State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2017

Name of Facility (as licensed) Orange Health Care Center		
Address (No. & Street, City, State, Zip Code) 225 Boston Post Road, Orange, CT 06477		
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
	2361			070-5434

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	4978		

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

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Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR 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 Orange Health Care Center [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) Andree Acampora			Printed Name (Owner) Linda Silberstein	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Orange Health Care Center	Period Covered:		From 10/1/2016	To 9/30/2017
Address of Facility 225 Boston Post Road, Orange, CT 06477				
Report Prepared By Orange Health Care Center	Phone Number 203-795-0835		Date	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-795-0835	9/30/2017	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Orange Health Care Center	225 Boston Post Road, Orange, CT 06477

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	2361			070-5434

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.

On 10/26/2016, Linda Silberstein purchased the stock of Orange Health Care Center and is now the 100% owner

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
Andree Acampora		001280

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

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

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
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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
Dawn-Ra Corporation	225 Boston Post Road Orange, CT 06477	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Linda Silberstein	225 Boston Post Road Orange, CT 06477	President	1
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⊙ No

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

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

If "Yes," provide the following information:

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

* Use additional sheets if necessary.

** Provide the percentage amount of revenue received from non-related parties.

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General Information and Questionnaire
Basis for Allocation of Costs

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

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (*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.

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.

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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
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	○	⊙					
Wells Fargo	○	⊙	Ipad and wall mounts	03/19/15	36 months	2,523	3,688
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
						Total ***	3,688

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

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
** Attach copies of newly acquired leases.
*** Amount should agree to Page 22, Line 6e.

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General Information and Questionnaire
Accounting Basis

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

⊙ Accrual ○ Cash ○ Modified Cash

Is the accounting basis for this period the same as for the previous period? ⊙ Yes ○ No If "No," explain.

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Medillo & Cziedzic, P.C.	1 Evergreen Ave., Hamden, CT 06518
2 Craig J Lubitski Consulting	225 Pitkin St. East Hartford, CT 06108
3	
4	

Services Provided by This Firm (*describe fully*)

1	Federal and state tax returns, various other tax forms.	$ 2,375
2	Medicare cost reporting, assistance with wage enhancement	$ 3,625
3		$
4		$
		Charge for Services Provided $ 6,000

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

⊙ Yes ○ No PG 15 L 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Murtha Cullina	860-240-6000
2 Synodi & Videll, LLC	860-447-3220
3	
4	
5	

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

1 185 Asylum St
2 65 Boston Post Rd, Waterford, CT 06385
3
4
5

Services Provided by This Firm (*describe fully*)

1	General Matters regarding patient matters, IDR results and DPH communication	$ 7,500
2	Union negotions	$ 12,639
3		$
4		$
5		$
		Charge for Services Provided $ 20,139

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

⊙ Yes ○ No PG 15 L 1e

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				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	60	60			60	60			60	60		
B. On last day of THIS report period	60	60			60	60			60	60		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	58	58			58	58			52	52		
B. As of midnight of THIS report period	50	50			52	52			50	50		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,537	2,537			1,825	1,825			712	712		
B. Medicaid (Conn.)	16,407	16,407			12,550	12,550			3,857	3,857		
C. Medicaid (other states)												
D. Private Pay	1,368	1,368			1,088	1,088			280	280		
E. State SSI for RCH												
F. Other (Specify) Managed Care	29	29			29	29						
G. Total Care Days During Period (3A thru F)	20,341	20,341			15,492	15,492			4,849	4,849		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	119	119			119	119						
B. Other Bed Reserve Days	21	21			17	17			4	4		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	20,481	20,481			15,628	15,628			4,853	4,853		

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Schedule of Resident Statistics (Cont'd)

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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	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	5	42		3				
Per Diem Rate								
a. One bed rm.	Var							
b. Two bed rms.	Var	221.00		375.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	2,275	2,275		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	4,433	4,433		
2. Restorative Treatments				
C. Other				
D. ***Total Physical Therapy Treatments***	6,708	6,708		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	353	353		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	514	514		
2. Restorative Treatments				
C. Other				
D. ***Total Speech Therapy Treatments***	867	867		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	3,743	3,743		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	4,851	4,851		
2. Restorative Treatments				
C. Other				
D. ***Total Occupational Therapy Treatments***	8,594	8,594		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ○ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	91,555	2,244				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	140,427	5,918				
5. Dietary Service						
a. Head Dietitian	23,178	846				
b. Food Service Supervisor	52,549	2,491				
c. Dietary Workers	196,867	7,709				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	151,496	7,541				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	61,190	2,211				
b. Other Maintenance Workers						
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	43,458	2,100				
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	164,753	3,249				
b. RN						
1. Direct Care	338,772	9,494				
2. Administrative**	134,456	3,588				
c. LPN						
1. Direct Care	399,011	11,200				
2. Administrative**						
d. Aides and Attendants	1,074,780	48,113				
e. Physical Therapists	214,917	4,679				
f. Speech Therapists	29,473	532				
g. Occupational Therapists	102,109	2,189				
h. Recreation Workers	67,422	3,162				
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	53,558	1,751				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	8,588	719				
A-13. Total Salary Expenditures	3,348,559	119,736				

* 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**
Companion	$ 8,588	719				
Total	$ 8,588	719	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

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

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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

** Include **all** employment worked during the cost year.

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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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* **										
Ellen Casey (10/1/16 to 5/12/17)	53,131					1,356				
Andree Acampora (5/12/17 to 9/30/17)	38,424					888				
Section IV - Assistant Administrators										

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

** Include **all** other employment worked during the cost year.

*** If more than one Administrator is reported, include dates of employment for each.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	6,270	88				
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	1,139	16				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	14,406	125				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	653	22				
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	3,650	29				
b. Other						
10. Occupational Therapist						
a. Resident Care	6,695	54				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	10,199	126				
2. Administrative***	17,099	117				
b. LPN						
1. Direct Care	1,290	9				
2. Administrative***						
c. Aides	9,125	431				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	70,526	1,017				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Qaiyum Mujtaba M.D., 750 Savin Avenue, West Haven, CT	Medical Director	○	⊙	
Health Drive Dental One Prestige Dr, Meriden, CT	Dental	○	⊙	
Dr. Hafsa Nawaz, 17 Carriage Hill Rd, Woodbridge, CT 06525	Medical Director	○	⊙	
Clay and Associates, 257 Turnpike Rd, Suite 310, Southborough MA	Nursing consultant	○	⊙	
The Nurse Network, PO Box 982, Southington, CT 06489	Nursing pool	○	⊙	
Fusion Therapy, 44 Bluff Point Rd, South Glastonbury, CT 06073	Therapy Consultant	○	⊙	
#REF!	#REF!	○	⊙	
Terapia Consulting, PO Box 1158, Groton, MA 04150	Therapy Consultant	○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
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		○	○	
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		○	○	
		○	○	

* 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

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Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	182,028	182,028		
2. Disability Insurance	$				
3. Unemployment Insurance	$	57,808	57,808		
4. Social Security (F.I.C.A.)	$	246,371	246,371		
5. Health Insurance	$	437,328	437,328		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	26,798	26,798		
7. Pensions (Non-Discriminatory)	$	105,226	105,226		
(not-owners and not-operators)					
8. Uniform Allowance	$	645	645		
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	12,680	12,680		
d. Accounting and Auditing	$	6,000	6,000		
e. Legal (*Services should be fully described on Page 7)*	$	20,139	20,139		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	22,526	22,526		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	14,542	14,542		
2. Cellular Phones	$				
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$	291	291		
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	375,839	375,839		
Subtotal	$	1,508,221	1,508,221		

* 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**

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
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Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,508,221	1,508,221		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	250	250		
3. Gifts to Staff and Residents	$				
4. Employee Travel	$				
5. Education Expenses Related to Seminars and Conventions	$	15,569	15,569		
6. Automobile Expense (*not purchase or depreciation*)	$				
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*)***	$	206	206		
See Attached Schedule					
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	$	172	172		
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	4,837	4,837		
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	400	400		
9. Subscriptions	$				
10. Contributions***	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	93,879	93,879		
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	7,480	7,480		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	1,631,014	1,631,014		

* 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)
Promotionals	$ 206		
Total Other Advertising	$ 206	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CT Association of Health Care Facilities	$ 4,602		
Dept. of Enviromental Health	$ 235		
Total Dues	$ 4,837	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank fees	$ 3,586		
Employee physicals	$ 2,304		
Penalties	$ 1,290		
Miscellaneous	$ 300		
Total Other Administrative and General	$ 7,480	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
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Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

*** 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.**

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

Name of Facility	License No.	Report for Year Ended	Page of
Orange Health Care Center	2361	9/30/2017	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	101,803	101,803		
2. Non-Food Supplies	$	40,321	40,321		
3. Other (*Specify*)_____ Supplements	$	6,569	6,569		
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	148,693	148,693		
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*		156	156		

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.

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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
Orange Health Care Center	2361	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. $	490	490		
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)*	$	48,119	48,119		
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	48,609	48,609		

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
Orange Health Care Center	2361	9/30/2017	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	20,320	20,320		
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$				
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	20,320	20,320		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Partners Pharmacy		$	107,412	107,412		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	116,268	116,268		
d. Ambulance/Limousine***		$	14,543	14,543		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	19,622	19,622		
f. X-rays and Related Radiological Procedures***		$	11,144	11,144		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	17,747	17,747		
i. Recreation		$	11,908	11,908		
j. Other (Specify)**** See Attached Schedule		$	14,572	14,572		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	313,216	313,216		

* 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)
Physical Therapy supplies	$ 9,663		
Medical Equipment Rental	$ 4,909		
Total Other Resident Care	$ 14,572	$ -	$ -

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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
Orange Health Care Center	2361	9/30/2017	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Rinaldi Laundry Services		○	⊙		Laundry services	48,119			19	3b
Paycom	Oklahoma City, OK 73142	○	⊙		Payroll processing	19,471			16	m11
Paul Knutsen	33 Chesterfield Dr, Amston, CT	○	⊙		Administrative consulting	20,000			16	m11
Point Click Care	Suite 4, Mississauga, ON, L5N 8E9	○	⊙		Computer services	17,869			16	m11
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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	$	66,549	66,549		
b. Heat	$	12,610	12,610		
c. Light & Power	$	31,685	31,685		
d. Water	$	20,458	20,458		
e. Equipment Lease (*Provide detail on page 6*)	$	3,688	3,688		
f. Other (*itemize*)	$				
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	134,990	134,990		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	5,923	5,923		
b. Building & Building Improvements	$	28,546	28,546		
c. Non-Movable Equipment	$	7,187	7,187		
d. Movable Equipment	$	41,779	41,779		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	83,435	83,435		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	5,281	5,281		
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	5,281	5,281		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	51,353	51,353		
10. Property Taxes					
a. Real estate taxes paid by owner	$	37,509	37,509		
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	1,562	1,562		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	179,140	179,140		

* 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)
Total Other Repairs and Maintenance	$ -	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
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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	52,178		42,933	41,614	S/L	Various	113	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	121,821		121,821				5,810	
A-4. Subtotal								5,923
B. **Building and Building Improvements**								
1. Acquired prior to this report period	1,055,630		1,055,630	941,811	S/L	Various	19,159	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	305,398		305,398				9,387	
B-4. Subtotal								28,546
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	41,906		41,906	24,349	S/L	Various	4,071	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	62,311		62,311				3,116	
C-4. Subtotal								7,187

	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. 2012 Porche Cayane		x	2	2012	36,478		36,478	31,007	S/L	5 years	5,471	
b.					(36,478)		(36,478)	(36,478)				
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					220,188		220,188	155,434	S/L	Various	21,293	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					141,110		141,110				15,015	
D-3. Subtotal												41,779
E. ***Total Depreciation***												83,435

Orange Health Care Center
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Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
11/30/2017	Paving and fencing	$ 39,098	8	$ 772	
9/30/2017	Paving	$ 82,723		$ 5,038	
Total additions for Land Improvement		$ 121,821		$ 5,810	*
Deletions:					
Total deletions for Land Improvement		$ -		$ -	**

***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:					
11/30/2016	Architect	$ 76,996	15	$ 2,567	
11/30/2016	Boiler	$ 78,274	20	$ 1,957	
6/30/2017	Ceiling	$ 58,072	15	$ 1,936	
7/30/2017	Lighting	$ 75,130	15	$ 2,504	
7/30/2017	Flooring	$ 16,926	20	$ 423	
Total additions for Building Improvement		$ 305,398		$ 9,387	*
Deletions:					
Total deletions for Building Improvement		$ -		$ -	**

***Ties to Page 23, Line B3**
****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
5/21/2017	Washer	$ 15,374	10	$ 769	
7/20/2017	Wander guard	$ 46,937	10	$ 2,347	
Total additions for Non-Movable Equipmen		$ 62,311		$ 3,116	*
Deletions:					
Total deletions for Non-Movable Equipmen		$ -		$ -	**

***Ties to Page 23, Line C3**
****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
6/28/2017	McKesson (Therapy Heat System)	$ 8,197	5	$ 820	
6/27/2017	McKesson (modular Therapy system)	$ 4,483	5	$ 448	
3/30/2017	McKesson (Side entry tub)	$ 9,051	10	1810	
3/31/2017	Copier	$ 4,500	5	450	
6/15/2017	McKesson (Kinevia Duo exercisor)	$ 7,689	5	769	
5/30/2017	McKesson (Monitors)	$ 3,595	5	359	
5/18/2017	McKesson (Patient lifts)	$ 1,945	5	195	
5/31/2017	Direct Supply (Beds)	$ 29,477	5	2948	
5/12/2017	RF Tech (Phone sys)	$ 21,254	5	2125	
5/2/2017	Medline	$ 8,511	5	851	
6/30/2017	Geriatric (Beds	$ 7,836	5	783	
6/30/2017	Medline (Rehab equip)	$ 4,587	5	459	
9/12/2017	McKesson (Rehab equi)	$ 29,985	5	2998	
Total additions for Movable Equipmen		$ 141,110		$ 15,015	*
Deletions:					
Total deletions for Movable Equipmen		$ -		$ -	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Leasehold Improvemer		$ -		$ -	*
Deletions:					
Total deletions for Leasehold Improvemer		$ -		$ -	**

***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. Loan cost	7	14	30 years	45,625	4,710			5,281	
2.									
3.									
B-4. Subtotal									5,281
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									5,281

* 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	09/30/75
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	04/25/61
4. Date of Initial Licensure	1948
5. Total Licensed Bed Capacity	60
6. Square Footage	16,500
7. Acquisition Cost	
a. Land	25,000
b. Building	36,400

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Orange Health Care Center	2361	9/30/2017	26 | 37

Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$				
Name of Lender	Rate				
Address of Lender					
2. Second Mortgage	$				
Name of Lender	Rate				
Address of Lender					
3. Third Mortgage	$				
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage	$				
Name of Lender	Rate				
Address of Lender					
B. CHEFA Loan Information					
1. Original Loan Amount	$				
2. Loan Origination Date					
3. Interest Rate %					
4. Term					
5. CHEFA Interest Expense					
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5)	$				

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
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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*) $	174,152	174,152		
Purchase note				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	174,152	174,152		
14. Insurance				
a. Insurance on Property (buildings only) $	44,955	44,955		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $				
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	44,955	44,955		
15. ***Total All Expenditures (A-13 thru C-14)*** $	6,114,174	6,114,174		

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D. Adjustments to Statement of Expenditures

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)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.	10	A12g	Occupational Therapy $	102,109	102,109		
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians ** $	653	653		
6.	13	B10a	Occupational Therapy $	6,695	6,695		
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	12,680	12,680		
10.	15	1d	Accounting & Legal $	20,139	20,139		
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs 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	m2,m	Unallowable Advertising * $	206	206		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $				
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) $	142,482	142,482		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Salaries Adjustment			$ -	$ -	$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other A&G Adjustments			$ -	$ -	$ -

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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 $	142,482	142,482		
Page 20 - Resident Care Supplies***							
27.	20	5a	Prescription Drugs $	107,412	107,412		
28.	20	5d	Ambulance/Limousine $	14,543	14,543		
29.	20	5f	X-rays, etc $	11,144	11,144		
30.	20	5h	Laboratory $	17,747	17,747		
31.			Medical Supplies $				
32.	20	5e2	Oxygen (non emergency) $	19,622	19,622		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $				
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.	22	7d	Depreciation on Unallowable Motor Vehicles $	5,471	5,471		
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Research or Experimental Activities $				
43.			Radio and Television Revenue $				
44.			Vending Machine Revenue $				
45.			Purchase Discounts and Allowances $				
46.			Duplications of functions or services $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest $				
48.			Interest Income on Accounts Rec $				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $	16,314	16,314		
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)*** $	334,735	334,735		

*** 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

Orange Health Care Center
9/30/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Ancillary Costs			$ -	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30	IV8	Miscellaneous income	$ 16,314		
Total Other Adjustments			$ 16,314	$ -	$ -

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
Orange Health Care Center	2361	9/30/2017	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	6,057,086	6,057,086		
b. Medicaid Room and Board Contractual Allowance **	$	(2,419,494)	(2,419,494)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	925,719	925,719		
b. Medicare Room and Board Contractual Allowance **	$	(18,154)	(18,154)		
4. a. Private-Pay Residents and Other	$	888,680	888,680		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	81,340	81,340		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(81,340)	(81,340)		
c. Prescription Drugs - Non-Medicare	$	5,999	5,999		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$				
2. a. Medical Supplies - Medicare	$	11,625	11,625		
b. Medical Supplies - Medicare Contractual Allowance **	$	(11,625)	(11,625)		
c. Medical Supplies - Non-Medicare	$	611	611		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	394,898	394,898		
b. Physical Therapy - Medicare Contractual Allowance **	$	(347,110)	(347,110)		
c. Physical Therapy - Non-Medicare	$	23,370	23,370		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(9,093)	(9,093)		
4. a. Speech Therapy - Medicare	$	132,354	132,354		
b. Speech Therapy - Medicare Contractual Allowance **	$	(108,213)	(108,213)		
c. Speech Therapy - Non-Medicare	$	5,160	5,160		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(1,439)	(1,439)		
5. a. Occupational Therapy - Medicare	$	530,143	530,143		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(444,430)	(444,430)		
c. Occupational Therapy - Non-Medicare	$	24,343	24,343		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(13,273)	(13,273)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	5,627,157	5,627,157		
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)*	$	21	21		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	16,314	16,314		
V. Total Other Revenue (1 thru 8)	$	16,335	16,335		
VI. Total All Revenue (III +V)	$	5,643,492	5,643,492		

* *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)
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30IV5	Interest income		$ 21		
Total Interest Income			$ 21	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV8	Miscellaneous	$ 16,314		
Total Other Revenue		$ 16,314	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2017	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 112,150
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 784,210
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 70,590
a. Insurance		49,444		
b. Other		21,146		
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 199,617
Workers Comp Escrow		196,365		
Tax Deposits		3,252		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,166,567
B. Fixed Assets				
1. Land				$ 40,600
2. Land Improvements	*Historical Cost	164,754		$ 117,217
	Accum. Depreciation	47,537	Net	
3. Buildings	*Historical Cost	1,361,028		$ 390,671
	Accum. Depreciation	970,357	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	104,217		$ 72,681
	Accum. Depreciation	31,536	Net	
6. Movable Equipment	*Historical Cost	361,298		$ 169,556
	Accum. Depreciation	191,742	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 790,725

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2017	32	37

Account				Amount
			Total Brought Forward:	$ 1,957,292
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$ 20,317
2. Land Improvements	*Historical Cost	9,245		
	Accum. Depreciation		Net	$ 9,245
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$ 29,562
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 155,093
Deferred financing fees		155,093		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 155,093
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 2,141,947

* 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
Orange Health Care Center	2361	9/30/2017	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 623,854
2. Notes Payable (*itemize*)				$ 91,020
Due to 223 Boston Post Road	91,020			
3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 193,646
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 5,152
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*)				$ 413,612
Provider fee payable	86,623			
Due to owners	326,989			
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 1,327,284

* 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
Orange Health Care Center	2361	9/30/2017	34	37

Account	Amount
Total Brought Forward:	1,327,284
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*)		$ 2,589,409
Celtic Bank	2,589,409	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 2,589,409
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 3,916,693

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

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2017	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$ 29,562
	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	$ 29,562
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$ 45,410
	3. Paid-in Surplus	$ 1,100,431
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (2,479,467)
	6. Gain or Loss for Period 10/1/2016 thru 9/30/2017	$ (470,682)
	7. Total Net Worth	$ (1,804,308)
C.	***Total Reserves and Net Worth***	$ (1,774,746)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 2,141,947

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2017	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2016			$ (2,471,467)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 5,643,492
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 6,114,174
D.	Net Income or Deficit			$ (470,682)
E.	Balance			$ (2,942,149)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$ 8,000
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	Andree Acampora	Former Owner	8,000	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$ 8,000
H.	***Balance at End of Period*** 09/30/17			$ (2,950,149)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	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. 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
Orange Health Care Center

Address	Phone Number
225 Boston Post Rd., Orange, CT 06477	203-795-0835