State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2018

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) ☑ Other		
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018	

License Numbers:	CCNH	RHNS	Other	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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2018	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Orange Health Care Center [facility name], for the cost report period beginning October 1, 2017 and ending September 30, 2018, 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 10/1/2017	To 9/30/2018
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	Other
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	9/30/2018	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

License Numbers:	CCNH	RHNS	Other	Medicare Provider No.
	2361			070-5434

Type of Facility (Check appropriate box(es))

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

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.:
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

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.

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	2,918
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total ***** 2,918

* 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 Craig J Lubitski Consulting	225 Pitkin St. East Hartford, CT 06108
2 Simione Macca and Larrow	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Medicare cost reporting, assistance with wage enhancement	$ 6,363
2	Tax returns	$ 5,500
3		$
4		$
		Charge for Services Provided $ 11,863

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 Milford Probate Court	
2 Attorney Bruce Temkin	860-206-5575
3 Nugent and Bryant	203-234-6040
4 American Arbitration Association	
5	

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

1 70 West River St. Milford, CT 06460
2 970 Farmington Ave., West Hartford CT 06107
3 36 State St #1, North Haven CT 06473
4
5

Services Provided by This Firm (*describe fully*)

1	Probate records	$ 8
2	Lease consulting (disallow)	$ 684
3	Lien consulting (disallow)	$ 650
4	Union grevience	$ 275
5		$
		Charge for Services Provided $ 1,617

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 Other	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Other	Total	CCNH	RHNS	Other
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	50	50			50	50			54	54		
B. As of midnight of THIS report period	58	58			54	54			58	58		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,434	2,434			1,791	1,791			643	643		
B. Medicaid (Conn.)	16,122	16,122			12,421	12,421			3,701	3,701		
C. Medicaid (other states)												
D. Private Pay	1,827	1,827			1,114	1,114			713	713		
E. State SSI for RCH												
F. Other (Specify) Managed care	307	307			206	206			101	101		
G. Total Care Days During Period (3A thru F)	20,690	20,690			15,532	15,532			5,158	5,158		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	86	86			77	77			9	9		
B. Other Bed Reserve Days	3	3			2	2			1	1		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	20,779	20,779			15,611	15,611			5,168	5,168		

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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	Other	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Other	

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	Other
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	Other	R.C.H.	ICF-MR
No. of Residents	7	40		11				
Per Diem Rate								
a. One bed rm.	Various	222.66		416.00				
b. Two bed rms.	Various	222.66		375.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	Other
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	4,272	4,272		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	138	138		
2. Restorative Treatments	5,808	5,808		
C. Other				
D. ***Total Physical Therapy Treatments***	10,218	10,218		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	180	180		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	324	324		
C. Other				
D. ***Total Speech Therapy Treatments***	504	504		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,855	2,855		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	78	78		
2. Restorative Treatments	5,756	5,756		
C. Other				
D. ***Total Occupational Therapy Treatments***	8,689	8,689		

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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	Other	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)	90,249	2,000				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	120,954	5,231				
5. Dietary Service						
a. Head Dietitian	11,119	388				
b. Food Service Supervisor	43,532	2,080				
c. Dietary Workers	183,236	9,034				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	151,505	7,338				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	50,103	1,914				
b. Other Maintenance Workers						
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	50,256	2,103				
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	180,759	3,768				
b. RN						
1. Direct Care	314,422	9,237				
2. Administrative**	120,509	1,594				
c. LPN						
1. Direct Care	357,391	12,613				
2. Administrative**						
d. Aides and Attendants	1,071,366	52,090				
e. Physical Therapists	274,711	5,487				
f. Speech Therapists	20,448	365				
g. Occupational Therapists	84,630	1,793				
h. Recreation Workers	49,843	1,993				
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	52,870	1,574				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	9,619	758				
A-13. Total Salary Expenditures	3,237,522	121,360				

* 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		Other	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Companion	$ 9,619	758				
Total	$ 9,619	758	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		Other	
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	Other							
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	Other							
Section III - Administrators* **										
Andree Acampora	90,249					2,000				
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	Other	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	11,265	66				
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	984	15				
b. Other	1,000	20				
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	22,991	79				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	907	17				
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						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	3,590	39				
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides	563	23				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	41,300	259				

* 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	○	⊙	
Fusion Therapy, 44 Bluff Point Rd, South Glastonbury, CT 06073	Therapy Consultant	○	⊙	
The Nurse Network, PO Box 982, Southington, CT 06489	Nursing pool	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
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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	Other
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	213,913	213,913		
2. Disability Insurance	$				
3. Unemployment Insurance	$	50,189	50,189		
4. Social Security (F.I.C.A.)	$	242,827	242,827		
5. Health Insurance	$	375,816	375,816		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	24,783	24,783		
7. Pensions (Non-Discriminatory)	$	97,628	97,628		
(not-owners and not-operators)					
8. Uniform Allowance	$	4,775	4,775		
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	15,636	15,636		
d. Accounting and Auditing	$	11,863	11,863		
e. Legal (*Services should be fully described on Page 7)*	$	1,617	1,617		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	12,142	12,142		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	18,147	18,147		
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*	$				
2. Other (*Specify*)	$	3,434	3,434		
See Attached Schedule					
3. Resident Day User Fee	$	380,903	380,903		
Subtotal	$	1,453,673	1,453,673		

* 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	Other
Total	$ -	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	Other
Dept of Revenue services	$ 3,434		
Total	$ 3,434	$ -	$ -

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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	Other
Subtotals Brought Forward:		1,453,673	1,453,673		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	1,249	1,249		
3. Gifts to Staff and Residents	$				
4. Employee Travel	$				
5. Education Expenses Related to Seminars and Conventions	$	13,695	13,695		
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*)	$	150	150		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	381	381		
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	$	6	6		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	6,200	6,200		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
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)*	$	102,164	102,164		
12. Administrative Management Services**	$				
13. Other (*Specify*) See Attached Schedule	$	7,960	7,960		
C-14 Total Administrative & General Expenditures	$	1,585,478	1,585,478		

* 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	Other
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	Other
Promotional	$ 381		
Total Other Advertising	$ 381	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	Other
DEA	$ 731		
CT License renewal	$ 740		
CT Association of Health Care Facilities	$ 4,444		
Department of Enviromental Health	$ 285		
Total Dues	$ 6,200	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	Other
Total Contributions	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	Other
Bank charges	$ 6,016		
Employee physicals	$ 1,899		
Miscellaneous	$ 45		
Total Other Administrative and General	$ 7,960	$ -	$ -

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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	9/30/2018	18 | 37

Item		Total	CCNH	RHNS	Other
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	110,457	110,457		
2. Non-Food Supplies	$	42,815	42,815		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	153,272	153,272		

		Total	CCNH	RHNS	Other
2F.	Dietary Questionnaire				
G.	Resident Meals: Total no. of meals served per day:*	171	171		

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.

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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	9/30/2018	19 | 37

Item		Total	CCNH	RHNS	Other
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	Amt. $	4,297	4,297		
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)*	$	172	172		
c. Other (*Specify*)	$				
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	4,469	4,469		

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.

*** 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	9/30/2018	20	37

Item			Total	CCNH	RHNS	Other
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	19,301	19,301		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	19,301	19,301		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Partners Pharmacy		$	107,465	107,465		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	63,876	63,876		
d. Ambulance/Limousine***		$	6,546	6,546		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	19,847	19,847		
f. X-rays and Related Radiological Procedures***		$	11,061	11,061		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	18,512	18,512		
i. Recreation		$	16,197	16,197		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	7,927	7,927		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	251,431	251,431		

* 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	Other
Medical equipment rental	$ 7,927		
Total Other Resident Care	$ 7,927	$ -	$ -

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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	Other	Pg	Line
Paycom	Oklahoma City, OK 73142	○	⊙		Payroll processing	23,198			16	m11
Paul Knutsen	33 Chesterfield Dr, Amston, CT	○	⊙		Administrative consulting	26,000			16	m11
Point Click Care	Suite 4, Mississauga, ON, L5N 8E9	○	⊙		Computer services	21,654			16	m11
Health Drive Dental	888 Worcester St, Wellesley, MA 02482	○	⊙		Dental Services	11,265			13	b2
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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	Other
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	22,407	22,407		
b. Heat	$	13,485	13,485		
c. Light & Power	$	29,612	29,612		
d. Water	$	28,145	28,145		
e. Equipment Lease (*Provide detail on page 6*)	$	2,918	2,918		
f. Other (*itemize*)	$				
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	96,567	96,567		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	18,297	18,297		
b. Building & Building Improvements	$	37,687	37,687		
c. Non-Movable Equipment	$	9,586	9,586		
d. Movable Equipment	$	44,365	44,365		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	109,935	109,935		
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	$				
10. Property Taxes					
a. Real estate taxes paid by owner	$	34,509	34,509		
b. Real estate taxes paid by lessor	$	2,490	2,490		
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	152,215	152,215		

* 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	Other
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	173,999		164,754	47,537	S/L	Various	15,343	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	49,598						2,954	
A-4. Subtotal								18,297
B. **Building and Building Improvements**								
1. Acquired prior to this report period	1,361,028		1,361,028	970,356	S/L	Various	29,396	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	219,789						8,291	
B-4. Subtotal								37,687
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	104,217		104,217	31,537	S/L	Various	8,045	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	30,819						1,541	
C-4. Subtotal								9,586

	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					361,298		361,298	191,742	S/L	Various	44,265	
b. Disposals (attach schedule)					(20,369)			2,036				
c. Acquired during this report period (attach schedule)					1,000						100	
D-3. Subtotal												44,365
E. ***Total Depreciation***												109,935

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
11/1/2017	Paving	$ 37,898	8 yr	$ 2,369	
11/1/2017	Side Parking lights	$ 4,128	10 yr	$ 206	
6/18/2018	Shed	$ 2,072	10 yr	$ 104	
6/30/2018	Exterior sign	$ 5,500	10 yr	$ 275	
Total additions for Land Improvements		$ 49,598		$ 2,954	*
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:					
6/29/2018	Jones and Jones	$ 500	20 years	$ 13	
5/10/2018	Granite counters	$ 5,917	10 years	$ 296	
7/26/2018	Sky Rest (New Roof)	$ 18,485	20 years	$ 462	
9/5/2018	Home Depot (windows)	$ 757	20 years	$ 19	
9/12/2018	Hone Depot (Cabinets)	$ 621	15 years	$ 21	
9/6/2018	Home Depot (Toilets)	$ 5,308	15 years	$ 177	
3/2/2018	Call bell system / Phone	$ 17,003	20 years	$ 425	
8/16/2018	Flooring	$ 7,375	10 years	$ 369	
8/16/2018	Building Painting	$ 57,518	15 years	$ 1,917	
3/2/2018	Construction Mangement	$ 10,000	15 years	$ 333	
5/24/2018	Construction Mangement	$ 11,250	15 years	$ 375	
8/26/2018	Construction Mangement	$ 13,088	15 years	$ 436	
3/2/2018	Renovation Supplies (Tim)	$ 18,816	10 years	$ 941	
8/16/2018	Renovation Supplies (Tim)	$ 17,988	10 years	$ 899	
6/14/2018	Construction labor (Tim)	$ 11,490	10 years	$ 575	
11/1/2017	Construction Management	$ 3,842	15 years	$ 128	
11/1/2017	Overhead & Profit	$ 5,115	15 years	$ 170	
11/1/2017	Olympic Flooring - Vinyl & Ceramic Floor Tile	$ 5,026	10 years	$ 251	
11/1/2017	CIP 9: Vinyl tile modification	$ 5,197	10 years	$ 260	
11/1/2017	ECM 1: Lighting	$ 1,845	10 years	$ 92	
11/1/2017	Parking lot signs	$ 2,648	10 years	$ 132	
Total additions for Building Improvements		$ 219,789		$ 8,291	*
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:				

5/15/2018	Ebay (Burner Range Stove tables)	$ 2,947	10 year	$ 147	
11/1/2017	Delta Communications - Phone system	$ 4,251	10 years	$ 213	
11/1/2017	Nurse call station upgrade to state regs.	23621	10 years	1181	
Total additions for Non-Movable Equipment		$ 30,819		$ 1,541	*
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:					
2/27/2018	Rehab Bike	$ 1,000	5 year	$ 100	
Total additions for Movable Equipment		$ 1,000		$ 100	*
Deletions:					
9/30/2018	Therapy equipment	$ (20,369)			
Total deletions for Movable Equipment		$ (20,369)		$ -	**

***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. Loan cost	7	14	30 years	45,625	9,991			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
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Item		Total	CCNH	RHNS	Other
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	Other
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*) $	210,122	210,122		
Purchase note				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	210,122	210,122		
14. Insurance				
a. Insurance on Property (buildings only) $	52,804	52,804		
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)*** $	52,804	52,804		
15. ***Total All Expenditures (A-13 thru C-14)*** $	5,804,481	5,804,481		

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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	Other
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.	10	A12g	Occupational Therapy $	84,630	84,630		
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians ** $	907	907		
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	15,636	15,636		
10.	15	1e	Accounting $	1,334	1,334		
10a.			Legal $	1,617	1,617		
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	m3	Unallowable Advertising * $	381	381		
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) $	104,505	104,505		

* 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	Other
Total Other Salaries Adjustment			$ -	$ -	$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
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
Orange Health Care Center	2361	9/30/2018	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
			Subtotals Brought Forward $	104,505	104,505		
Page 20 - Resident Care Supplies***							
27.	20	5a	Prescription Drugs $	107,465	107,465		
28.	20	5d	Ambulance/Limousine $	6,546	6,546		
29.	20	5f	X-rays, etc $	11,061	11,061		
30.	20	5h	Laboratory $	18,512	18,512		
31.	20	5c	Medical Supplies $	3,194	3,194		
32.	20	5e2	Oxygen (non emergency) $	19,847	19,847		
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 $	11,630	11,630		
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Other - Indirect $				
43.			Interest Income on Account Rec. $				
44.			Other - Miscellaneous Administrative $				
45.			Management Fees Direct $				
46.			Management Fees Indirect $				
47.			Other - Direct $	5,750	5,750		
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
49.	***Total Amount of Decrease (Items 1 - 48)***		$	288,510	288,510		

*** 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

Schedule of Other Ancillary Costs

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

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
22	6a	Repairs and maintenance (offsets with rental income in misc income line)	$ 10,242		
22	6c	Electric (offsets with rental income in misc income line)	$ 691		
22	6b	Heating (offsets with rental income in misc income line)	$ 357		
22	6d	Water (offsets with rental income in misc income line)	$ 340		
Total Other Property Adjustments			$ 11,630	$ -	$ -

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
30	IV8	Therapy payable settlement	$ 2,000		
30	IV8	Old A/P write off	$ 3,750		
Total Other Adjustments			$ 5,750	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Other
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	9/30/2018	30	37

Item		Total	CCNH	RHNS	Other
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	6,187,775	6,187,775		
b. Medicaid Room and Board Contractual Allowance **	$	(2,681,604)	(2,681,604)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	969,719	969,719		
b. Medicare Room and Board Contractual Allowance **	$	333,992	333,992		
4. a. Private-Pay Residents and Other	$	830,934	830,934		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	84,344	84,344		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(84,344)	(84,344)		
c. Prescription Drugs - Non-Medicare	$	27,755	27,755		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(27,755)	(27,755)		
2. a. Medical Supplies - Medicare	$	19,619	19,619		
b. Medical Supplies - Medicare Contractual Allowance **	$	(19,619)	(19,619)		
c. Medical Supplies - Non-Medicare	$	1,527	1,527		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(1,527)	(1,527)		
3. a. Physical Therapy - Medicare	$	569,671	569,671		
b. Physical Therapy - Medicare Contractual Allowance **	$	(434,948)	(434,948)		
c. Physical Therapy - Non-Medicare	$	53,720	53,720		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(53,720)	(53,720)		
4. a. Speech Therapy - Medicare	$	78,609	78,609		
b. Speech Therapy - Medicare Contractual Allowance **	$	(63,146)	(63,146)		
c. Speech Therapy - Non-Medicare	$	2,575	2,575		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(2,575)	(2,575)		
5. a. Occupational Therapy - Medicare	$	521,366	521,366		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(426,195)	(426,195)		
c. Occupational Therapy - Non-Medicare	$	52,750	52,750		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(52,750)	(52,750)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	5,886,173	5,886,173		
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)*	$	24	24		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	32,176	32,176		
V. Total Other Revenue (1 thru 8)	$	32,200	32,200		
VI. Total All Revenue (III +V)	$	5,918,373	5,918,373		

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Other
Total Other Resident Revenue		$ -	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	Other
30 IV5	Other		$ 24		
Total Interest Income			$ 24	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Other
30 IV8	Misc income	$ 32,176		
Total Other Revenue		$ 32,176	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2018	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 404,934
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 682,410
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 76,539
a. Prepaid insurance		51,983		
b. Other prepaid		24,556		
c.				
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 40,413
Loan escrow		37,161		
Deposits		3,252		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,204,296
B. Fixed Assets				
1. Land				$ 40,600
2. Land Improvements	*Historical Cost	214,352		$ 148,518
	Accum. Depreciation	65,834	Net	
3. Buildings	*Historical Cost	1,580,817		$ 572,774
	Accum. Depreciation	1,008,043	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	135,036		$ 93,913
	Accum. Depreciation	41,123	Net	
6. Movable Equipment	*Historical Cost	341,929		$ 105,822
	Accum. Depreciation	236,107	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 961,627

* 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	9/30/2018	32	37

Account				Amount
			Total Brought Forward:	$ 2,165,923
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*)				$ 149,812
Deferred financing fees		149,812		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 149,812
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 2,345,297

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

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			$ -

Schedule of Other Current Assets (itemized) Page 31 Line A8

Page Ref	Line Ref	Description	
Total Other Current Assets (Itemize)			$ -

Schedule of Other Fixed Assets (Itemize) Page 31 Line B9

Page Ref	Line Ref	Description	
Total Other Other Fixed Assets (Itemize)			$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

Schedule of Other Current Liabilities (Itemize) Page 33 Line A12

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

Schedule of Other Long-Term Liabilities (Itemize) Page 34 Line B4

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

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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	9/30/2018	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 513,100
2. Notes Payable (*itemize*)					$ 79,698
Due to 233 Boston Post			79,698		
See Schedule					
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*)					$ 216,345
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 5,719
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*)					$ 348,195
Accrued expenses	36,188				
Provider fee payable	94,779				
Due to owners	217,228				
See Schedule					
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 1,163,057

* 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	9/30/2018	34	37

Account				Amount
			Total Brought Forward:	1,163,057
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*)				$ 2,843,094
Celtic Bank	2,843,094			
See Schedule				
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 2,843,094
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 4,006,151

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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	9/30/2018	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	$ (2,950,149)
6.	Gain or Loss for Period 10/1/2017 thru 9/30/2018	$ 113,892
7.	Total Net Worth	$ (1,690,416)
C.	***Total Reserves and Net Worth***	$ (1,660,854)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 2,345,297

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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	9/30/2018	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2017			$ (2,950,149)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 5,918,373
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 5,804,481
D.	Net Income or Deficit			$ 113,892
E.	Balance			$ (2,836,257)
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***	09/30/18		$ (2,836,257)

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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	9/30/2018	37	37

Check appropriate category

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

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
Orange Health Care Center

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