facility					License No.		Report for Year Ended			Page		of
Riverside Health Care Center, Inc.					1000c		9/30/2017			23a		37

	Movable Equipment - Motor vehicles (specify name, model and year of each vehicle)	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	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
		Yes	No	Month	Year								
D1a	1989 Van			4	1995	2,000		2,000	2,000	SL	10	-	
D1b	2011 Ford/Starcraft			10	2011	50,390		50,390	50,390	SL	4	-	
D1c	Sales tax on #715-new bus			12	2011	3,200		3,200	3,200	SL	4	-	
						55,590		**55,590**	**55,590**			**-**	

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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:					
10/21/2016	Direct Supply- Lifter Scale 600lb	$ 757	10	$ 38	
11/17/2016	McKesson- Electric Bed	$ 1,931	12	$ 80	
10/31/2016	Ecolab- Steamer Control Board	$ 1,350	10	$ 68	
12/6/2016	Yankee Equip- Bearings for washer	$ 6,318	10	$ 316	
12/30/2016	SIGNA Pump	$ 1,074	10	$ 54	
12/6/2016	Yankee Equip- Air Cylinder	$ 425	10	$ 21	
12/30/2016	MJ Daly- Heat Exchanger	$ 5,194	15	$ 173	
1/23/2017	PC Connection- PC & Monitor	$ 860	5	$ 86	
1/20/2017	PC Connection- PC & Monitor	$ 860	5	$ 86	
1/26/2017	MJ Daly-Heat Actuator Module	$ 2,891	15	$ 96	
1/26/2017	MJ Daly- Heat Exchange Roof Top Unit	$ 4,675	15	$ 156	
2/17/2017	H&R Health - SIGNA Pump	$ 2,148	7	$ 153	
2/28/2017	H&R Health - Pump & Battery Pack	$ 585	10	$ 29	
2/20/2017	MJ Daly- Holby Tempering Mixing Valve	$ 8,243	20	$ 206	
2/9/2017	Electric Bed	$ 1,931	10	$ 97	
4/25/2017	PC Richards- GE Gas Range Stove	$ 605	10	$ 30	
4/11/2017	Ecolab- Heater	$ 1,975	10	$ 99	
4/4/2017	Daniels- UniMac Washer	$ 16,905	10	$ 845	
6/1/2017	Culinary Depot- Blender/Chopper	$ 1,309	10	$ 65	
6/30/2017	PC & Monitor	$ 1,319	5	$ 132	
6/30/2017	8 Chromebooks	$ 2,030	5	$ 203	
7/31/2017	Feeding Pump	$ 1,018	10	$ 51	
7/31/2017	H&R Healthcare- Pump	$ 1,803	10	$ 90	
5/31/2017	Integrated Health System - Chromebooks, Servers, Software	$ 209,274	5	$ 20,927	
8/31/2017	Direct Supply- Vacuum	$ 635	8	$ 40	
8/31/2017	Direct Supply Digital Scale	$ 1,269	10	$ 63	
8/31/2017	Dining Chairs	$ 3,191	15	$ 106	
2/28/2017	Daniel's- UniMac Washer	$ 4,726	15	$ 158	
1/31/2017	Daniel's Equip- Washer Bearing	$ 2,000	15	$ 67	
2/28/2017	Dining Chairs	$ 7,180	8	$ 449	
8/31/2017	Ecolab- Pump Assembly	$ 2,972	10	$ 149	
9/30/2017	Electric Bed	$ 2,007	12	$ 84	
9/30/2017	Desk	$ 481	20	$ 12	
9/30/2017	Ecolab- Ice Machine	$ 2,982	10	$ 149	
9/30/2017	Dryer	$ 10,800	10	$ 540	
Total additions for Movable Equipment		$ 313,723		$ 25,918	*
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:				
10/31/2016	Heat Pump	$ 2,225	10	$ 111
11/14/2016	New Vinyl Floor	$ 2,152	10	$ 108
11/18/2016	Wall Bumpers/Caps	$ 1,909	5	$ 191
2/16/2017	Smoke Dampers	$ 2,818	10	$ 141
2/28/2017	Door	$ 1,868	10	$ 93
6/1/2017	HVAC Pump Replacement	$ 4,406	15	$ 147
12/1/2016	MJ Daly- Heat Pump	$ 7,252	10	$ 363
2/21/2017	MJ Daly- Heat Pumps	$ 7,252	10	$ 363
7/31/2017	MJ Daly- 2 Heat Pumps	$ 7,252	15	$ 242

Total additions for Leasehold Improvement		$ 37,134		$ 1,759	* Attachment Pages 23 24
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
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Item	Date of Acquisition Month	Date of Acquisition Year	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
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			Various	2,891,810	1,693,251	SL		208,644	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)			Various	37,134		SL		1,759	
C-4. Subtotal									210,403
D. ***Total Amortization***									210,403

* 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.

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

Name of Facility	License No.	Report for Year Ended	Page of
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11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?*   ⦿ Yes   ○ No   If "Yes," complete Part B. If "No," complete Part C.

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	09/08/80
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	345
6. Square Footage	144,794
7. Acquisition Cost	
a. Land	365,846
b. Building	19,933,873

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	04/30/03			
c. Interest Rate for the Cost Year	3.75%			
d. Term of Mortgage (number of years)	34 years, 6 mo			
e. Amount of Principal Borrowed	18,891,400			
f. Principal balance outstanding as of 9/30/17	15,164,709			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility	License No.	Report for Year Ended	Page of
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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
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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*) Property interest $1,113, Interest Admin $6,673			$	7,786	7,786		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)			$	7,786	7,786		
14. Insurance a. Insurance on Property (buildings only)			$	29,230	29,230		
b. Insurance on Automobiles			$	7,694	7,694		
c. Insurance other than Property (as specified above) 1. Umbrella (*Blanket Coverage*)			$	46,800	46,800		
2. Fire and Extended Coverage			$				
3. Other (*Specify*) Liability Ins. $130,000; Mortgage Ins. $76,964			$	206,964	206,964		
14d. ***Total Insurance Expenditures (14a + b + c)***			$	290,688	290,688		
15. ***Total All Expenditures (A-13 thru C-14)***			$	32,002,767	32,002,767		

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Riverside Health Care Center, Inc.	1000c	9/30/2017	28 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages								
1.			Outpatient Service Costs	$				
2.	10	12M	Salaries not related to Resident Care	$	42,999	42,999		
3.			Occupational Therapy	$				
4.			Other - See attached Schedule	$	175,034	175,034		
Page 13 - Professional Fees								
5.			Resident Care Physicians **	$				
6.	13	B10a	Occupational Therapy	$	789,769	789,769		
7.			Other - See attached Schedule	$	155,740	155,740		
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.			Bad Debts	$				
10.	15	1e/1d	Accounting & Legal	$	62,815	62,815		
11.			Telephone	$				
12.	15	1h2	Cellular Telephone	$	4,185	4,185		
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.			Automobile Expense (e.g. personal use)	$				
18.	16	M3	Unallowable Advertising *	$	99,641	99,641		
19.	15	1j	Income Tax / Corporate Business Tax	$	250	250		
20.	16	M10	Fund Raising / Contributions	$	1,500	1,500		
21.	16	m12	Unallowable Management Fees	$	639,827	639,827		
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	271,720	271,720		
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)	$	2,243,480	2,243,480		

* 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	A12i4	Salary - Director Respiratory	$ 87,738		
10	A12i4	Salary - Respiratory	$ 64,988		
10	A2	Salary - Administrator (overlap)	$ 22,308		
Total Other Salaries Adjustment			$ 175,034	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B8e	Psychiatrist	$ 2,725		
13	B12	Consulting Fees - Rehabilitation, Therapy and Ancillary	$ 31,815		
13	B2	Dentist	$ 9,403		
13	B3	Pharmacist	$ 19,940		
13	B8a	Medical Director (over the limit)	$ 91,857		
Total Other Fees Adjustments			$ 155,740	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
15	1a	Benefits on Salaries Not Related to Resident Care - Resp Therapy & Admin	60,636		
16	M13	Penalties - Administration	$ 7,849		
16	M13	Bank Charges - Administration	$ 54,627		
16	M13	Miscellaneous Expense - Administration	$ 25,073		
16	M13	Crime Insurance - Administration	$ 6,098		
16	l3	Gifts	$ 42,671		
16	M8	Employees- disallowed dues	$ 390		
16	M13	Consulting Fees - Marketing	$ 69,840		
16	M9	Disallowed Dues - Chamber of Commerce	$ 750		
16	L6	Auto Expense	$ 3,786		
Total Other A&G Adjustments			$ 271,720	$ -	$ -

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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	$	2,243,480	2,243,480		
Page 20 - Resident Care Supplies*								
27.	20	5a2	Prescription Drugs	$	625,447	625,447		
28.	20	5f	Ambulance/Limousine	$	6,941	6,941		
29.	20	5h	X-rays, etc	$	27,283	27,283		
30.	20	5c	Laboratory	$	35,335	35,335		
31.	20	5c	Medical Supplies	$	26,279	26,279		
32.	20	5j	Oxygen (non emergency)	$	55,508	55,508		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	133,542	133,542		
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$	11,672	11,672		
36.			Depreciation on Unallowable Motor Vehicles	$				
37.	22	10c	Unallowable Property and Real Estate Taxes	$	821	821		
38.			Rental of Building Space or Rooms	$				
39.			Other - See Attached Schedule	$	16,838	16,838		
Page 27 - Insurance								
40.	27	14c3	Mortgage Insurance	$	76,964	76,964		
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	$	21,440	21,440		
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)***	$	3,281,550	3,281,550		

*** 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

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

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV Therapy Supplies - Rehabilitation Therapy and Ancillary	$ 46,035		
20	5j	Equipment Rental - Nursing	$ 21,488		
20	5j	Equipment Rental - Rehabilitation Therapy and Ancillary	$ 19,193		
20 / 13	5a2 / B3	Disallowance on Procare Price Markups	$ 1,530		
20	5j	Flu Vaccine - Medical Services	$ 11,610		
20	5i	Cable TV Expense - Resident Rooms	$ 33,686		
Total Other Ancillary Costs			$ 133,542	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	6d	Kore Balance System and Other Rehab Equip., DVR, Mattress & TV's	$ 11,672		
Total Excess Movable Equipment Depreciation			$ 11,672	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	6e	Auto Lease Expense	$ 9,144		
27	14b	Auto Insurance	$ 7,694		
Total Other Property Adjustments			$ 16,838	$ -	$ -

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30	IV5	Interest Income	$ 1,035		
30	IV8	Miscellaneous Other Income (Medical Records & Other)	$ 6,460		
30	IV8	Miscellaneous Other Income - PY Adjustment	$ 6,159		
27	12d	Interest - Admin	$ 7,786		
Total Other Adjustments			$ 21,440	$ -	$ -

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
Riverside Health Care Center, Inc.	1000c	9/30/2017	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	40,834,669	40,834,669		
b. Medicaid Room and Board Contractual Allowance **	$	(16,996,281)	(16,996,281)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	4,211,719	4,211,719		
b. Medicare Room and Board Contractual Allowance **	$	447,335	447,335		
4. a. Private-Pay Residents and Other	$	3,073,957	3,073,957		
b. Private-Pay Room and Board Contractual Allowance **	$	(1,011,695)	(1,011,695)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	401,777	401,777		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(401,777)	(401,777)		
c. Prescription Drugs - Non-Medicare	$	173,763	173,763		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(172,816)	(172,816)		
2. a. Medical Supplies - Medicare	$	9,141	9,141		
b. Medical Supplies - Medicare Contractual Allowance **	$	(9,142)	(9,142)		
c. Medical Supplies - Non-Medicare	$	2,192	2,192		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(2,192)	(2,192)		
3. a. Physical Therapy - Medicare	$	859,489	859,489		
b. Physical Therapy - Medicare Contractual Allowance **	$	(733,868)	(733,868)		
c. Physical Therapy - Non-Medicare	$	239,557	239,557		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(236,819)	(236,819)		
4. a. Speech Therapy - Medicare	$	223,993	223,993		
b. Speech Therapy - Medicare Contractual Allowance **	$	(147,871)	(147,871)		
c. Speech Therapy - Non-Medicare	$	50,556	50,556		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(46,465)	(46,465)		
5. a. Occupational Therapy - Medicare	$	1,149,985	1,149,985		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(931,824)	(931,824)		
c. Occupational Therapy - Non-Medicare	$	429,838	429,838		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(284,136)	(284,136)		
6. a. Other *(Specify)* - Medicare	$	36,567	36,567		
b. Other *(Specify)* - Non-Medicare	$	(1,221)	(1,221)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	31,168,431	31,168,431		
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)*	$	1,035	1,035		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	48,977	48,977		
V. Total Other Revenue (1 thru 8)	$	50,012	50,012		
VI. Total All Revenue (III +V)	$	31,218,443	31,218,443		

* *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 Part A Lab	$ 18,108		
30, line II6a	Medicare Part A X-Ray	$ 13,975		
30, line II6a	Medicare Part B Flu/Pneumonia	$ 2,575		
30, line II6a	Medicare Part B Prior Period	$ (7,936)		
30, line II6a	Medicare Pt A Contra Other	$ (55,004)		
30, line II6a	Medicare Pt A IV Therapy	$ 22,519		
30, line II6a	Mgd Medicare Contra Other	$ (37,603)		
30, line II6a	Mgd Medicare IV Therapy	$ 14,699		
30, line II6a	Mgd Medicare Lab	$ 13,159		
30, line II6a	Mgd Medicare X-Ray	$ 11,531		
30, line II6a	Mgd Medicare Glucose	$ 17,185		
30, line II6a	Medicare Pt A Settlement	$ 23,359		
Total Other Resident Revenue - Medicare		$ 36,567	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30, line II6b	Medicaid Contra Other	$ (5,762)		
30, line II6b	Medicaid IV Therapy	$ 690		
30, line II6b	Medicaid Lab	$ 2,922		
30, line II6b	Comm Insurance Contra Other	$ (4,561)		
30, line II6b	Comm Insurance Lab	$ 2,090		
30, line II6b	Comm Insurance X-Ray	$ 2,633		
30, line II6b	Hospice Contra Other	$ (56)		
30, line II6b	Hospice Lab	$ 56		
30, line II6b	Medicaid X-Ray	$ 767		
Total Other Resident Revenue		$ (1,221)	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
30, line IV5	Interest Income		$ 1,035		
Total Interest Income			$ 1,035	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30, line IV8	Miscellaneous Other Income (UHC Dividends $61,515;	$ 67,975		
	Medical Records $878; Legal Recovery $1,526, Other Miscellaneous Income $4,056)			
30, line IV8	Miscellaneous Other Income PY Adjustment	$ (6,159)		
30, line IV8	Prior Period Other	$ (12,839)		
Total Other Revenue		$ 48,977	$ -	$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page of
Riverside Health Care Center, Inc.	1000c	9/30/2017	31 | 37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 195,338
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 3,171,354
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 44,106
5. Prepaid Expenses				$ 563,895
a. Insurance		14,772		
b. Taxes (personal property, real estate, corp.)		348,779		
c. Management Fees		153,936		
d. Other Prepaid Expenses		46,408		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 585,915
Patient Funds		98,349		
Escrow Deposits		487,566		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 4,560,608
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	2,928,944		$ 1,025,290
	Accum. Depreciation	1,903,654	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	1,969,642		$ 803,448
	Accum. Depreciation	1,166,194	Net	
7. Motor Vehicles	*Historical Cost	106,951		$
	Accum. Depreciation	106,951	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 1,828,738

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

(*Carry Total forward to next page*)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Riverside Health Care Center, Inc.	1000c	9/30/2017	32 | 37

Account				Amount
			Total Brought Forward:	$ 6,389,346
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	20,614,833	Net	$ 20,614,833
4. Non-Movable Equipment	*Historical Cost Accum. Depreciation	1,048,608	Net	$ 1,048,608
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)				$ 21,663,441
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*)				$ 149,813
Name and Address	Amount	Loan Date		
Marlborough Health Care Center, Inc.	149,813	9/30/07		
7. Other Assets (*itemize*)				$ 395,769
Security Deposits		33,978		
Reserve for Replacement		361,791		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 545,582
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 28,598,369

* 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
Riverside Health Care Center, Inc.	1000c	9/30/2017	33 | 37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 3,503,259
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*)	$ 1,241,528
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*)	$ 2,581,653

Item	Amount	Item	Amount
Accrued Pension	61,844	Due to Realty	89,889
Accrued Accounting Fees	29,196	Due to Related Party	1,478,417
Accrued Revenue Assessment	435,526	Patient Personal Funds	98,349
Accrued Expenses	177,795	Due to Third Party	210,637

Account	Amount
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 7,326,440

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

(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
Riverside Health Care Center, Inc.	1000c	9/30/2017	34	37

Account				Amount
			Total Brought Forward:	7,326,440
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				$
3. Loans from Owners or Related Parties (*itemize*)				$
Name and Address of Lender	Amount	Loan Date		
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)				$ 7,326,440

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

Name of Facility	License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2017	35	37

Account		Amount
A. **Reserves**		
1. Reserve for value of leased land	$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$	20,614,833
3. Reserve for depreciation value of leased personal property (*Equity)*	$	1,048,608
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	$	21,663,441
B. **Net Worth**		
1. Owner's Capital	$	
2. Capital Stock	$	5,000
3. Paid-in Surplus	$	
4. Treasury Stock	$	
5. Cumulated Earnings	$	387,812
6. Gain or Loss for Period 10/1/2016 thru 9/30/2017	$	(784,324)
7. Total Net Worth	$	(391,512)
C. ***Total Reserves and Net Worth***	$	21,271,929
D. ***Total Liabilities, Reserves, and Net Worth***	$	28,598,369

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page of
Riverside Health Care Center, Inc.	1000c	9/30/2017	36 | 37

	Account		Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2016	$	617,759
B.	Total Revenue (*From Statement of Revenue Page 30*)	$	31,218,443
C.	Total Expenditures (*From Statement of Expenditures Page 27*)	$	32,002,767
D.	Net Income or Deficit	$	(784,324)
E.	Balance	$	(166,565)
F.	Additions		
	1. Additional Capital Contributed (*itemize*)		
	Tax Refund 10,053		
	2. Other (*itemize*)		
F-3.	Total Additions	$	10,053
G.	Deductions		
	1. Drawings of Owners/Operators/Partners (*Specify*)	$	240,000

Name and Address (*No., City, State, Zip*)	Title	Amount
Partner Drawings	Various	240,000

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

Purpose	Amount

	Account		Amount
	3. Total Deductions	$	240,000
H.	***Balance at End of Period*** 09/30/17	$	(396,512)

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Riverside Health Care Center, Inc.	1000c	9/30/2017	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer	
Blum Shapiro & Co	

Address	Phone Number
2 Enterprise Drive, Shelton, CT, 06484	203-944-2100