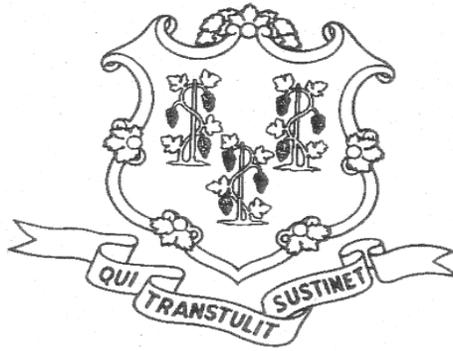


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2017

Name of Facility (as licensed) Milford Health Care Center, Inc.	
Address (No. & Street, City, State, Zip Code) 195 Platt Street, Milford, CT 06460	
Type of Facility <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH 1056-C	RHNS	(Specify)	Medicare Provider 75064
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Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
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For Department Use Only

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

Table of Contents

General Information - Administrator's/Owner's Certification	1
General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
General Information and Questionnaire - Type of Facility - Organization Structure	2
General Information and Questionnaire - Partners/Members	3
General Information and Questionnaire - Corporate Owners	3A
General Information and Questionnaire - Individual Proprietorship	3B
General Information and Questionnaire - Related Parties	4
General Information and Questionnaire - Basis for Allocation of Costs	5
General Information and Questionnaire - Leases	6
General Information and Questionnaire - Accounting Basis	7
Schedule of Resident Statistics	8
Schedule of Resident Statistics (Cont'd)	9
A. Report of Expenditures - Salaries & Wages	10
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B. Report of Expenditures - Professional Fees	13
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C. Expenditures Other than Salaries - Administrative and General	15
C. Expenditures Other than Salaries (Cont'd) - Administrative and General	16
Schedule C-1 - Management Services	17
C. Expenditures Other than Salaries (Cont'd) - Dietary	18
C. Expenditures Other than Salaries (Cont'd) - Laundry	19
C. Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
Depreciation Schedule	23
Amortization Schedule	24
C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C. Expenditures Other than Salaries (Cont'd) - Interest	26
C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D. Adjustments to Statement of Expenditures	28
D. Adjustments to Statement of Expenditures (Cont'd)	29
F. Statement of Revenue	30
G. Balance Sheet	31
G. Balance Sheet (Cont'd)	32
G. Balance Sheet (Cont'd)	33
G. Balance Sheet (Cont'd)	34
G. Balance Sheet (Cont'd) - Reserves and Net Worth	35
H. Changes in Total Net Worth	36
I. Preparer's/Reviewer's Certification	37

General Information

Name of Facility (as licensed) Milford Health Care Center, Inc.	License No. 1056-C	Report for Year Ended 9/30/2017	Page 1	of 37
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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 IMPRISONMENT 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 Milford Health Care Center, Inc. [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

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

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Milford Health Care Center, Inc.		Period Covered:	From 10/1/2016	To 9/30/2017
Address of Facility 195 Platt Street, Milford, CT 06460				
Report Prepared By Blum Shapiro & Co.		Phone Number (203) 944-2100	Date 2/1/2018	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-878-5958		Report for Year Ended 9/30/2017	Page 2	of 37
Name of Facility (as shown on license) Milford Health Care Center, Inc.		Address (No. & Street, City, State, Zip) 195 Platt Street, Milford, CT 06460		
License Numbers:	CCNH 1056-C	RHNS (Specify)	Medicare Provider No. 75064	
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Benjamin M Schiano		Nursing Home Administrator's License No.:	001893	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

General Information and Questionnaire Corporate Owners

Name of Facility Milford Health Care Center, Inc.	License No. 1056-C	Report for Year Ended 9/30/2017	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address	State(s) in Which Incorporated		
Milford Health Care Center, Inc.	195 Platt Street, Milford, CT 06460	CT		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Agnes Zitter	9 Dogwood Lane, Lawrence, NY 11559	President	50	
Marvin Ostreicher	184 Wildacre Ave, Lawrence, NY 11559	Secretary	50	
Names of Stockholders Owning at Least 10% of Shares				
Agnes Zitter	9 Dogwood Lane, Lawrence, NY 11559	President	50	
Marvin Ostreicher	184 Wildacre Ave, Lawrence, NY 11559	Secretary	50	

**General Information and Questionnaire
 Related Parties***

Name of Facility Milford Health Care Center, Inc.	License No. 1056-C	Report for Year Ended 9/30/2017	Page 4	of 37
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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	%**				
See attachment		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					

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

**General Information and Questionnaire
Related Parties***

Name of Facility Milford Health Care Center, Inc.		License No. 1056-C		Report for Year Ended 9/30/2017		Page 4		of 37	
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?						<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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?						<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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	%**					
Preferred Therapy Solutions	850 Silas Deane Highway, Wethersfield, CT 06109	<input checked="" type="checkbox"/>	<input type="checkbox"/>	37%	PT,OT,ST Services/Consulting	13 5a,9a,10a,12	931,253	919,938	
Milford Health Care Realty	20 Sunrise Hwy, Valley Stream, NY 11581	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Rent	22 9	650,716	650,716	
National Health Care Associates - Aetna	850 Silas Deane Highway, Wethersfield, CT 06109	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Health Insurance Trust***	15 1a5	944,450	944,450	
NOA Diagnostics	6851 Jericho Turnpike, Suite 150 Syosset, NY 11791	<input checked="" type="checkbox"/>	<input type="checkbox"/>	82%	Radiology	20 5f	26,173	24,170	
National Health Care Associates	20 Sunrise Hwy, Valley Stream, NY 11581	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Banking Transactions	16 13	24,651	24,651	
National Health Care Associates	20 Sunrise Hwy, Valley Stream, NY 11581	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Shared Expenses/Consulting Fees	16 12/m13	499,295	499,295	
20Sunrise	20 Sunrise Highway, Valley Stream NY 11581	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Shared Expenses	16 12	9,565	9,565	
850 Silas Deane Realty	850 Silas Deane Highway, Wethersfield, CT 06109	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Shared Expenses	16 12	1,740	1,740	
Stauderman Realty	46 Stauderman Ave Lynbrook, NY	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Shared Expenses	16 12	238	238	
Procure LTC Pharmacy Of MA LLC	155 Northboro Rd STE 4 Southborough MA 01772	<input checked="" type="checkbox"/>	<input type="checkbox"/>	92%	Drugs	20 5a2	8,504	7,606	
Procure LTC Pharmacy of CT	1492 Highland Ave., Cheshire CT 06410	<input checked="" type="checkbox"/>	<input type="checkbox"/>	92%	Drugs/OTC's/Supplies/Consulting	20/13/16 5a2,b,c/B12; m5	560,885	501,686	

* Use additional sheets if necessary.
 ** Provide the percentage amount of revenue received from non-related parties.
 *** Consolidated for all National Healthcare CT Facilities, control and ownership pass upon transfer of funds to insurance company manager. Information required by previous state auditor.

**General Information and Questionnaire
Related Parties***

Name of Facility Milford Health Care Center, Inc.	License No. 1056-C	Report for Year Ended 9/30/2017	Page 4	of 37
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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		Cost Reported	Actual Cost to the Related Party
		Yes	No	%**		Page # / Line #			
National Health Care Associates	20 East Sunrise Highway, Valley Stream, NY 11581	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Due from Related	31	A8	1,011,977	1,011,977
Cambridge Manor of Fairfield, LLC	2428 Easton Turnpike, Fairfield, CT 06824	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Due from Related	31	A8	6,826	6,826
Bristol Crossings LLC	61 Bellevue Ave, Bristol, CT 06010	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Due from Related	31	A8	6,752	6,752
Colony Center for Health & Rehabilitation	277 Washington St, Abington, MA 02351	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Due from Related	31	A8	12,243	12,243
Bloomfield Health Care Center of CT, LLC	355 Park Ave Bloomfield, CT 06002	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Due from Related	31	A8	10,009	10,009
Riverside Health Care Center, Inc.	745 Main St., East Hartford, CT 06108	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Due from Related	31	A8	21,945	21,945
New Milford Crossings LLC	19 Poplar St., New Milford, CT 06776	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Due from Related	31	A8	12,297	12,297
Preferred Therapy Solutions	850 Silas Deane Highway, Wethersfield, Ct 06109	<input checked="" type="checkbox"/>	<input type="checkbox"/>	37%	Due from Related	31	A8	4,244	4,244
National Health Care Associates - Aetna	850 Silas Deane Highway, Wethersfield, CT 06109	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Accounts payable	33	A1	488,013	488,013
Milford Health Care Realty	20 Sunrise Hwy, Valley Stream, NY 11581	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Due to Related	33	A12	228,692	228,692
Millborough Realty	85 Stage Harbor Road, Marlborough, CT 06447	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Due to Related	33	A12	347,452	347,452
Cold Spring Hills Center for Nursing & Rehabilitation	378 Syosset-Woodbury Rd, Woodbury, NY 11797	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Due to Related	33	A12	21,029	21,029
Regency House Wallingford	181 East Main Street, Wallingford, CT 06492	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Due to Related	33	A12	26,618	26,618
NOA Diagnostics	6851 Jericho Turnpike, Suite 150 Syosset, NY 11791	<input checked="" type="checkbox"/>	<input type="checkbox"/>	82%	Due to Related	33	A12	6,143	6,143
National Health Care Associates	20 East Sunrise Highway, Valley Stream, NY 11581	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Due to Related (Debt)	33	A12	110,160	110,160
Procare LTC Pharmacy of CT	1492 Highland Ave Cheshire CT 06410	<input checked="" type="checkbox"/>	<input type="checkbox"/>	92%	Due to Related	33	A12	564,564	564,564
Procare LTC Pharmacy of MA	155 Northboro Rd STE 4 Southborough MA 01772	<input checked="" type="checkbox"/>	<input type="checkbox"/>	92%	Due to Related	33	A12	6,474	6,474

* Use additional sheets if necessary.
 ** Provide the percentage amount of revenue received from non-related parties.
 *** Consolidated for all National Healthcare CT Facilities, control and ownership pass upon transfer of funds to insurance company manager. Information required by previous state auditor.

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility Milford Health Care Center, Inc.	License No. 1056-C	Report for Year Ended 9/30/2017	Page 5	of 37
If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:				
Item		Method of Allocation		
Dietary		Number of meals served to residents		
Laundry		Number of pounds processed		
Housekeeping		Number of square feet serviced		
Nursing		Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants		
Direct Resident Care Consultants		Number of hours of resident care provided by EACH specialist (<i>See listing page 13</i>)		
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? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				
2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.				
Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.				
3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)				
<input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				
N/A				

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 Milford Health Care Center, Inc.		License No. 1056-C	Report for Year Ended 9/30/2017			Page 6	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
Reliable Health Systems, Nostrand Ave, Brooklyn, NY 11230	<input type="radio"/>	<input checked="" type="radio"/>	Computer Equipment	10/01/08	60 / ongoing	2,951	2,951
Wescom Solutions, PO Box 674802, Detroit, MI 48267	<input type="radio"/>	<input checked="" type="radio"/>	Software	03/07/12	Ongoing	16,836	16,836
Leaf, P.O. Box 644006, Cincinnati, OH 45264	<input type="radio"/>	<input checked="" type="radio"/>	Copier	04/11/13	39	2,449	408
De Lage Landen #501862 P.O. Box 41602, Philadelphia, PA, 19101	<input type="radio"/>	<input checked="" type="radio"/>	Copiers	01/21/15	36	6,068	6,068
Lexus Financial, P.O. Box 17187, Baltimore, MD	<input type="radio"/>	<input checked="" type="radio"/>	Auto Lease	12/13/13	36	11,976	1,994
Lexus Financial, P.O. Box 17187, Baltimore, MD	<input type="radio"/>	<input checked="" type="radio"/>	Auto Lease	12/31/16	36	13,668	11,390
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
Is a Mileage Log Book Maintained for All Leased Vehicles ?						<input type="radio"/> Yes	<input checked="" type="radio"/> No
Total ***							39,647

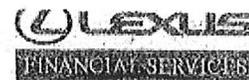
* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

** Attach copies of newly acquired leases.

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

MOTOR VEHICLE LEASE AGREEMENT NEW YORK

DEAL#66865
STK# 170326
CUST#2399050



Lease Date 12/22/2016

1. Parties

LESSOR (DEALER) NAME AND ADDRESS LEXUS OF MANHATTAN 662 11TH AVE NEW YORK, NY PHONE NUMBER: 2129774400	LESSEE AND CO-LESSEE NAME AND LESSEE'S BILLING ADDRESS MILFORD HEALTH CARE, CTR INC. AGNES O ZITTER 195 PLATT STREET MILFORD CT. 06460 COUNTY: <u>P12/31</u>	VEHICLE GARAGING ADDRESS, IF DIFFERENT THAN LESSEE'S BILLING ADDRESS
--	---	--

This is a Lease for the Vehicle described below. The words "you", "your" and "yours" refer to the Lessee and any Co-Lessee. The words "we", "us" and "our" refer to the Lessor, and after assignment, to the Toyota Lease Trust ("TLT") and any subsequent assignee. Lexus Financial Services, a division of Toyota Motor Credit Corporation ("LFS") will be servicing this Lease on behalf of TLT. By signing this Lease, you agree to lease the Vehicle described below from us under the terms of this Lease, to pay all amounts due and to perform all of your obligations under this Lease.

2. Description of Leased Vehicle

You are leasing from us, and received in satisfactory condition, the following Vehicle:

New, Used or Demo	Year	Make	Model	Body Style	Vehicle Identification No.	Odometer Mileage
NEW	2017	LEXUS	LS460		JTHCL5EF9H5027855	10

Primary Use: Personal, Family or Household Business, Agricultural or Commercial

FEDERAL CONSUMER LEASING ACT SEGREGATED DISCLOSURES

3. Amount Due at Lease Signing or Delivery (Itemized in Section 7 below) \$ <u>3843.71</u>	4. Monthly Payments Your first Monthly Payment of \$ <u>1139.00</u> is due on <u>12/22/2016</u> , followed by <u>35</u> payments of \$ <u>1139.00</u> due on the <u>21st</u> of each month. The total of your Monthly Payments is \$ <u>41004.00</u> .	5. Other Charges (not part of your Monthly Payment) Disposition fee (if you do not purchase the Vehicle) Total \$ <u>350.00</u>	6. Total of Payments (The amount you will have paid by the end of the Lease) \$ <u>44050.71</u>
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7. Amount Due at Lease Signing or Delivery:

a. Capitalized Cost Reduction	\$ <u>1691.33</u>
b. First Monthly Payment	\$ <u>1139.00</u>
c. Refundable Security Deposit	\$ <u>0.00</u>
d. Title Fees	\$ <u>70.00</u>
e. Registration Fees	\$ <u>0.00</u>
f. License Fees	\$ <u>0.00</u>
g. Tax on Capitalized Cost Reduction	\$ <u>145.88</u>
h. Acquisition Fee	\$ <u>700.00</u>
i. N/A	\$ <u>0.00</u>
j. PROCESSING	\$ <u>75.00</u>
k. STATE TIRE	\$ <u>12.50</u>
l. INSPECTION	\$ <u>10.00</u>
m. Total	\$ <u>3843.71</u>

8. How the Amount Due at Lease Signing or Delivery will be Paid:

a. Net Trade-In Allowance	
Year <u>N/A</u> Make <u>N/A</u> Model <u>N/A</u>	
VIN <u>N/A</u>	
(i) Agreed Upon Value: \$ <u>0.00</u>	
(ii) Less: Pay Off \$ <u>0.00</u>	
(iii) Less: Cash to Lessee \$ <u>0.00</u>	
Net Trade In [(i) - (ii) - (iii), no less than 0] \$ <u>0.00</u>	
b. Rebates and Noncash Credits	\$ <u>1139.00</u>
c. N/A	\$ <u>0.00</u>
d. N/A	\$ <u>0.00</u>
e. N/A	\$ <u>0.00</u>
f. Amount to be Paid in Cash	\$ <u>3843.71</u>
g. Total	\$ <u>3843.71</u>

Payable to will lease

9a. Gross Capitalized Cost. The agreed upon value of the Vehicle (\$ <u>74991.19</u>) and any items you pay over the Lease Term (such as service contracts, insurance, and any outstanding prior credit or lease balance). For an itemization of this amount, see Section 13. \$ <u>79077.93</u>	e. Depreciation and any Amortized Amounts. The amount charged for the Vehicle's decline in value through normal use and for other items paid over the Lease Term. = \$ <u>34510.13</u>
b. Capitalized Cost Reduction. The amount of any net trade-in allowance, rebate, noncash credit, or cash you pay that reduces the Gross Capitalized Cost. - \$ <u>1691.33</u>	f. Rent Charge. The amount charged in addition to the Depreciation and any Amortized Amounts. + \$ <u>6493.87</u>
c. Adjusted Capitalized Cost. The amount used in calculating your Base Monthly Payment. = \$ <u>77386.60</u>	g. Total of Base Monthly Payments. The Depreciation and any Amortized Amounts plus the Rent Charge. = \$ <u>41004.00</u>
d. Residual Value. The value of the Vehicle at the end of the Lease used in calculating your Base Monthly Payment. - \$ <u>42876.47</u>	h. Lease Payments. The number of payments in your Lease. + <u>36</u>
	i. Base Monthly Payment = \$ <u>1139.00</u>
	j. Monthly Sales/Use Tax + \$ <u>0.00</u>
	k. N/A + \$ <u>0.00</u>
	l. Total Monthly Payment ("Monthly Payment") = \$ <u>1139.00</u>

Early Termination. You may have to pay a substantial charge if you end this Lease early. The charge may be up to several thousand dollars. The actual charge will depend on when the Lease is terminated. The earlier you end the Lease, the greater this charge is likely to be.

- 10. Excessive Wear and Use.** You may be charged for excessive wear based on our standards for normal use and for mileage in excess of 30,000 miles over the odometer mileage disclosed above, at the rate of \$ 0.25 per mile.
- 11. Purchase Option at End of Lease Term.** You have an option to purchase the Vehicle at the end of the Lease Term for \$ 42876.47. That amount does not include other charges you may be required to pay pursuant to Section 33.
- 12. Other Important Terms.** Review this Lease for additional information on early termination, purchase options and maintenance responsibilities, warranties, late and default charges, insurance, and any security interest, if applicable.

13. Itemization of Gross Capitalized Cost

You will pay for the following items over the Lease Term, as part of your Monthly Payment:

a. Annet Lion Value of the Vehicle	\$ <u>74001.10</u>
------------------------------------	--------------------

UNLESS WE MAKE A WRITTEN WARRANTY OR ENTER INTO A SERVICE CONTRACT WITHIN 90 DAYS FROM THE DATE OF THIS LEASE AND EXCEPT AS STATED IN THE PARAGRAPH IMMEDIATELY ABOVE, YOU ARE LEASING THIS VEHICLE "AS IS" THERE ARE NO WARRANTIES AS TO THE VEHICLE'S

b. Taxes	+	3586.74 ^(e)
c. Initial Title, License and Registration Fees	+	0.00
d. Optional Mechanical Breakdown Protection	+	0.00
e. Optional Maintenance Agreement	+	0.00
f. Optional Credit Life and/or Disability Insurance	+	0.00
g. Optional Excess Wear and Use Protection Plan	+	500.00
h. Optional Tire and Wheel Protection Plan	+	0.00
i. Outstanding Prior Credit or Lease Balance	+	0.00
j. Acquisition Fee	+	0.00
k. N/A	+	0.00
l. N/A	+	0.00
m. N/A	+	0.00
n. N/A	+	0.00
o. Gross Capitalized Cost	=	7907.93

(e) means estimate

14. Lease Term and Scheduled Maturity Date

The Lease Term of this Lease is 36 months, and the Scheduled Maturity Date of this Lease is 12/21/2019.

15. Required Insurance

You must provide the following insurance during the Lease Term, with the Lessee and/or Co-Lessee as an insured driver. No other types of insurance are required and no Required Insurance is provided by us in this Lease:

- a) primary automobile liability insurance with minimum limits for bodily injury or death of
 - i) \$ 50,000 for any one person, and
 - ii) \$100,000 for any one accident, and
 - iii) \$ 10,000 for property damage; and
- b) physical damage insurance for the full value of the Vehicle, with a maximum deductible of \$1,000.

See Section 25 for additional information.

You have provided us today with the following insurance information:

CHUBB Insurance Provider Policy No. 1300073701
 CHUBB Agent's Name / Address
 Agent's Phone No.

CONDITION, MERCHANTABILITY, SUITABILITY, OR FITNESS FOR A PARTICULAR PURPOSE.

19. Optional Insurance and Other Products

You are not required to buy any of the Optional Insurance or Other Products listed below to enter into this Lease, and they are not a factor in our credit decision. These insurance and other products will not be provided unless the appropriate box is checked, all information is filled in, you initial below, and you are accepted by the Provider. By your initials below, you agree that you have received a notice of the terms of the insurance or product, and you want to obtain the insurance or product for the premium or charge shown. A portion of the premium or charge shown may be retained by the Lessor (Dealer).

- Optional Credit Life Insurance \$ 0.00 Beginning Coverage N/A
 Insured(s) N/A
 Provider N/A Premium 0.00 Lessee / Co-Lessee Initials N/A
 - Optional Credit Disability Insurance \$ 0.00 Maximum Monthly Coverage N/A
 Insured(s) N/A
 Provider N/A Premium 0.00 Lessee / Co-Lessee Initials N/A
 - Optional Mechanical Breakdown Protection N/A miles/coverage N/A months
 Provider N/A Premium or Charge 0.00 Lessee / Co-Lessee Initials N/A
 - Optional Maintenance Agreement N/A Premium or Charge 0.00 Lessee / Co-Lessee Initials N/A
 - Optional Excess Wear and Use Protection Plan TMSC Premium or Charge 500.00 Lessee / Co-Lessee Initials N/A
 - Optional Tire and Wheel Protection Plan N/A Premium or Charge 0.00 Lessee / Co-Lessee Initials N/A
- Total Premiums and Charges \$ 500.00

20. Complete Agreement or Modification

By your initials, you acknowledge that this Lease contains the entire agreement for the Lease of this Vehicle. There are no other agreements. Any change to this Lease must be in writing, and signed by you and by us.

21. Agreement to Arbitrate

By checking the "opt-in" box and initialing below, you agree that at the request of either you or us any controversy or claim between you and us shall be determined by neutral binding arbitration under the Federal Arbitration Act. See the Arbitration Provision in Section 48 for definitions, terms and conditions. IF YOU DO NOT WISH TO BE BOUND BY THE ARBITRATION PROVISION, CHECK THE "OPT-OUT" BOX AND INITIAL BELOW. By checking a box and initialing below, you agree that you have read and received the Arbitration Provision.

- OPT IN: You agree to be bound by the Arbitration Provision
- OPT OUT: You do not wish to be bound by the Arbitration Provision

17. Estimated Official Fees and Taxes

\$ 3802.62

This is an estimate of the total amount you will pay over the Lease Term for official and license fees, registration, title, and taxes (including personal property taxes), whether included in your Total Monthly Payment (Section 9.I), the Amount Due at Lease Signing or Delivery (Section 7) or billed separately. The actual total of Official Fees and Taxes may be higher or lower than this estimate depending on the tax rates in effect or the value of the Vehicle at the time a fee or tax is assessed. This estimate is based on your current address and may increase if you move or if tax rates change. You are responsible for paying any increases. See Section 28 for additional information.

18. Warranty

If the Vehicle is a new or a demo Vehicle, the Vehicle is subject to the standard new warranty from the manufacturer. If the Vehicle is used, it is not covered by a warranty unless required by law or identified below:

- Remainder of standard new vehicle warranty from manufacturer.
- Used vehicle warranty from manufacturer

New York State Motor Vehicle Retail Leasing Act Disclosures

Capitalized Cost. (The sum of the Adjusted Capitalized Cost and the Capitalized Cost Reduction. The Capitalized Cost and the amount of the Base Monthly Payment may be negotiable.) (Same as Gross Capitalized Cost, Section 9a) \$ 7907.93

Adjusted Capitalized Cost. (The amount which is capitalized in connection with this Lease and is used in determining the amount of your Base Monthly Payment. This amount will be used determining the legal limit on your early termination liability. Although the "Adjusted Capitalized Cost" is not referred to in the early termination provisions of this Lease, the "Adjusted Capitalized Cost" may be used to compare the early termination provisions of competing lessors.) (Same as Section 9c) \$ 77386.60

Estimated Residual Value (Same as residual Value, Section 9d) \$ 42876.47

PLEASE READ ALL PAGES FOR ADDITIONAL TERMS AND CONDITIONS

WARNING: Important consumer protections may not apply if this agreement indicates that you are leasing the Vehicle primarily for agricultural, business or commercial use.

NOTICE TO LESSEE AND CO-LESSEE: (1) DO NOT SIGN THIS LEASE BEFORE YOU READ ALL PAGES OR IF THIS LEASE CONTAINS ANY BLANK SPACES; (2) YOU ARE ENTITLED TO A COMPLETELY FILLED IN COPY OF THIS LEASE WHEN YOU SIGN IT.

By signing below, you acknowledge that: (1) You have read the entire Lease, including all pages; (2) You agree to all of the provisions of this Lease; (3) You have received a completely filled-in copy of this Lease; and (4) This is a lease; you have no ownership interest in the Vehicle

General Information and Questionnaire
Accounting Basis

Name of Facility Milford Health Care Center, Inc.	License No. 1056-C	Report for Year Ended 9/30/2017	Page 7	of 37
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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 1 Blum Shapiro 2 3 4	Address (No. & Street, City, State, Zip Code) 2 Enterprise Drive, Shelton, CT, 06484
--	---

Services Provided by This Firm (*describe fully*)

1	Compliation, preparation of Medicare and Medicaid cost reports, HUD audit, and year end tax services	\$	29,355
2		\$	
3		\$	
4		\$	
			Charge for Services Provided
			\$ 29,355

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No Page 15, line 1d

Legal Services Information

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

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

Services Provided by This Firm (*describe fully*)

1	See attachment	\$	4,832
2		\$	
3		\$	
4		\$	
5		\$	
			Charge for Services Provided
			\$ 4,832

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No Page 15, line 1e

General Information and Questionnaire
Accounting Basis

Name of Facility Milford Health Care Center, Inc.		License No. 9134	Report for Year Ended 9/30/2017	Page 7	of 37
Legal Services Information					
Name of Legal Firm or Independent Attorney			Telephone Number		
1	Rogin Nassau, LLC		(860) 278-7480		
2	Berchem & Moses, P.C.		(203)-783-1200		
3	Russ Hodgson		(716) 856-4000		
4	Walker & Dunlop				
5	Goldman Gruber & Wood		(203)-899-8900		
6	Treasurer State of Connecticut				
7	Milford Probate Court				
8	Amerassist AR Solutions				
Address (No. & Street, City, State, Zip Code)					
1	185 Asylum Street 2nd Floor, Hartford CT 06103-3460				
2	75 Broad Street Milford, CT. 06460				
3	140 Pearl Street, Suite 100 Buffalo NY 14202-4040				
4	PO Box 90498, Chicago, IL 60696-0498				
5	200 Connecticut Avenue, Norwalk, CT 06854				
6	Hartford, CT				
7					
8	2400 Veterans Blvd, Suite 300, Kenner LA 70062				
Services Provided by This Firm (<i>describe fully</i>)					
1	Administration - Disallowed			\$	1,000
2	Labor			\$	125
3	Administration - Disallowed			\$	1,073
4	Administration - Disallowed			\$	1,352
5	Collections - Disallowed			\$	66
6	Conservator - Disallow			\$	225
7	Conservator - Disallow			\$	450
8	Collections - Disallowed			\$	541
				Charge for Services Provided	
				\$ 4,832	
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.					
<input checked="" type="radio"/> Yes		<input type="radio"/> No		Page 15 line 1e	

Schedule of Resident Statistics

Name of Facility Milford Health Care Center, Inc.			License No. 1056-C		Report for Year Ended 9/30/2017				Page 8	of 37		
	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	120	120			120	120			120	120		
B. On last day of THIS report period	120	120			120	120			120	120		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	117	117			117	117			118	118		
B. As of midnight of THIS report period	117	117			118	118			117	117		
3. Total Number of Days Care Provided During Period												
A. Medicare	8,764	8,764			6,411	6,411			2,353	2,353		
B. Medicaid (Conn.)	29,281	29,281			22,053	22,053			7,228	7,228		
C. Medicaid (other states)												
D. Private Pay	2,744	2,744			1,901	1,901			843	843		
E. State SSI for RCH												
F. Other (Specify) Managed Care	915	915			828	828			87	87		
G. Total Care Days During Period (3A thru F)	41,704	41,704			31,193	31,193			10,511	10,511		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	137	137			127	127			10	10		
B. Other Bed Reserve Days	68	68			60	60			8	8		
5. Total Resident Days (3G + 4A + 4B)	41,909	41,909			31,380	31,380			10,529	10,529		

Schedule of Resident Statistics (Cont'd)

Name of Facility Milford Health Care Center, Inc.			License No. 1056-C			Report for Year Ended 9/30/2017			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> 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			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
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	RHNS	CCNH	RHNS	(Specify)	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR			
No. of Residents	21		79			17							
Per Diem Rate													
a. One bed rm.	PPS		247.72			520/655							
b. Two bed rms.	PPS		247.72			470/530							
c. Three or more bed rms.	PPS												
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									2,525	2,525			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									221	221			
C. Other									18,421	18,421			
D. Total Physical Therapy Treatments									21,167	21,167			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									674	674			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									8	8			
C. Other									1,980	1,980			
D. Total Speech Therapy Treatments									2,662	2,662			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									2,512	2,512			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									168	168			
C. Other									22,530	22,530			
D. Total Occupational Therapy Treatments									25,210	25,210			

Report of Expenditures - Salaries & Wages

Name of Facility Milford Health Care Center, Inc.	License No. 1056-C	Report for Year Ended 9/30/2017	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> 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)	24,599	52				
2. Administrator(s) (Complete also Sec. III of Schedule A1)	155,909	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	204,052	9,775				
5. Dietary Service						
a. Head Dietitian	24,022	807				
b. Food Service Supervisor	71,765	2,096				
c. Dietary Workers	404,082	23,809				
6. Housekeeping Service						
a. Head Housekeeper	31,384	1,533				
b. Other Housekeeping Workers	385,066	24,323				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	58,101	2,150				
b. Other Maintenance Workers	41,806	1,820				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	125,779	7,877				
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	173,720	3,480				
b. RN						
1. Direct Care	831,761	17,755				
2. Administrative**	215,978	5,348				
c. LPN						
1. Direct Care	1,071,794	41,180				
2. Administrative**	38,530	1,139				
d. Aides and Attendants	2,009,398	120,356				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	118,588	5,777				
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	344,955	10,625				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	6,331,289	281,982				

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

Name of Facility				License No.	Report for Year Ended				Page	of
Milford Health Care Center, Inc.				1056-C	9/30/2017				11	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Marvin J. Ostreicher, 184 Wildacre Ave, Lawrence, NY 11559	24,599			Non-preferential	Supervises operations, deals with DNS & other patient care,	52	a1	See attached		
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

MARVIN J. OSTREICHER - OWNER
 TIME STUDY
 YEAR END SEPTEMBER 30, 2017

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

**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	
Milford Health Care Center, Inc.				1056-C	9/30/2017			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Joanne Wallack (10/1/16-3/17/17)	61,031			Non-preferential	Management & supervision of healthcare facility	912	a2			
Benjamin M Schiano (3/17/17-9/30/17)	94,878			Non-preferential	Management & supervision of healthcare facility	1,168	a2			
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.

Annual Report of Long-Term Care Facility

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Milford Health Care Center, Inc.	1056-C	9/30/2017	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian	123	4				
2. Dentist	6,600	Disallowed				
3. Pharmacist	13,624	Disallowed				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	382,674	7,968				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	57,000	122				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	32,128	Disallowed				
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	95,313	1,371				
b. Other						
10. Occupational Therapist						
a. Resident Care	454,988	7,640				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care	407	9				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	18,173	Disallowed				
B-13 Total Fees Paid in Lieu of Salaries	1,061,030	17,114				

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

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

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

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

Name of Facility Milford Health Care Center, Inc.		License No. 1056-C		Report for Year Ended 9/30/2017		Page 14		of 37	
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship					
		Yes	No						
Gerident Solutions, PO Box 290539, Weathersfield CT 06129	Dentist	<input type="radio"/>	<input checked="" type="radio"/>						
Melissa Alward, 56 Nashville Rd Ext, Bethel CT 06801	Dietician	<input type="radio"/>	<input checked="" type="radio"/>						
Procure LTC, 111 Executive Blvd Farmingdale NY 11735	Pharmacist , Consulting - Nursing	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership					
Preferred Therapy Solutions, 809 Main Street, East Hartford, CT. 06108	PT, OT, ST, Consulting - Rehab, Therapy	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership					
Dr. Garumuni DeSilva, 15 Aldo Drive, Woodbridge, Ct., 16525	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>						
Amit Lahav, MD, 849 Boston Post Rd, Milford CT 06460	Resident Care	<input type="radio"/>	<input checked="" type="radio"/>						
Dr Lazaros Lazarides, 31 Heavenly Lane, Trumbull, CT 06611	Resident Care	<input type="radio"/>	<input checked="" type="radio"/>						
St. Vincent Medical Center PO Box 785112 Philadelphia PA 19178	Resident Care	<input type="radio"/>	<input checked="" type="radio"/>						
Pain and Spine Specialists PO Box 714234 Cincinnati, OH 45271-4234	Resident Care	<input type="radio"/>	<input checked="" type="radio"/>						
Urological Associates of Bridgeport PO Box 11901 Belfast ME 04951-4010	Resident Care	<input type="radio"/>	<input checked="" type="radio"/>						
Swallowing Diagnostics - P.O. Box 484 Avon, CT 06001	ST	<input type="radio"/>	<input checked="" type="radio"/>						
AAA Nursing Care LLC- 3303 Main Street Stamford, CT 06614	LPN	<input type="radio"/>	<input checked="" type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2017	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 315,844	315,844		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 72,926	72,926		
4. Social Security (F.I.C.A.)	\$ 463,654	463,654		
5. Health Insurance	\$ 944,450	944,450		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 59,661	59,661		
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$			
d. Accounting and Auditing	\$ 29,355	29,355		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 4,832	4,832		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 22,619	22,619		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 29,617	29,617		
2. Cellular Phones	\$ 2,778	2,778		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 332	332		
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$			
2. Other (<i>Specify</i>) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 696,707	696,707		
Subtotal	\$ 2,642,775	2,642,775		

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended		Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2017		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:		2,642,775	2,642,775		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	1,295	1,295		
3. Gifts to Staff and Residents	\$	11,184	11,184		
4. Employee Travel	\$	1,994	1,994		
5. Education Expenses Related to Seminars and Conventions	\$	2,987	2,987		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	2,315	2,315		
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	1,588	1,588		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	29,022	29,022		
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	\$	4,068	4,068		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	8,539	8,539		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$	1,500	1,500		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$				
12. Administrative Management Services**	\$	500,784	500,784		
13. Other (<i>Specify</i>) See Attached Schedule	\$	194,990	194,990		
C-14 Total Administrative & General Expenditures	\$	3,403,041	3,403,041		

* Do not include Subscriptions, which should go in item 9.

** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Advertising Promotional - Marketing - Disallowed	\$ 26,106		
Advertising Promotional - Administration - Disallowed	\$ 2,916		
Total Other Advertising	\$ 29,022	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 8,539		
Total Dues	\$ 8,539	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
IT Services - Administration	\$ 33,346		
Consulting Fees - Fiscal Operations	\$ 2,365		
Consulting Fees - Administration - Disallowed via management fee	\$ 10,054		
Purch Services - Fiscal Operations	\$ 33,643		
Purch Services - Administration	\$ 2,200		
Licenses and Permits - Administration	\$ 640		
Bank Charges - Administration - Disallowed	\$ 50,808		
Background Check - Administration	\$ 4,184		
Crime Insurance - Administration - Disallowed	\$ 812		
Miscellaneous Expense - Administration - Disallowed	\$ 31,921		
Penalties - Administration - Disallowed	\$ 17		
Recruiting for Administrator	\$ 25,000		
Total Other Administrative and General	\$ 194,990	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Milford Health Care Center, Inc.	License No. 1056-C	Report for Year Ended 9/30/2017	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
National Healthcare	500,784	See Attached	Page 16, line M12

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

National Health Care
Profit and Loss Allocated by GL Account

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

	0101	0102	0103	0104	0105	0106	0107	0108	0109	0110	0112	0113	0114
	Bloomfield	Bristol	Cambridge	Ludlowe	Maple View Manor	Marlborough	Milford	New Milford	Regency	Riverside	Water's Edge	Bethel Health and Rehabilitation Center	HEBREW HOME
300001-0000-00-000-0	TROY Shared Cost	(3,082.11)	(3,390.21)	(4,109.29)	(3,698.60)	(3,082.11)	(3,082.11)	(2,439.75)	(3,338.75)	(8,861.25)	(3,852.66)	(9,214.41)	(4,920.43)
391500-0000-00-000-0	Misc. Other Income-Nat. Mgmt. - -	(230.77)	(253.85)	(307.69)	(276.93)	(230.77)	(230.77)	(182.66)	(249.96)	(663.47)	(288.48)	(493.21)	(494.21)
400000-0000-00-000-0	Salary-National Healthcare Management - -	315,626.39	347,189.87	416,571.18	378,754.68	315,626.39	315,626.39	251,580.28	344,284.39	907,444.85	394,532.95	539,945.39	510,738.73
401000-0000-04-000-0	FICA-National Healthcare Management-Fiscal Op -	20,604.17	22,664.72	27,084.42	24,725.44	20,604.17	20,604.17	16,511.41	22,595.70	59,238.55	25,755.42	35,585.87	35,056.66
401100-0000-04-000-0	FUI-National Healthcare Management-Fiscal Op -	91.21	100.31	120.44	109.45	91.21	91.21	72.19	98.81	262.25	114.01	156.06	184.12
401200-0000-04-000-0	SUI-National Healthcare Management-Fiscal Op -	1,334.59	1,468.09	1,754.79	1,601.56	1,334.59	1,334.59	1,055.97	1,445.10	3,837.06	1,668.31	2,274.74	2,740.85
401201-0000-00-000-0	SUI - NY-National Healthcare Management - -	(102.24)	(112.46)	(136.33)	(122.72)	(102.24)	(102.24)	(80.96)	(110.78)	(293.99)	(127.83)	(172.98)	(109.49)
401250-0000-00-000-0	NY MTA Tax-Nat. Mgmt. - -	596.40	656.05	779.98	715.79	596.40	596.40	596.40	480.35	657.42	1,714.83	745.53	1,039.96
401300-0000-04-000-0	Health Insurance-National Healthcare-Fiscal Op -	33,107.00	36,417.24	44,141.92	39,730.92	33,107.00	33,107.00	26,207.09	35,864.31	95,186.98	41,386.05	56,027.91	57,068.30
401400-0000-04-000-0	Workers Compensation-National Health-Fiscal Op -	2,355.62	2,591.29	3,140.82	2,826.94	2,355.62	2,355.62	1,864.50	2,551.68	6,772.78	2,944.77	3,985.43	5,044.92
401500-0000-04-000-0	Medical Benefits-National Healthcare-Fiscal Op -	(7.67)	(8.44)	(10.33)	(9.20)	(7.67)	(7.67)	(6.07)	(8.31)	(22.05)	(9.59)	(12.98)	(16.43)
401600-0000-04-000-0	Disability Expense-National Healthca-Fiscal Op -	(91.06)	(100.12)	(121.39)	(109.29)	(91.06)	(91.06)	(72.05)	(98.64)	(261.82)	(113.84)	(154.04)	(133.07)
401700-0000-04-000-0	Pension-National Healthcare Managem-Fiscal Op -	6,418.84	7,060.44	8,558.00	7,702.73	6,418.84	6,418.84	5,081.06	6,953.32	18,454.51	8,023.53	10,859.59	10,007.07
401800-0000-04-000-0	Employee Benefits - Other-National H-Fiscal Op -	708.47	779.27	944.60	850.19	708.47	708.47	560.82	767.42	2,036.84	885.57	1,198.07	1,118.67
402000-0000-04-000-0	Holiday Expense-National Healthcare - Fiscal Op -	106.86	117.55	142.46	128.21	106.86	106.86	84.59	115.76	307.20	133.55	180.77	74.55
410000-0000-04-000-0	Supplies-National Healthcare Managem-Fiscal Op -	2,856.68	3,142.36	3,808.96	3,428.12	2,856.68	2,856.68	2,261.43	3,094.65	8,213.37	3,570.94	4,791.09	5,014.89
410000-0000-08-000-0	Supplies-National Healthcare Managem-Maintenan-	10.69	11.75	14.25	12.82	10.69	10.69	8.47	11.60	30.73	13.69	18.09	0.70
410000-0000-09-000-0	Supplies-National Healthcare Managem-Housekeep-	22.52	24.76	30.00	27.01	22.52	22.52	17.84	24.36	64.72	28.15	40.42	42.47
411000-0000-04-000-0	Food-National Healthcare Management-Fiscal Op -	27.76	30.52	37.01	33.33	27.76	27.76	21.96	30.08	79.83	30.08	46.97	35.88
431000-0000-03-000-0	Consulting Fees-National Healthcare -Administ-	18.03	19.84	24.04	21.64	18.03	18.03	14.27	19.53	51.84	22.54	30.51	38.62
431000-0000-04-000-0	Consulting Fees-National Healthcare -Fiscal Op -	8,620.19	9,481.77	11,493.28	10,344.69	8,620.19	8,620.19	6,823.93	9,338.21	24,783.91	10,775.60	14,401.14	12,800.60
432000-0000-03-000-0	Accounting Fees-National Healthcare -Administ-	541.16	595.30	721.49	649.41	541.16	541.16	428.36	586.30	1,555.96	676.47	915.53	749.23
433000-0000-03-000-0	Legal Fees-National Healthcare Managem-Administ-	8,472.34	9,219.49	11,296.21	10,167.38	8,472.34	8,472.34	6,706.49	9,177.86	24,359.05	10,690.96	14,331.19	14,974.30
440000-0000-03-000-0	Purch Services-National Healthcare M-Administ-	11,050.58	12,155.52	14,733.60	13,261.53	11,050.58	11,050.58	8,747.49	11,970.89	31,771.33	13,813.66	18,696.03	18,753.34
440000-0000-08-000-0	Purch Services-National Healthcare M-Maintenan-	4,060.58	4,466.78	5,414.06	4,872.98	4,060.58	4,060.58	3,214.16	4,398.65	11,674.64	5,076.06	6,869.97	7,979.89
440000-0000-09-000-0	Purch Services-National Healthcare M-Housekeep-	1,489.60	1,638.50	1,986.19	1,787.73	1,489.60	1,489.60	1,179.29	1,613.64	4,282.32	1,862.18	2,520.33	2,368.28
440000-0000-12-000-0	Purch Services-National Healthcare Ma-Security -	3.49	3.83	4.65	4.18	3.49	3.49	2.76	3.78	10.03	4.36	5.90	7.47
440001-0000-08-000-0	Ground Services-Nat. Mgmt.-Maintenance -	18.25	20.07	24.33	21.89	18.25	18.25	14.42	19.77	52.43	22.81	30.84	27.68
441000-0000-03-000-0	Computer Expense-National Healthcare-Administ-	12,976.69	14,274.04	17,301.36	15,572.95	12,976.69	12,976.69	10,272.48	14,057.75	37,308.86	16,221.30	21,685.61	18,439.19
442000-0000-08-000-0	Pest Control-Nat. Mgmt.-Maintenance -	8.17	8.98	10.89	9.80	8.17	8.17	6.47	8.85	23.49	10.21	13.82	
452000-0000-25-000-0	Equipment Rental-National Healthcare-Fiscal Op -	2,879.22	3,166.92	3,838.70	3,455.18	2,879.22	2,879.22	2,279.21	3,119.01	8,277.99	3,599.21	4,871.10	4,882.71
461000-0000-03-000-0	Telephone-National Healthcare Managem-Administ-	3,831.96	4,215.02	5,109.25	4,598.59	3,831.96	3,831.96	3,033.57	4,151.25	11,017.47	4,790.27	6,483.10	5,691.40
461100-0000-03-000-0	Telephone - Cell-National Healthcare-Administ-	1,779.85	1,957.75	2,373.00	2,135.85	1,779.85	1,779.85	1,408.86	1,928.03	5,117.10	2,224.80	3,004.55	2,866.05
462000-0000-25-000-0	Electric-National Healthcare Managem-Property -	2,842.62	3,126.81	3,790.05	3,411.30	2,842.62	2,842.62	2,250.29	3,079.44	8,172.84	3,553.35	4,809.26	4,075.05
463000-0000-25-000-0	Gas-National Healthcare Managem-Property -	286.27	314.91	381.68	343.56	286.27	286.27	226.63	310.10	823.08	357.94	484.34	512.52
464000-0000-25-000-0	Water-National Healthcare Management-Property -	125.39	137.94	167.19	150.50	125.39	125.39	99.25	135.83	360.51	156.75	212.16	197.85
471000-0000-25-000-0	Rent-National Healthcare Management-Property -	11,904.14	13,093.27	15,871.29	14,285.51	11,904.14	11,904.14	9,424.58	12,896.53	34,225.14	14,880.11	20,139.49	12,476.79
472000-0000-25-000-0	Personal Property Taxes-National Hsa-Fiscal Op -	1,061.56	1,167.79	1,415.52	1,273.89	1,061.56	1,061.56	840.35	1,150.01	3,052.09	1,326.90	1,795.85	2,207.16
473000-0000-25-000-0	Real Estate Taxes-National Healthcare-Fiscal Op -	3,443.49	3,788.25	4,591.57	4,132.72	3,443.49	3,443.49	2,725.32	3,729.98	9,900.97	4,305.09	5,826.20	9,261.26
484000-0000-04-000-0	Amort Exp - LHI-National Healthcare -Fiscal Op -	2,516.86	2,768.45	3,355.70	3,020.36	2,516.86	2,516.86	1,992.36	2,726.52	7,236.24	3,146.16	4,258.13	3,941.29
486000-0000-04-000-0	Dep Exp - Moveable Equip-National He-Fiscal Op -	11,227.34	12,349.82	14,969.42	13,473.47	11,227.34	11,227.34	8,887.35	12,162.26	32,279.85	14,034.76	18,994.98	19,585.47
491000-0000-03-000-0	Dues and Subscriptions-National Heal-Administ-	923.05	1,015.35	1,230.71	1,107.72	923.05	923.05	730.65	999.93	2,653.89	1,153.87	1,561.71	1,636.89
500000-0000-03-000-0	Licenses and Permits-National Health-Administ-	581.40	639.59	775.21	697.74	581.40	581.40	460.26	629.82	1,671.67	726.81	983.64	1,079.59
501000-0000-03-000-0	Advertising Employment-National Heal-Administ-	5,904.90	6,494.59	7,872.45	7,085.66	5,904.90	5,904.90	4,674.72	6,396.87	16,976.31	7,380.55	9,989.70	5,795.97
501100-0000-03-000-0	Advertising Promotional-National Health-Administ-	6,751.42	7,426.73	9,002.04	8,102.13	6,751.42	6,751.42	5,344.56	7,313.87	19,411.29	8,439.87	11,380.63	10,816.81
502000-0000-03-000-0	Interest-National Healthcare Managem-Administ-	2,273.15	2,500.56	3,030.81	2,728.05	2,273.15	2,273.15	1,799.44	2,462.54	6,535.70	2,841.61	3,846.98	3,787.91
503000-0000-03-000-0	Penalties-National Healthcare Managem-Administ-												
503600-0000-03-000-0	Bank Charges-Nat. Mgmt.-Administration -	1,390.29	1,529.34	1,853.49	1,668.44	1,390.29	1,390.29	1,100.51	1,506.09	3,997.26	1,737.92	2,352.16	2,304.72
504000-0000-03-000-0	Postage-National Healthcare Managem-Administ-	1,028.24	1,131.09	1,370.92	1,233.97	1,028.24	1,028.24	813.92	1,113.82	2,956.35	1,285.36	1,739.60	1,917.74
509000-0000-03-000-0	Seminars-National Healthcare Managem-Administ-	580.46	638.51	773.95	696.66	580.46	580.46	459.55	628.81	1,668.93	725.66	981.20	904.13
510000-0000-03-000-0	Liability Insurance-National Healthca-Administ-	2,222.62	2,444.82	2,963.43	2,667.30	2,222.62	2,222.62	1,759.39	2,407.73	6,390.26	2,778.40	3,760.36	3,648.18
511000-0000-03-000-0	Auto Insurance-National Healthcare M-Administ-	1,464.24	1,610.68	1,952.30	1,757.20	1,464.24	1,464.24	1,159.11	1,586.22	4,209.98	1,830.43	2,477.33	2,517.47
512000-0000-03-000-0	Umbrella Insurance-National Healthca-Administ-	1,199.48	1,319.43	1,599.27	1,439.48	1,199.48	1,199.48	949.48	1,299.36	3,448.64	1,499.41	2,029.36	2,047.90
513000-0000-03-000-0	Crime Insurance-National Healthcare -Administ-	67.24	73.99	89.66	80.71	67.24	67.24	53.23	72.86	193.35	84.07	113.74	125.48
517000-0000-03-000-0	Workmans Comp Insurance-National	1,245.82	1,370.25	1,660.94	1,494.91	1,245.82	1,245.82	986.23	1,349.58	3,581.65	1,557.19	2,107.67	1,318.23
520000-0000-03-000-0	Auto Expense-National Healthcare Man-Administ-	1,940.32	2,134.10	2,586.87	2,328.27	1,940.32	1,940.32	1,536.21	2,102.07	5,578.30	2,425.16	3,282.49	1,300.95
520100-0000-03-000-0	Auto Lease Expense-National Healthca-Administ-	3,326.39	3,658.73	4,434.78	3,991.57	3,326.39	3,326.39	2,633.34	3,603.08	9,563.31	4,157.82	5,641.63	4,606.91
521000-0000-00-000-0	Travel Expense-Nat. Mgmt. - -	11.04	12.14	14.72	13.24	11.04	11.04	8.74	11.95	31.74	13.79	18.67	23.63
521000-0000-03-000-0	Travel Expense-National Healthcare M-Administ-	7,274.81	8,002.45	9,699.71									

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
Milford Health Care Center, Inc.		1056-C	9/30/2017	18	37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 301,539	301,539		
2.	Non-Food Supplies	\$ 33,782	33,782		
3.	Other (Specify) _____	\$			
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)		\$ 335,321	335,321		
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?		<input type="radio"/> Yes	<input checked="" type="radio"/> No		
I. Did you receive revenue from employees?		<input type="radio"/> Yes	<input checked="" type="radio"/> 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?		<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify cost.
L. Is any revenue collected from these people?		<input type="radio"/> Yes	<input checked="" type="radio"/> 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?		<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify cost.
O. Is any revenue collected from employees?		<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify amt.
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)					

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Name of Facility Milford Health Care Center, Inc.		License No. 1056-C	Report for Year Ended 9/30/2017		Page 19	of 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. \$	-86	-86		
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 (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)		\$	278	278		
c. Management Services**		\$				
d. Other (<i>Specify</i>) Diapers \$54,500 Supplies \$8,551		\$	63,101	63,101		
3E. Total Laundry Expenditures (3a + b + c + d)		\$	63,293	63,293		
3F. Laundry Questionnaire						
G.	Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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.

**C. Expenditures Other Than Salaries (cont'd) - Housekeeping and Resident Care
 Basis for Allocation of Costs (See Note on Page 5)**

Name of Facility Milford Health Care Center, Inc.		License No. 1056-C	Report for Year Ended 9/30/2017		Page 20	of 37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
1.	Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	34,131	34,131		
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$				
c.	Management Services*	\$				
d.	Other (<i>Specify</i>)	\$				
4E.	Total Housekeeping Expenditures (4a + b + c + d)	\$	34,131	34,131		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from PCA	\$	506,397	506,397		
b.	Medicine Cabinet Drugs	\$	37,203	37,203		
c.	Medical and Therapeutic Supplies	\$	177,117	177,117		
d.	Ambulance/Limousine***	\$	1,325	1,325		
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	32,313	32,313		
f.	X-rays and Related Radiological Procedures***	\$	26,173	26,173		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	64,262	64,262		
i.	Recreation	\$	31,755	31,755		
j.	Other (Specify)**** See Attached Schedule	\$	97,347	97,347		
5K.	Total Resident Care Expenditures (5a - 5j)	\$	973,892	973,892		

* 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)
IV Therapy Supplies - Rehabilitation Therapy and Ancillary	\$ 15,933		
Purchased services - Nursing	\$ 3,239		
Equipment Rental - Nursing	\$ 59,894		
Equipment Rental - Rehabilitation Therapy and Ancillary	\$ 13,794		
Medical Services - Flu Vaccine	\$ 4,455		
Supplies- Rehabilitation Therapy and Ancillary	\$ 32		
Total Other Resident Care	\$ 97,347	\$ -	\$ -

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

Name of Facility Milford Health Care Center, Inc.			License No. 1056-C		Report for Year Ended 9/30/2017			Page of 21 37		
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
ADM Enviromental Group	1370 Coney Island Ave. Brooklyn, NY 11230	<input type="radio"/>	<input checked="" type="radio"/>		Waste Services/Monthly Recycling Services	27,892			22	6f
Milford Quality Landscaping	P.o. Box 329 Milford, CT 06460	<input type="radio"/>	<input checked="" type="radio"/>		Landscaping	19,735			22	6f
ADP	P.O. Box 842875 Boston, MA 02284	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Service	13,740			16	m13
MJ Daly	110 Mattatuck HTS, Waterbury CT 06705	<input type="radio"/>	<input checked="" type="radio"/>		HVAC	24,787			22	6a
Integrated Health Systyems	PO Box 23072 Overland Park, KS 66283	<input type="radio"/>	<input checked="" type="radio"/>		Computer Maintenance Systems	11,372			16	m13
Total Lawn Care & More LLC	15 Clark St. Apt1. Milford CT 06460	<input type="radio"/>	<input checked="" type="radio"/>		Landscaping	10,508			22	6f
Junga Electric, LLC	19 CandleWood Road, Milford, CT 06461	<input type="radio"/>	<input checked="" type="radio"/>		Electrical Services	10,730			22	6a
Otis Elevator	PO Box 13716 Newark, NJ 07188	<input type="radio"/>	<input checked="" type="radio"/>		Electrical Services	11,082			22	6a
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

* List all contracted services over \$10,000. Use additional sheets if necessary.
 ** Refer to Page 4 for definition of related.
 *** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended			Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2017			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 160,559	160,559				
b. Heat	\$ 63,176	63,176				
c. Light & Power	\$ 136,111	136,111				
d. Water	\$ 26,220	26,220				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 39,647	39,647				
f. Other (<i>itemize</i>)	\$ 74,739	74,739				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 500,452	500,452				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 61,023	61,023				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 61,023	61,023				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 77,849	77,849				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 77,849	77,849				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 650,716	650,716				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 159,939	159,939				
c. Personal property taxes	\$ 8,283	8,283				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 957,810	957,810				

* 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)
Supplies - Security	\$ 1,785		
Ground Supplies- Maintenance	\$ 104		
Purchased Services - Security	\$ 9,132		
Pest Control - Maintenance	\$ 1,760		
Carting- Maintenance	\$ 28,991		
Grounds Services- Maintenance	\$ 31,695		
IT Rentals	\$ 600		
Short Term Lease - Postage Machine	\$ 672		
Total Other Repairs and Maintenance	\$ 74,739	\$ -	\$ -

Depreciation Schedule

Name of Facility Milford Health Care Center, Inc.			License No. 1056-C			Report for Year Ended 9/30/2017			Page 23	of 37		
Property Item			Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals		
A. Land Improvements												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal												
B. Building and Building Improvements												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
B-4. Subtotal												
C. Non-Movable Equipment												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
C-4. Subtotal												
	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. Movable Equipment												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period												
					742,681		742,681	501,739	SL		49,133	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)												
					162,994		162,994		SL		11,890	
D-3. Subtotal												
E. Total Depreciation												
											61,023	
											61,023	

Milford Health Care Center, Inc.
9/30/2017

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:				
11/29/2016	Direct Supply- Refrigerator	\$ 2,630	10	\$ 241
12/4/2016	Tristate - REXX Hi-Low Bed	\$ 920	12	\$ 64
12/6/2016	McKesson- Electric Bed	\$ 873	12	\$ 61
1/19/2017	H&R Healthcare-Electric Bed	\$ 1,967	12	\$ 123
1/25/2017	Direct Supply- Vacuum	\$ 635	8	\$ 59
2/9/2017	2016 Office Home & Business- Latitude Computer	\$ 1,329	5	\$ 177
2/13/2017	Direct Supply- Vacuum	\$ 1,230	8	\$ 103
2/15/2017	Tristate- Hi Lo Bed	\$ 920	12	\$ 127
2/28/2017	Tristate-Hi Lo Bed	\$ 920	12	\$ 51
3/2/2017	Label Tape- Printer	\$ 982	5	\$ 115
3/2/2017	Ice Maker	\$ 3,090	10	\$ 180
3/8/2017	Tristate-Hi Lo Bed	\$ 865	12	\$ 43
3/22/2017	MJ Daly- B&G Assembly Culinary Depot- Ice Maker	\$ 2,761	15	\$ 107
4/19/2017	Direct Supply- Throw Spread McKesson- Vita Scan	\$ 1,090	5	\$ 51
5/8/2017	Sys Scan Vitascan LT Blad	\$ 8,340	7	\$ 109
5/31/2017	Integrated Health System - Chromebooks, Servers, Software	\$ 110,160	5	\$ 9,180
6/9/2017	Magnum Industries Arm Chairs	\$ 5,722	15	\$ 496
7/31/2017	55" LED TV	\$ 512	5	\$ 26
7/31/2017	PC Connect- HP Monitor	\$ 860	5	\$ 42
7/31/2017	PC Connect - PC	\$ 860	5	\$ 43
7/31/2017	PC Connect - PC	\$ 893	5	\$ 45
7/31/2017	PC Connect- PC & Monitor	\$ 1,328	5	\$ 66
7/31/2017	PC Connect- 10 Laptops Amazon-LED TV	\$ 2,780	5	\$ 139
8/18/2017	Enhanced Cart Side Mount	\$ 1,021	5	\$ 17
8/31/2017	McKesson- Electric Bed	\$ 936	12	\$ 13
8/31/2017	10x14" HP Chromebook, 2xEnhanced Cart Side Mount	\$ 4,530	5	\$ 151
9/30/2017	Round Tabletop & Base	\$ 590	5	\$ 5
9/30/2017	Heavy Duty Vacuum	\$ 635	8	\$ 7
9/30/2017	Tristate - REXX Hi-Low Bed	\$ 865	12	\$ 14
9/30/2017	PC Connection Chromebooks	\$ 1,015	5	\$ 17
9/30/2017	Knights Inc Snow Blower	\$ 2,127	10	\$ 18
	Misc adjustment	-392		
Total additions for Movable Equipment		\$ 162,994		\$ 11,890 *
Deletions:				
Total deletions for Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/31/2016	MJ Daly-Replace RTU Compressor	\$ 14,762	15	\$ 984
10/13/2016	Cast Pipe	\$ 1,200	25	\$ 48
10/31/2016	Fittings	\$ 1,199	25	\$ 48
10/31/2016	2 Sidewalk Sprinklers	\$ 1,853	25	\$ 74
11/2/2016	Sink	\$ 1,364	20	\$ 63
11/15/2016	Ceiling Tile Work	\$ 1,030	10	\$ 94
11/16/2016	Duct Work	\$ 8,187	15	\$ 500
11/28/2016	Pump	\$ 1,489	15	\$ 91
12/14/2016	Passage & Privacy Leverset	\$ 1,596	10	\$ 133
12/30/2016	HVAC RTU Compressor	\$ 5,269	15	\$ 292
1/20/2017	Wall & Tile	\$ 1,100	5	\$ 165
1/30/2017	Elevator Hydraulic Valve	\$ 15,320	20	\$ 574
2/22/2017	Metal Fire Door System	\$ 5,189	25	\$ 138
7/31/2017	Piping Installation	\$ 2,861	25	\$ 29
7/31/2017	HVAC Nurse Station	\$ 13,326	15	\$ 222
8/31/2017	Fire Doors	\$ 1,271	20	\$ 11
8/31/2017	Decking	\$ 1,200	10	\$ 20
Total additions for Leasehold Improvement		\$ 78,216		\$ 3,486 *

Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ -

Attachment Pages 23 24

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

**

Amortization Schedule*

Name of Facility			License No.		Report for Year Ended			Page	of
Milford Health Care Center, Inc.			1056-C		9/30/2017			24	37
Item	Date of Acquisition		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
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period				1,191,869	693,733	SL		74,363	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				78,216		SL		3,486	
C-4. Subtotal									77,849
D. Total Amortization									77,849

* Straight-line method must be used.

** Specify which of the following bases were used:

- A. Minimum of 5 years or 60 months.
- B. Life of mortgage; OR
- C. Remaining Life of Lease; OR
- D. Actual Life if owned by Related Party.

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

Name of Facility Milford Health Care Center, Inc.	License No. 1056-C	Report for Year Ended 9/30/2017	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description		Total		
1. Date Land Purchased				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity		120		
6. Square Footage		59,396		
7. Acquisition Cost				
a. Land				
b. Building				
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)		Fixed		
b. Date Mortgage Obtained		07/29/04		
c. Interest Rate for the Cost Year		6.39%		
d. Term of Mortgage (number of years)		40		
e. Amount of Principal Borrowed		9,387,600		
f. Principal balance outstanding as of 9/30/17		8,620,567		
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
Part C - Arms-Length Leases for Real Property Improvements Only				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility		License No.	Report for Year Ended			Page	of
Milford Health Care Center, Inc.		1056-C	9/30/2017			26	37
Item		Total	CCNH	RHNS	(Specify)		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
2. Second Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
3. Third Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
4. Fourth Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount		\$					
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expense							
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$					

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Milford Health Care Center, Inc.		1056-C		9/30/2017		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$			
12. D. Other Interest Expense (Specify) Property Interest \$70, Interest Admin \$308				\$ 378	378		
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$ 378	378		
14. Insurance							
a. Insurance on Property (buildings only)				\$ 14,869	14,869		
b. Insurance on Automobiles				\$ 1,136	1,136		
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$ 11,440	11,440		
2. Fire and Extended Coverage				\$			
3. Other (Specify) Liability \$50,960; Mortgage \$39,014				\$ 89,974	89,974		
14d. Total Insurance Expenditures (14a + b + c)				\$ 117,419	117,419		
15. Total All Expenditures (A-13 thru C-14)				\$ 13,778,056	13,778,056		

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.				1056-C	9/30/2017	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.	10	12M	Salaries not related to Resident Care	\$ 47,593	47,593		
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.	13	8c	Resident Care Physicians **	\$ 32,128	32,128		
6.	13	10a	Occupational Therapy	\$ 454,988	454,988		
7.			Other - See attached Schedule	\$ 75,272	75,272		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.	15	1e	Accounting & Legal	\$ 11,432	11,432		
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 1,698	1,698		
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 *	\$ 29,022	29,022		
19.			Income Tax / Corporate Business Tax	\$ 332	332		
20.	16	m10	Fund Raising / Contributions	\$ 1,500	1,500		
21.	16 / 1	m12/1	Unallowable Management Fees	\$ 218,743	218,743		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 108,698	108,698		
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)				\$ 981,406	981,406		

* 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)
13	B2	Dentist	\$ 6,600		
13	B12	Consulting Fees - Nursing	\$ 11,614		
13	B12	Consulting Fees - Rehab Therapy and Ancillary - PTS	\$ 6,559		
13	B8a	Medical Director (over the limit)	\$ 36,875		
13	B2	Pharmacist	\$ 13,624		
Total Other Fees Adjustments			\$ 75,272	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	L3	Gifts to residents & staff	\$ 11,184		
16	M13	Miscellaneous expenses	\$ 31,921		
16	M13	Bank charges	\$ 50,808		
16	M13	Penalties	\$ 17		
16	M13	Crime Insurance	\$ 812		
16	1a	Benefits on salaries not related to resident care	\$ 13,956		
Total Other A&G Adjustments			\$ 108,698	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.				1056-C	9/30/2017	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 981,406	981,406		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 506,397	506,397		
28.	20	5d	Ambulance/Limousine	\$ 1,325	1,325		
29.	20	5f	X-rays, etc	\$ 26,173	26,173		
30.	20	5h	Laboratory	\$ 64,262	64,262		
31.	20	5c	Medical Supplies	\$ 18,411	18,411		
32.	20	5e2	Oxygen (non emergency)	\$ 32,313	32,313		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 105,888	105,888		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.	22	10c	Unallowable Property and Real Estate Taxes	\$ 409	409		
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 22,120	22,120		
Page 27 - Insurance							
40.	27	14c3	Mortgage Insurance	\$ 39,014	39,014		
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	\$ 24,854	24,854		
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)			\$ 1,822,572	1,822,572		

*** 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.

Milford Health Care Center, Inc.
9/30/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Flu Vaccine	\$ 4,455		
20	5j	IV Therapy Supplies	\$ 15,933		
20	5j	Purchased Services-Nursing	\$ 1,313		
20	5j	Equipment Rental-Nursing	\$ 59,894		
20	5j	Equipment Rental Rehab Therapy & Ancillary	\$ 13,794		
20	Misc	Procare disallowed price markup	\$ 2,303		
20	5i	Cable TV Expense - Resident Rooms	\$ 8,164		
20	5j	Supplies- Rehabilitation Therapy and Ancillary	\$ 32		
Total Other Ancillary Costs			\$ 105,888	\$ -	\$ -

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)
22	6e	Auto Leases	\$ 13,386		
27	14b	Auto Insurance	\$ 1,136		
16	L6	Auto Expense	\$ 2,315		
22	7d	Depreciation on Mattresses & TV's	\$ 5,283		
Total Other Property Adjustments			\$ 22,120	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30	IV8	Misc Other Income	\$ 23,863		
27	12D	Other interest expense	\$ 378		
30	IV5	Interest Income	\$ 613		
Total Other Adjustments			\$ 24,854	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2017			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 13,088,455	13,088,455				
b. Medicaid Room and Board Contractual Allowance **	\$ (6,194,236)	(6,194,236)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 4,741,208	4,741,208				
b. Medicare Room and Board Contractual Allowance **	\$ (79,561)	(79,561)				
4. a. Private-Pay Residents and Other	\$ 2,553,311	2,553,311				
b. Private-Pay Room and Board Contractual Allowance **	\$ (607,818)	(607,818)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 375,418	375,418				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (350,797)	(350,797)				
c. Prescription Drugs - Non-Medicare	\$ 68,928	68,928				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (61,145)	(61,145)				
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	\$ 689,020	689,020				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (626,004)	(626,004)				
c. Physical Therapy - Non-Medicare	\$ 71,488	71,488				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (70,267)	(70,267)				
4. a. Speech Therapy - Medicare	\$ 202,390	202,390				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (154,600)	(154,600)				
c. Speech Therapy - Non-Medicare	\$ 20,999	20,999				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (20,999)	(20,999)				
5. a. Occupational Therapy - Medicare	\$ 865,796	865,796				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (782,074)	(782,074)				
c. Occupational Therapy - Non-Medicare	\$ 91,759	91,759				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (89,799)	(89,799)				
6. a. Other (<i>Specify</i>) - Medicare	\$ 24,635	24,635				
b. Other (<i>Specify</i>) - Non-Medicare	\$ 1,784	1,784				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 13,757,891	13,757,891				
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 (<i>Specify</i>)	\$ 613	613				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 4,818	4,818				
V. Total Other Revenue (1 thru 8)	\$ 5,431	5,431				
VI. Total All Revenue (III +V)	\$ 13,763,322	13,763,322				

* 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.

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2017	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	99,634
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,858,644
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	49,403
5. Prepaid Expenses			\$	156,696
a. Taxes (personal property, real estate, corp)	84,571			
b. Management fees	51,498			
c. Insurance	9,387			
d. Prepaid Expenses Other	11,240			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	1,295,456
Patient Funds	34,122			
Escrow deposits	175,041			
Due from Related Party	1,086,293			
A-9. Total Current Assets (Lines A1 thru 8)			\$	3,459,833
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 <u>1,270,085</u>		\$	498,503
	Accum. Depreciation <u>771,582</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>905,675</u>		\$	342,913
	Accum. Depreciation <u>562,762</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	841,416

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Milford Health Care Center, Inc.	License No. 1056-C	Report for Year Ended 9/30/2017	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	4,301,249
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	_____		
	Accum. Depreciation	_____	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)				\$
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 (<i>itemize</i>)				\$

6. Loans to Owners or Related Parties (<i>itemize</i>)				\$
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)				\$
	Security Deposits	11,500		
	Reserve for Replacement	164,560		
D-8. Total Investments and Other Assets (Lines D1 thru 7)				\$ 176,060
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)				\$ 4,477,309

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

Annual Report of Long-Term Care Facility

CSP-33 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.		1056-C	9/30/2017	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	1,037,975
2. Notes Payable (<i>itemize</i>)				\$	
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	435,829
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	1,656,459
Accrued expenses	35,316	CT User Fee	171,860		
Patient funds	34,122	Accounting Fee	29,335		
Due to Third Party	15,033	Due to Related Party	1,082,440		
Due to Realty	228,692	Accrued Pension	59,661		
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	3,130,263

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Milford Health Care Center, Inc.	License No. 1056-C	Report for Year Ended 9/30/2017	Page 34	of 37
Account				Amount
Total Brought Forward:				3,130,263
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$

B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$
C. Total All Liabilities (Lines A-13 + B-5)				\$ 3,130,263

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

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2017	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	1,360,780
6. Gain or Loss for Period			\$	(14,734)
10/1/2016 thru 9/30/2017				
7. Total Net Worth			\$	1,347,046
C. Total Reserves and Net Worth			\$	1,347,046
D. Total Liabilities, Reserves, and Net Worth			\$	4,477,309

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Milford Health Care Center, Inc.	1056-C	9/30/2017	36	37		
Account			Amount			
A. Balance at End of Prior Period as shown on Report of 09/30/2016			\$	1,896,538		
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	13,763,322		
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	13,778,056		
D. Net Income or Deficit			\$	(14,734)		
E. Balance			\$	1,881,804		
F. Additions						
1. Additional Capital Contributed <i>(itemize)</i>						
CT tax refund	9,242					
2. Other <i>(itemize)</i>						
F-3. Total Additions					\$	9,242
G. Deductions						
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	500,000		
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount			
Marvin Ostreicher, 184 Wildacre Ave, Lawrence, NY 11559		President	240,000			
Agnes Zitter, 9 Dogwood Lane, Lawrence, NY 11559		Secretary	260,000			
2. Other Withdrawings <i>(Specify)</i>			\$	45,000		
Purpose		Amount				
State Taxes		45,000				
3. Total Deductions			\$	545,000		
H. Balance at End of Period		09/30/17	\$	1,346,046		

I. Preparer's/Reviewer's Certification

Name of Facility Milford Health Care Center, Inc.	License No. 1056-C	Report for Year Ended 9/30/2017	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>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.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
Blum Shapiro & Co				
Address		Phone Number		
2 Enterprise Drive Shelton, CT 06484-1488		(203) 944-2100		