State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2017

Name of Facility (as licensed) Talmadge Park Health Care		
Address (No. & Street, City, State, Zip Code) 38 Talmadge Ave, East Haven, CT 06512		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning Oct 1 2016	Report for Year Ending Sept 30 2017	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	209951			07-5294

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	9951		

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 Talmadge Park Health Care [facility name], for the cost report period beginning Oct 1 2016 and ending Sept 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) Michael Fiore			Printed Name (Owner) Estate of Donald Franco	
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 Talmadge Park Health Care	Period Covered:		From Oct 1 2016	To Sept 30 201
Address of Facility 38 Talmadge Ave, East Haven, CT 06512				
Report Prepared By Michael J Lipnicki	Phone Number		Date 2/25/2018	

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.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-469-2316	Sept 30 2017	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Talmadge Park Health Care	38 Talmadge Ave, East Haven, CT 06512

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	209951			07-5294

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.:
Michael Fiore	876

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
Talmadge Park Inc	38 Talmadge Ave East Haven, CT	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Estate of Donald Franco	38 Talmadge Ave East Haven, CT	President	1
Lorraine Franco	38 Talmadge Ave East Haven, CT	Secretary	
Names of Stockholders Owning at Least 10% of Shares			
Estate of Donald Franco	38 Talmadge Ave East Haven, CT	President	

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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

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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	%**				
Donald Franco	38 Talmadge Ave East Haven CT	⊙	○		no services			
Lorraine Franco	38 Talmadge Ave East Haven CT	⊙	○		coporate secretary and Administration	P10 LA4		
Deborah Franco	38 Talmadge Ave East Haven CT	⊙	○		IT	P10 LA4		
Leonard Franco	38 Talmadge Ave East Haven CT	⊙	○		Recreation	P10 L12h		
Talmadge Park Real Estate Associates LLC	38 Talmadge Ave East Haven CT	⊙	○		rental of real estate	P22 L9	732,000	
DLF Associates LLC	38 Talmadge Ave East Haven CT	⊙	○		management services	P16 mgent fees	87,800	none allowable
		○	○					
		○	○					
		○	○					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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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.

DLF Associates mgent fees disallowed and Talmadge Park Real Estate Associates rent to be replaced with medicaid fair rent system.

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
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

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

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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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	DeCaprio, Fazzuoli & D'Augustino PC	500 E Main St Branford, CT
2	MJL LLC	38 Talmadge Ave E Haven CT
3	Jerry Muhl Accounting Consulting	38 Talmadge Ave E Haven CT
4		

Services Provided by This Firm (*describe fully*)

1	tax return and YE accounting for tax retrun	$ 2,100
2	cost reports and other ad hoc fiscal services	$ 12,000
3	monthly general ledger, FS's and government audits	$ 66,518
4		$
		Charge for Services Provided: $ 80,618

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

⊙ Yes ○ No — P15 1d

Legal Services Information

	Name of Legal Firm or Independent Attorney	Telephone Number
1	Voltre and Associates	203-498-0065
2	Pellegrino Law	
3	CT probabte fees	
4	Murtha Cullina / Ryan and Ryan	
5	Ct Marshall	

	Address (*No. & Street, City, State, Zip Code*)
1	90 Grove St Ridgefield CT
2	
3	
4	
5	

Services Provided by This Firm (*describe fully*)

1	General corporate matters, litigation and tax matters	$ 53,882
2	RE tax appeal	$ 4,585
3	filing fees with court	$ 231
4	Health matters surveys / Labor: 8931 / 375	$ 9,306
5	sheriff fees	$ 7,050
		Charge for Services Provided: $ 75,054

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

⊙ Yes ○ No — P15 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	90	90			90	90			90	90		
B. On last day of THIS report period	90	90			90	90			90	90		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	81	81			81	81			82	82		
B. As of midnight of THIS report period	80	80			82	82			80	80		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,279	2,279			1,812	1,812			467	467		
B. Medicaid (Conn.)	22,264	22,264			16,579	16,579			5,685	5,685		
C. Medicaid (other states)												
D. Private Pay	1,901	1,901			1,443	1,443			458	458		
E. State SSI for RCH												
F. Other (Specify) managed care and hospice	2,221	2,221			1,462	1,462			759	759		
G. Total Care Days During Period (3A thru F)	28,665	28,665			21,296	21,296			7,369	7,369		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	28,665	28,665			21,296	21,296			7,369	7,369		

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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	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents								
Per Diem Rate								
a. One bed rm.				375.00				
b. Two bed rms.	rug's rates			345.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	5,376	5,376		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	444	444		
2. Restorative Treatments	5,984	5,984		
C. Other	14	14		
D. ***Total Physical Therapy Treatments***	11,818	11,818		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	919	919		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	2	2		
2. Restorative Treatments	977	977		
C. Other				
D. ***Total Speech Therapy Treatments***	1,898	1,898		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	4,523	4,523		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	785	785		
2. Restorative Treatments	5,547	5,547		
C. Other	12	12		
D. ***Total Occupational Therapy Treatments***	10,867	10,867		

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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)	112,966	3,089				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	347,011	15,633				
5. Dietary Service						
a. Head Dietitian	17,663	508				
b. Food Service Supervisor	60,158	2,080				
c. Dietary Workers	275,347	19,841				
6. Housekeeping Service						
a. Head Housekeeper	23,971	897				
b. Other Housekeeping Workers	140,807	9,930				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	59,894	2,080				
b. Other Maintenance Workers	9,596	746				
8. Laundry Service						
a. Supervisor	20,158	889				
b. Other Laundry Workers	81,849	5,294				
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	144,023	3,423				
b. RN						
1. Direct Care	606,160	15,611				
2. Administrative**	65,205	1,716				
c. LPN						
1. Direct Care	714,324	25,919				
2. Administrative**						
d. Aides and Attendants	1,052,490	68,289				
e. Physical Therapists	136,057	2,706				
f. Speech Therapists	68,499	1,297				
g. Occupational Therapists	118,796	3,529				
h. Recreation Workers	112,341	5,538				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
scheduler and med records	35,814	1,717				
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	101,970	3,767				
n. Marketing						
o. Other (Specify)						
See Attached Schedule						
A-13. Total Salary Expenditures	4,305,099	194,499				

* 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**
Total	$ -	-	$ -	-	$ -	-

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*

Name of Facility	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 I - Operators/Owners										
Lorraine Franco	HI and PTO			#REF!	corp. secrty & Adm and cash mgemnt	1,009	a4	none		
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).										
Deborah Franco	HI and PTO			#REF!	IT and med records	2,083	a4	none		
Leonard Franco	6,857				part time recreation	193	12h	none		

* 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* **										
				#REF!						
Ted Vinci (part of year, then changed to Michael Fiore) Hrs include PTO paid out, not worked	11,427			HI and PTO	licensed Adm	1,169	a2	none		
Michael Fiore	101,539			HI and PTO	licensed Adm	1,920	a2	none		
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	4,400	52				
3. Pharmacist	3,277	121				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	97,849	1,310				
b. Other	66,032					
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	32,313	191				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care	112	3				
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	11,590					
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	215,573	1,677				

* 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	
Partners Pharmacy	prescription drugs	○	⊙	
LTC Management	dental	○	⊙	
Dr Wallyiyadda	Med Dir	○	⊙	
Fusion Therapy	therapies	○	⊙	
National Staffing Solutions	therapies	○	⊙	
Jackson, Shelley	nursing	○	⊙	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
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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

Name of Facility	License No.	Report for Year Ended	Page	of
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Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	378,931	378,931		
2. Disability Insurance	$				
3. Unemployment Insurance	$	102,410	102,410		
4. Social Security (F.I.C.A.)	$	329,144	329,144		
5. Health Insurance	$	465,145	465,145		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	1,035	1,035		
7. Pensions (Non-Discriminatory)	$				
(not-owners and not-operators)					
8. Uniform Allowance	$	117	117		
9. Other (*Specify*)	$	11,842	11,842		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	80,618	80,618		
e. Legal (*Services should be fully described on Page 7)*	$	75,054	75,054		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	17,089	17,089		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	10,047	10,047		
2. Cellular Phones	$				
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	$	531,490	531,490		
Subtotal	$	2,003,172	2,003,172		

* 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**

Talmadge Park Health Care
Sept 30 2017

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
background screening	$ 4,127		
drug screening	$ 350		
employee welfare	$ 2,707		
employee other misc banefits	$ 4,658		
Total	$ 11,842	$ -	$ -

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
Talmadge Park Health Care	209951	Sept 30 2017	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,003,172	2,003,172		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	457	457		
5. Education Expenses Related to Seminars and Conventions	$	3,432	3,432		
6. Automobile Expense (*not purchase or depreciation*)	$	5,026	5,026		
7. Other (*Specify*)	$	4,350	4,350		
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*)***	$	2,241	2,241		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$	990	990		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	1,601	1,601		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	6,492	6,492		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	2,968	2,968		
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	25,503	25,503		
12. Administrative Management Services**	$	87,800	87,800		
13. Other (*Specify*) See Attached Schedule	$	235,776	235,776		
C-14 Total Administrative & General Expenditures	$	2,379,808	2,379,808		

* 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)
travel and entertainment	$ 466		
employee christmas party	$ 3,884		
Total Other Travel and Entertainment	$ 4,350	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
PR	$ 2,241		
Total Other Advertising	$ 2,241	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 6,492		
Total Dues	$ 6,492	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
collection cost	$ 2,106		
penalties	$ 1,160		
penalties	$ 109,967		
employee meals	$ 71		
interior decorating	$ 280		
interest exp.	$ 3,391		
finance charges	$ 42,062		
bank charges	$ 4,495		
user fee penalties	$ 50,109		
user fee interest	$ 19,714		
misc and purch. Serv - office	$ 2,421		
Total Other Administrative and General	$ 235,776	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Talmadge Park Health Care	License No. 209951	Report for Year Ended Sept 30 2017	Page 17 | of 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 #
DLF Associates LLC	disallowed	overall operational management	P16 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.**

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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
Talmadge Park Health Care	209951	Sept 30 2017	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	201,279	201,279		
2. Non-Food Supplies	$	33,060	33,060		
3. Other (*Specify*)_____ minor equip	$	723	723		
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)	$	235,062	235,062		

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.

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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
Talmadge Park Health Care	209951	Sept 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. $	8,041	8,041		
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*) supplies	$	9,188	9,188		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	17,229	17,229		

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
Talmadge Park Health Care	209951	Sept 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.	$	29,863	29,863		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	29,863	29,863		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Partners pharmacy		$	126,334	126,334		
b. Medicine Cabinet Drugs		$	39,548	39,548		
c. Medical and Therapeutic Supplies		$	32,458	32,458		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	15,116	15,116		
f. X-rays and Related Radiological Procedures***		$	2,910	2,910		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	13,289	13,289		
i. Recreation		$	2,493	2,493		
j. Other (Specify)**** See Attached Schedule		$	163,635	163,635		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	395,783	395,783		

* 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)
resident tele and tv	$ 4,694		
resident pers needs	$ 10		
nursing supplies	$ 48,326		
nursing non med supplies	$ 11,491		
incontinent supplies	$ 66,743		
nursing rentals	$ 23,037		
nuring minor equip	$ 9,334		
Total Other Resident Care	$ 163,635	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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	$	14,924	14,924		
b. Heat	$	27,439	27,439		
c. Light & Power	$	129,542	129,542		
d. Water	$	41,854	41,854		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	143,378	143,378		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	357,137	357,137		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	6,643	6,643		
b. Building & Building Improvements	$	173,461	173,461		
c. Non-Movable Equipment	$	617	617		
d. Movable Equipment	$	39,327	39,327		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	220,048	220,048		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	6,051	6,051		
c. Leasehold Improvements	$	6,060	6,060		
d. Other (*Specify*)	$	35,467	35,467		
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	47,578	47,578		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	732,000	732,000		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	130,278	130,278		
c. Personal property taxes	$	6,702	6,702		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,136,606	1,136,606		

* 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)
purch service	$ 70,152		
oil-diesel fuel for generators	$ 2,340		
purch serv repairs	$ 9,356		
snow removal	$ 12,762		
grounds keeping	$ 823		
fire system maint	$ 22,832		
sprinkler system maint	$ 2,992		
waste disposal	$ 19,962		
pest control	$ 2,159		
Total Other Repairs and Maintenance	$ 143,378	$ -	$ -

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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								
2. Disposals (attach schedule)	112,045		112,045	89,125	SL	varies	6,643	
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								6,643
B. **Building and Building Improvements**								
1. Acquired prior to this report period	7,178,649		7,178,649	3,447,158	SL	varies	179,521	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								179,521
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	9,938		9,938	5,745	SL	varies	617	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								617

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					994,204		994,204	895,514		var	38,974	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					7,073				sl	10	353	
D-3. Subtotal												39,327
E. ***Total Depreciation***												226,108

Talmadge Park Health Care
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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:					
4/1/2017	washer	$ 7,073	10	$ 353	
Total additions for Movable Equipment		$ 7,073		$ 353	*
Deletions:					
Total deletions for Movable Equipment		$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report period

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

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
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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. financing cost				211,786	67,298	211,786		6,051	
2.									
3.									
B-4. Subtotal									6,051
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period				532,000	302,469	532,000		35,467	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									35,467
D. ***Total Amortization***									41,518

* 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	01/01/78
2. Date Structure Completed	01/01/79
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	12/01/78
5. Total Licensed Bed Capacity	90
6. Square Footage	42,000
7. Acquisition Cost	
a. Land	5,000
b. Building	75,000

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	HUD fixed			
b. Date Mortgage Obtained	10/01/15			
c. Interest Rate for the Cost Year	367.00%			
d. Term of Mortgage (number of years)	35			
e. Amount of Principal Borrowed	5,984,000			
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
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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*) $				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $				
14. Insurance a. Insurance on Property (buildings only) $				
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)*** $				
15. ***Total All Expenditures (A-13 thru C-14)*** $	9,072,160	9,072,160		

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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.			Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $				
10.	15	1e	Accounting & Legal $	65,748	65,748		
11.			Telephone $				
12.			Cellular Telephone $				
13.	15	1a6	Life insurance premiums on the life of Owners, Partners, Operators $	1,035	1,035		
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.	16	i6	Automobile Expense (e.g. personal use) $	5,026	5,026		
18.	16	m3	Unallowable Advertising * $	2,241	2,241		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.	16	m12	Unallowable Management Fees $	87,800	87,800		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	1,177	1,177		
Page 18 - Dietary Expenditures							
24.	16	i7	Meals to employees, guests and others who are not residents $	466	466		
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) $	163,493	163,493		

* 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)
30	iv8	other revenue	$ 1,177		
Total Other A&G Adjustments			$ 1,177	$ -	$ -

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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	$	163,493	163,493		
Page 20 - Resident Care Supplies***								
27.	20	5a2	Prescription Drugs	$	126,324	126,324		
28.			Ambulance/Limousine	$				
29.	20	5f	X-rays, etc	$	2,910	2,910		
30.	20	5h	Laboratory	$	13,289	13,289		
31.	20	5c	Medical Supplies	$	32,458	32,458		
32.	20	500	Oxygen (non emergency)	$	15,116	15,116		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$				
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$				
36.			Depreciation on Unallowable Motor Vehicles	$				
37.			Unallowable Property and Real Estate Taxes	$				
38.			Rental of Building Space or Rooms	$				
39.			Other - See Attached Schedule	$				
Page 27 - Insurance								
40.			Mortgage Insurance	$				
41.			Property Insurance	$				
Other - Miscellaneous								
42.			Research or Experimental Activities	$				
43.			Radio and Television Revenue	$				
44.			Vending Machine Revenue	$				
45.			Purchase Discounts and Allowances	$				
46.			Duplications of functions or services	$				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	$				
48.			Interest Income on Accounts Rec	$				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	$	229,239	229,239		
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)***			$	582,829	582,829		

*** 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

Talmadge Park Health Care
Sept 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)
16	m13	collection cost	$ 2,106		
16	m13	penalties	$ 1,160		
16	m13	penalties	$ 109,967		
16	m13	interest	$ 3,391		
16	m13	finance charge	$ 42,062		
16	m13	user fee penalty	$ 50,109		
16	m13	user fee interest	$ 19,714		
16	m13	misc	$ 730		
Total Other Adjustments			$ 229,239	$ -	$ -

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
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Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	8,160,125	8,160,125		
b. Medicaid Room and Board Contractual Allowance **	$	(2,834,167)	(2,834,167)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	771,181	771,181		
b. Medicare Room and Board Contractual Allowance **	$	815,721	815,721		
4. a. Private-Pay Residents and Other	$	695,555	695,555		
b. Private-Pay Room and Board Contractual Allowance **	$	16,948	16,948		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	88,491	88,491		
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$	33,543	33,543		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$				
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	1,023,900	1,023,900		
b. Physical Therapy - Medicare Contractual Allowance **	$				
c. Physical Therapy - Non-Medicare	$	158,300	158,300		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	263,000	263,000		
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$	31,900	31,900		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	900,200	900,200		
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$	186,400	186,400		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	19,928	19,928		
b. Other *(Specify)* - Non-Medicare	$	6,557	6,557		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	10,337,582	10,337,582		
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)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	(2,353,594)	(2,353,594)		
V. Total Other Revenue (1 thru 8)	$	(2,353,594)	(2,353,594)		
VI. Total All Revenue (III +V)	$	7,983,988	7,983,988		

* *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)
116a	radiology, lab and IV - medicare	$ 13,596		
116a	oxygen medicare	$ 6,332		
Total Other Resident Revenue - Medicare		$ 19,928	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
116a	radiology, lab and IV - non medicare	$ 4,839		
116b	oxygen non medicare	$ 1,718		
Total Other Resident Revenue		$ 6,557	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Total Interest Income			$ -	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
1v8	other ancillary manged care CA	$ (14,541)		
1v8	other ancillary medicaid CA	$ (129,000)		
1v8	other ancillary managed care CA	$ (287,901)		
1v8	other ancillary medicare part b CA	$ (748,160)		
1v8	other revenue	$ 1,177		
1v8	other ancillary medicare CA	$ (1,175,169)		
Total Other Revenue		$ (2,353,594)	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Talmadge Park Health Care	209951	Sept 30 2017	31	37

Account					Amount
Assets					
A. Current Assets					
1. Cash (*on hand and in banks*)					$ 329,269
2. Resident Accounts Receivable (Less Allowance for Bad Debts)					$ 824,838
3. Other Accounts Receivable (Excluding Owners or Related Parties)					$
4 Inventories					$ 22,944
5. Prepaid Expenses					$
a.					
b.					
c.					
d.					
6. Interest Receivable					$
7. Medicare Final Settlement Receivable					$
8. Other Current Assets (*itemize*)					$
A-9. ***Total Current Assets*** (Lines A1 thru 8)					$ 1,177,051
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	486,214			$ 53,580
	Accum. Depreciation	432,634		Net	
5. Non-Movable Equipment	*Historical Cost				$
	Accum. Depreciation			Net	
6. Movable Equipment	*Historical Cost	679,502			$ 45,237
	Accum. Depreciation	634,265		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)					$ 98,817

* 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
Talmadge Park Health Care	209951	Sept 30 2017	32	37

	Account				Amount
			Total Brought Forward:	$	1,275,868
C.	Leasehold or like property recorded for Equity Purposes.				
	1. Land			$	
	2. Land Improvements	*Historical Cost	112,045		
		Accum. Depreciation	95,768 Net	$	16,277
	3. Buildings	*Historical Cost	6,692,435		
		Accum. Depreciation	3,194,045 Net	$	3,498,390
	4. Non-Movable Equipment	*Historical Cost	9,938		
		Accum. Depreciation	6,362 Net	$	3,576
	5. Movable Equipment	*Historical Cost	321,775		
		Accum. Depreciation	300,576 Net	$	21,199
	6. Motor Vehicles	*Historical Cost			
		Accum. Depreciation	Net	$	
	7. Minor Equipment-Not Depreciable			$	
C-8	***Total Leasehold or Like Properties*** (C1 thru 7)			$	3,539,442
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*)			$	332,501
	mortgage exp - from related party		138,437		
	bed license		194,064		
	6. Loans to Owners or Related Parties (*itemize*)			$	
	Name and Address	Amount	Loan Date		
	7. Other Assets (*itemize*)			$	
D-8.	***Total Investments and Other Assets*** (Lines D1 thru 7)			$	332,501
D-9.	***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$	5,147,811

* 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
Talmadge Park Health Care	209951	Sept 30 2017	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 2,865,323
	2. Notes Payable (*itemize*)				$
	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*)				$ 90,555
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 1,131,644
	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*)				$ 614,928
	accrued PTO	109,683			
	accrued sales tax and pp tax	1,741			
	accrued CT user fees	283,162			
	due DSS - settlement	220,342			
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 4,702,450

* 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
Talmadge Park Health Care	209951	Sept 30 2017	34	37

Account	Amount
Total Brought Forward:	4,702,450
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*)		$ 14,284
note payable - pharmacy	80,000	
due related parties	(65,716)	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 14,284
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 4,716,734

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

Name of Facility	License No.	Report for Year Ended	Page	of
Talmadge Park Health Care	209951	Sept 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)*	$ 21,199
	4. Reserve for leasehold real properties on which fair rental value is based	$ 3,850,744
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$ 3,871,943
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$ 1,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (2,738,555)
	6. Gain or Loss for Period Oct 1 2016 thru Sept 30 2017	$ (703,311)
	7. Total Net Worth	$ (3,440,866)
C.	***Total Reserves and Net Worth***	$ 431,077
D.	***Total Liabilities, Reserves, and Net Worth***	$ 5,147,811

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Talmadge Park Health Care	209951	Sept 30 2017	36	37

Account				Amount
A.	##			$
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 7,983,988
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 9,072,160
D.	Net Income or Deficit			$
E.	Balance			$
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period*** Sept 30 2017			$

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Talmadge Park Health Care	209951	Sept 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	
Michael J Lipnicki	
Address	**Phone Number**
38 Talmadge Ave East Haven CT	2034692316