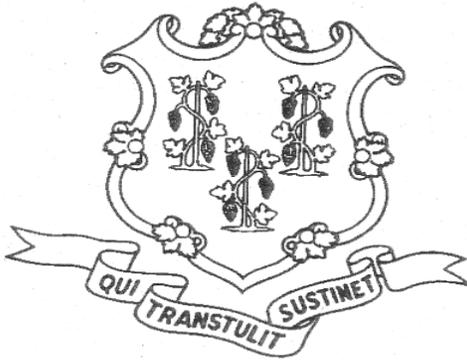


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2022

Name of Facility (as licensed) Orange Health Care Center	
Address (No. & Street, City, State, Zip Code) 225 Boston Post Road, Orange, CT 06477	
Type of Facility Chronic and Convalescent Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input type="checkbox"/> Supervision only <input type="checkbox"/> (Specify) (CCNH) (RHNS)	
Report for Year Beginning 10/1/2021	Report for Year Ending 9/30/2022

License Numbers:	CCNH 2361	RHNS	(Specify)	Medicare Provider 070-5434
------------------	--------------	------	-----------	-------------------------------

Medicaid Provider Numbers:	CCNH 4978	RHNS	ICF-IID
----------------------------	--------------	------	---------

For Department Use Only

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

General Information

Name of Facility (as licensed) Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2022	Page 1	of 37
---	---------------------	------------------------------------	-----------	----------

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 Orange Health Care Center [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) Andree Acampora			Printed Name (Owner) Linda Silberstein		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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

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 Orange Health Care Center		Period Covered:	From 10/1/2021	To 9/30/2022
Address of Facility 225 Boston Post Road, Orange, CT 06477				
Report Prepared By Orange Health Care Center		Phone Number 203-795-0835	Date 2/9/2023	
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 203-795-0835		Report for Year Ended 9/30/2022		Page 2	of 37
Name of Facility (as shown on license) Orange Health Care Center			Address (No. & Street, City, State, Zip) 225 Boston Post Road, Orange, CT 06477		
License Numbers:	CCNH 2361	RHNS	(Specify)	Medicare Provider No. 070-5434	
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 Andree Acampora			Nursing Home Administrator's License No.:	001280	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		

**General Information and Questionnaire
Related Parties***

Name of Facility Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2022	Page 4	of 37
---	---------------------	------------------------------------	-----------	----------

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

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Gladeview Health Care	60 Boston Post Road, Old Saybrook, CT	<input type="radio"/>	<input checked="" type="radio"/>		Payroll sharing	P 10 , Lines A4, A5a, A	50,866	50,866
Linda Silberstein	60 Boston Post Road, Old Saybrook, CT	<input type="radio"/>	<input checked="" type="radio"/>		Loan repayment	P 33 Line a12	26,000	26,000
Paul Knutsen	33 Chesterfield Road, Amston, CT 06231	<input type="radio"/>	<input checked="" type="radio"/>		Administrative consulting	P 16 Line m11	26,000	26,000
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

* Use additional sheets if necessary.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2022	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? Yes No If "No," explain fully why such allocation was not made.

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

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

Yes No If "No," explain fully why such allocation was not made.

General Information and Questionnaire Leases (Excluding Real Property)

Operating Leases - Include all long-term leases for motor vehicles and equipment that have not been capitalized. Short-term leases or as needed rentals should not be included in these amounts.

Name of Facility		License No.		Report for Year Ended			Page	of
Orange Health Care Center		2361		9/30/2022			6	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						
CIT Bank	<input type="radio"/>	<input checked="" type="radio"/>	Xerox copier	10/16/18	63 months	5,888	8,414	
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input checked="" type="radio"/> No	Total ***
							8,414	

* 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.

General Information and Questionnaire

Accounting Basis

Name of Facility Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2022	Page 7	of 37
The records of this facility for the period covered by this report were maintained on the following basis:				
<input checked="" type="radio"/> Accrual <input type="radio"/> Cash <input type="radio"/> Modified Cash				
Is the accounting basis for this period the same as for the previous period? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain.				
Independent Accounting Firm				
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)		
1	Simione Macca and Larrow	4130 Whitney Ave, Hamden, CT 06518		
2	Craig Lubitski Consulting	225 Pitkin St. East Hartford, CT 06108		
3				
4				
Services Provided by This Firm (<i>describe fully</i>)				
1	Tax returns	\$	3,150	
2	Medicare cost reporting	\$	2,300	
3		\$		
4		\$		
			Charge for Services Provided	
			\$	5,450
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 PG 15 L 1d				
Legal Services Information				
Name of Legal Firm or Independent Attorney			Telephone Number	
1	American Arbitration Association			
2	Jackson Lewis		914-872-8060	
3	Znngari, Cohn, Cuthbertson Duhl & Grello		203-789-0001	
4	Jacobi Case & Speranzini		203-874-7110	
5				
Address (<i>No. & Street, City, State, Zip Code</i>)				
1				
2	44 South Broadway, White Plains, NY 10601			
3	59 Elm St, New Haven, CT 06510			
4	185 Plains Rd Suite 103E, Milford, CT 06461			
5				
Services Provided by This Firm (<i>describe fully</i>)				
1	Arbitration with union issues	\$	1,125	
2	Union and labor issues	\$	88,395	
3	Collection issues	\$	5,236	
4	Collection issues	\$	2,323	
5		\$		
			Charge for Services Provided	
			\$	97,079
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 PG 15 L 1e				

Schedule of Resident Statistics

Name of Facility Orange Health Care Center			License No. 2361		Report for Year Ended 9/30/2022				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	60	60			60	60							
B. On last day of THIS report period	60	60							60	60			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	47	47			47	47							
B. As of midnight of THIS report period	49	49							49	49			
3. Total Number of Days Care Provided During Period													
A. Medicare	3,042	3,042			2,151	2,151			891	891			
B. Medicaid (Conn.)	12,983	12,983			9,552	9,552			3,431	3,431			
C. Medicaid (other states)													
D. Private Pay	2,017	2,017			1,633	1,633			384	384			
E. State SSI for RCH													
F. Other (Specify) Managed	102	102			49	49			53	53			
G. Total Care Days During Period (3A thru F)	18,144	18,144			13,385	13,385			4,759	4,759			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days													
B. Other Bed Reserve Days	56	56			53	53			3	3			
5. Total Resident Days (3G + 4A + 4B)	18,200	18,200			13,438	13,438			4,762	4,762			

Schedule of Resident Statistics (Cont'd)

Name of Facility Orange Health Care Center			License No. 2361			Report for Year Ended 9/30/2022			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	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	8		36		5								
Per Diem Rate													
a. One bed rm.	Various		277.00		466.00								
b. Two bed rms.	Various		277.00		440.00								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								1,809	1,809				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								34	34				
C. Other								5,641	5,641				
D. Total Physical Therapy Treatments								7,484	7,484				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								227	227				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other								390	390				
D. Total Speech Therapy Treatments								617	617				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								1,548	1,548				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								23	23				
C. Other								6,110	6,110				
D. Total Occupational Therapy Treatments								7,681	7,681				

Report of Expenditures - Salaries & Wages

Name of Facility Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2022	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)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	105,915	2,032				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	78,536	2,775				
5. Dietary Service						
a. Head Dietitian	15,641	511				
b. Food Service Supervisor	56,261	2,071				
c. Dietary Workers	247,966	10,462				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	202,720	8,863				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	66,860	2,094				
b. Other Maintenance Workers						
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	52,441	2,223				
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	183,998	2,345				
b. RN						
1. Direct Care	338,916	8,797				
2. Administrative**	137,764	3,591				
c. LPN						
1. Direct Care	354,531	10,591				
2. Administrative**	73,905	1,696				
d. Aides and Attendants	1,076,404	47,144				
e. Physical Therapists	179,379	3,222				
f. Speech Therapists	40,375	710				
g. Occupational Therapists	250,838	5,167				
h. Recreation Workers	53,590	1,920				
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	65,507	1,782				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	3,581,547	117,996				

* 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	
Orange Health Care Center				2361	9/30/2022			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										
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.

**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	
Orange Health Care Center				2361	9/30/2022			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***										
Andree Acampora	105,915			Health insurance. Payroll taxes	Day to day operations of the nursing home.	2,032	A3			
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.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Orange Health Care Center	2361	9/30/2022	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	4,008					
3. Pharmacist						
4. Podiatrist	223					
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	18,000	75				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	159					
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	100					
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	89,736	668				
2. Administrative***						
b. LPN						
1. Direct Care	147,581	2,190				
2. Administrative***						
c. Aides	84,898	2,164				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	344,705	5,097				

* 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 Orange Health Care Center		License No. 2361	Report for Year Ended 9/30/2022	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Health Drive Dental One Prestige Dr, Meriden, CT	Dental	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Hafsa Nawaz, 17 Carriage Hill Rd, Woodbridge, CT 06525	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
The Nurse Network, PO Box 982, Southington, CT 06489	Nursing pool	<input type="radio"/>	<input checked="" type="radio"/>		
Intely Care, Inc. PO Box 200413, 500 Ross St. 154- 0455, Pittsburgh, PA 15251-0413	Nursing pool	<input type="radio"/>	<input checked="" type="radio"/>		
Nurse Network, 400 Park Ave. 18th Floor, New York, NY 10022	Nursing pool	<input type="radio"/>	<input checked="" type="radio"/>		
SambaCare, 410 Melville Ave, Lakewood, NJ 08701	Nursing pool	<input type="radio"/>	<input checked="" type="radio"/>		
Strategic Nursing Solutions, 169 Hattertown Rd. Monroe, CT 06468	Nursing pool	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" 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
Orange Health Care Center	2361	9/30/2022	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 145,039	145,039		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 37,634	37,634		
4. Social Security (F.I.C.A.)	\$ 271,006	271,006		
5. Health Insurance	\$ 490,445	490,445		
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 16,699	16,699		
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 164,818	164,818		
8. Uniform Allowance	\$ 4,582	4,582		
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*	\$ 41,797	41,797		
d. Accounting and Auditing	\$ 5,450	5,450		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 97,079	97,079		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$ 8,580	8,580		
g. Office Supplies	\$ 18,874	18,874		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 20,280	20,280		
2. Cellular Phones	\$ 227	227		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 150	150		
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	\$ 316,117	316,117		
Subtotal	\$ 1,638,777	1,638,777		

* 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 Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2022	Page 16	of 37
Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	1,638,777	1,638,777		
l. Travel and Entertainment				
1. Resident Travel and Entertainment \$				
2. Holiday Parties for Staff \$	4,294	4,294		
3. Gifts to Staff and Residents \$				
4. Employee Travel \$				
5. Education Expenses Related to Seminars and Conventions \$	15,325	15,325		
6. Automobile Expense (<i>not purchase or depreciation</i>) \$				
7. Other (<i>Specify</i>) See Attached Schedule \$				
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>) \$	17,345	17,345		
2. Advertising Telephone Directory (<i>all such expenses</i>)*** \$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule \$				
4. Fund-Raising*** \$				
5. Medical Records \$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)*** \$				
7. Postage \$				
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule \$	4,094	4,094		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.*** \$				
9. Subscriptions \$				
10. Contributions*** See Attached Schedule \$	200	200		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>) \$	135,302	135,302		
12. Administrative Management Services** \$				
13. Other (<i>Specify</i>) See Attached Schedule \$	8,166	8,166		
C-14 Total Administrative & General Expenditures	\$ 1,823,503	1,823,503		

* 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)
Total Other Advertising	\$ -	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CT Association of Health Care Facilities	\$ 4,094		
Total Dues	\$ 4,094	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Orange Fire Department	\$ 200		
Total Contributions	\$ 200	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Charges	\$ 3,214		
Employee background checks	\$ 1,816		
Licences	\$ 3,136		
Total Other Administrative and General	\$ 8,166	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2022	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 #

*** 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.**

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

Name of Facility Orange Health Care Center		License No. 2361	Report for Year Ended 9/30/2022	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 136,680	136,680		
2.	Non-Food Supplies	\$ 29,401	29,401		
3.	Other (Specify) _____	\$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$			
c. Other (Specify) _____		\$			
2D. Total Dietary Expenditures (2a + b + c + d)		\$ 166,081	166,081		
2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F.	Resident Meals: Total no. of meals served per day:*	165	165		
G.	Is cost of employee meals included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		
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 meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K.	Is any revenue collected 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)				
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
N.	Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
O.	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.

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

Name of Facility Orange Health Care Center		License No. 2361	Report for Year Ended 9/30/2022	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. \$	5,761	5,761	
2.	Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.			
		Amt. \$			
3.	Personal clothing of residents washed, ironed, and/or processed.***	Lbs.			
		Amt. \$			
4.	Repair and/or purchase of linens.***	Lbs.			
		Amt. \$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$			
c. Other (Specify)		\$			
3D. Total Laundry Expenditures (3a + b + c)		\$	5,761	5,761	
3E. Laundry Questionnaire					
F.	Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
G.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
H.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
I.	Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
J.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
K.	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 3D.

*** 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		License No.	Report for Year Ended		Page	of
Orange Health Care Center		2361	9/30/2022		20	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. \$	16,703	16,703		
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.	Other (<i>Specify</i>)	\$				
4D.	Total Housekeeping Expenditures (4a + b + c)	\$	16,703	16,703		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from	\$	122,739	122,739		
b.	Medicine Cabinet Drugs	\$				
c.	Medical and Therapeutic Supplies	\$	134,475	134,475		
d.	Ambulance/Limousine***	\$	137	137		
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	16,077	16,077		
f.	X-rays and Related Radiological Procedures***	\$	2,960	2,960		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	8,276	8,276		
i.	Recreation	\$	10,388	10,388		
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	330	330		
5M.	Total Resident Care Expenditures (5a - 5j)	\$	295,382	295,382		

* 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.

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

Name of Facility Orange Health Care Center			License No. 2361		Report for Year Ended 9/30/2022				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
Paycom	Oklahoma City, OK 73142	<input type="radio"/>	<input checked="" type="radio"/>		Payroll processing	30,018			16	m11
Paul Knutsen	33 Chesterfield Dr, Amston, CT	<input type="radio"/>	<input checked="" type="radio"/>		Administrative consulting	26,000			16	m11
Point Click Care	Suite 4, Mississauga, ON, L5N 8E9	<input type="radio"/>	<input checked="" type="radio"/>		Computer services	21,245			16	m11
John's Refuse	PO Box 387, Guilford, CT 06437	<input type="radio"/>	<input checked="" type="radio"/>		Rubish Removal	19,621			22	6a
Data Titans	PO Box 127, Colchester, CT 06415	<input type="radio"/>	<input checked="" type="radio"/>		Computer IT Services	13,756			16	m11
Pharmerica	PO Box 409251, Atlanta, GA 30384-9251	<input type="radio"/>	<input checked="" type="radio"/>		Pharmacy supplies and service	122,739			20	5a2
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" 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 Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2022			Page 22	of 37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 78,757	78,757				
b. Heat	\$ 14,074	14,074				
c. Light & Power	\$ 57,642	57,642				
d. Water	\$ 27,176	27,176				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 8,414	8,414				
f. Other (<i>itemize</i>)	\$ 7,790	7,790				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 193,853	193,853				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$ 21,251	21,251				
b. Building & Building Improvements	\$ 47,883	47,883				
c. Non-Movable Equipment	\$ 12,046	12,046				
d. Movable Equipment	\$ 14,465	14,465				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 95,645	95,645				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$ 5,281	5,281				
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 5,281	5,281				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$					
10. Property Taxes						
a. Real estate taxes paid by owner	\$ 36,816	36,816				
b. Real estate taxes paid by lessor	\$ 3,464	3,464				
c. Personal property taxes	\$					
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 141,206	141,206				

* 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)
Groundskeeping	\$ 7,790		
Total Other Repairs and Maintenance	\$ 7,790	\$ -	\$ -

Depreciation Schedule

Name of Facility Orange Health Care Center		License No. 2361			Report for Year Ended 9/30/2022			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		223,597		214,352	129,513	S/L	Various	21,251					
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal									21,251				
B. Building and Building Improvements													
1. Acquired prior to this report period		1,564,834		1,564,834	1,126,959	S/L	Various	47,883					
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal									47,883				
C. Non-Movable Equipment													
1. Acquired prior to this report period		152,753		152,753	70,324	S/L	Various	12,046					
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal									12,046				
		Is a mileage logbook maintained?		Date of Acquisition		Historical Cost	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	Exclusive of Land							
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						279,164		279,164	261,375	S/L	Various	14,465	
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
c. Administrative													
d. Standard Resident													
e. Specialized Resident													
Total Acquired during this report period													
D-3. Subtotal													14,465
E. Total Depreciation													95,645

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
Additions:					
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
Total additions for Movable Equipment			\$ -		\$ - *
Deletions:					
Total deletions for Movable Equipment			\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

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

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility Orange Health Care Center			License No. 2361		Report for Year Ended 9/30/2022			Page 24	of 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. Loan cost	7	14	30 years	45,625	31,116			5,281	
2.									
3.									
B-4. Subtotal									5,281
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									5,281

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2022	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" 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		09/30/75			
2. Date Structure Completed					
3. If NOT Original Owner, Date of Purchase		04/25/61			
4. Date of Initial Licensure		1948			
5. Total Licensed Bed Capacity		60			
6. Square Footage		16,500			
7. Acquisition Cost					
a. Land		25,000			
b. Building		36,400			
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)					
b. Date Mortgage Obtained					
c. Interest Rate for the Cost Year					
d. Term of Mortgage (number of years)					
e. Amount of Principal Borrowed					
f. Principal balance outstanding as of					
Complete if Mortgage was Refinanced During Current Cost Year					
g. Type of Financing (e.g., fixed, variable)					
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
l. Principal Outstanding on Note Paid-Off					
Part C - Arms-Length Leases for Real Property Improvements Only					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Orange Health Care Center		2361	9/30/2022		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
Orange Health Care Center		2361		9/30/2022		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)				\$	157,783	157,783	
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	157,783	157,783	
14. Insurance							
a. Insurance on Property (buildings only)				\$	74,275	74,275	
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$			
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. Total Insurance Expenditures (14a + b + c)				\$	74,275	74,275	
15. Total All Expenditures (A-13 thru C-14)				\$	6,800,799	6,800,799	

D. Adjustments to Statement of Expenditures

Name of Facility Orange Health Care Center				License No. 2361	Report for Year Ended 9/30/2022	Page 28	of 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.			Salaries not related to Resident Care	\$			
3.	10	A12g	Occupational Therapy	\$ 250,838	250,838		
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians **	\$ 159	159		
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 41,797	41,797		
10.			Accounting	\$			
10a.			Legal	\$ 97,079	97,079		
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.	15	1f	Life insurance premiums on the life of Owners, Partners, Operators	\$ 8,580	8,580		
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.			Unallowable Advertising *	\$			
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$			
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 398,453	398,453		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

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

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

Name of Facility				License No.	Report for Year Ended	Page	of
Orange Health Care Center				2361	9/30/2022	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 398,453	398,453		
Page 20 - Resident Care Supplies***							
27.	20	5a	Prescription Drugs	\$ 122,739	122,739		
28.	20	5d	Ambulance/Limousine	\$ 137	137		
29.	20	5f	X-rays, etc	\$ 2,960	2,960		
30.	20	5h	Laboratory	\$ 8,276	8,276		
31.	20	5c	Medical Supplies	\$ 20,171	20,171		
32.	20	5e2	Oxygen (non emergency)	\$ 16,077	16,077		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$			
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 2,580	2,580		
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 571,393	571,393		

*** 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.

Schedule of Other Ancillary Costs

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

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	6a	Repairs and maintenance (offsets with rental income in misc income line)	\$ 1,541		
22	6c	Electric (offsets with rental income in misc income line)	\$ 539		
22	6d	Water (offsets with rental income in misc income line)	\$ 500		
Total Other Property Adjustments			\$ 2,580	\$ -	\$ -

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

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct Adjustments

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

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
Orange Health Care Center	2361	9/30/2022			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 5,256,974	5,256,974				
b. Medicaid Room and Board Contractual Allowance **	\$ (1,718,149)	(1,718,149)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 2,227,391	2,227,391				
b. Medicare Room and Board Contractual Allowance **	\$ (698,286)	(698,286)				
4. a. Private-Pay Residents and Other	\$ 1,158,668	1,158,668				
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 7,063	7,063				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (5,951)	(5,951)				
c. Prescription Drugs - Non-Medicare	\$ 2,926	2,926				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (2,926)	(2,926)				
2. a. Medical Supplies - Medicare	\$ 67,475	67,475				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (67,475)	(67,475)				
c. Medical Supplies - Non-Medicare	\$ 43,145	43,145				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (43,145)	(43,145)				
3. a. Physical Therapy - Medicare	\$ 383,666	383,666				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (327,610)	(327,610)				
c. Physical Therapy - Non-Medicare	\$ 112,817	112,817				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (112,817)	(112,817)				
4. a. Speech Therapy - Medicare	\$ 73,260	73,260				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (62,506)	(62,506)				
c. Speech Therapy - Non-Medicare	\$ 24,256	24,256				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (24,256)	(24,256)				
5. a. Occupational Therapy - Medicare	\$ 452,641	452,641				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (393,097)	(393,097)				
c. Occupational Therapy - Non-Medicare	\$ 123,687	123,687				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (123,687)	(123,687)				
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 6,354,064	6,354,064				
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>)	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 143,755	143,755				
V. Total Other Revenue (1 thru 8)	\$ 143,755	143,755				
VI. Total All Revenue (III +V)	\$ 6,497,819	6,497,819				

* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

** Facility should report all contractual allowances and/or payer discounts.

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

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

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV8	Rental income	\$ 45,058		
30 IV8	HHS funding	\$ 89,890		
30 IV8	Miscellaneous	\$ 8,807		
Total Other Revenue		\$ 143,755	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2022	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	338,078
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,472,006
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	33,176
a. Prepaid other	9,952			
b. Taxes	14,455			
c. Insurance	8,769			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	180,690
Deposit	3,252			
Due from 233 Boston Post Realty	177,438			
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	2,023,950
B. Fixed Assets				
1. Land			\$	40,600
2. Land Improvements	*Historical Cost	214,352	\$	63,588
	Accum. Depreciation	150,764	Net	
3. Buildings	*Historical Cost	1,564,834	\$	389,992
	Accum. Depreciation	1,174,842	Net	
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	152,753	\$	70,383
	Accum. Depreciation	82,370	Net	
6. Movable Equipment	*Historical Cost	279,164	\$	3,324
	Accum. Depreciation	275,840	Net	
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	567,887

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			\$ -

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

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

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

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

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

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

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

G. Balance Sheet (cont'd)

Name of Facility Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2022	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$ 2,591,837	
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$ 20,317	
2. Land Improvements		*Historical Cost <u>9,245</u>		
		Accum. Depreciation _____		
		Net	\$ 9,245	
3. Buildings		*Historical Cost _____		
		Accum. Depreciation _____		
		Net	\$	
4. Non-Movable Equipment		*Historical Cost _____		
		Accum. Depreciation _____		
		Net	\$	
5. Movable Equipment		*Historical Cost _____		
		Accum. Depreciation _____		
		Net	\$	
6. Motor Vehicles		*Historical Cost _____		
		Accum. Depreciation _____		
		Net	\$	
7. Minor Equipment-Not Depreciable		\$		
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$ 29,562	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense		*Historical Cost _____		
		Accum. Depreciation _____		
		Net	\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<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>)			\$ 128,686	
Deferred financing fees		128,686		
See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ 128,686	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 2,750,085	

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

G. Balance Sheet (cont'd)

Name of Facility Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2022		Page 34	of 37
Account				Amount	
Total Brought Forward:				2,024,017	
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>)				\$	
Celtic Bank		2,593,860			
See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 2,593,860	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 4,617,877	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2022	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>)			\$	29,562
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	29,562
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	45,410
3. Paid-in Surplus			\$	167,431
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(1,807,215)
6. Gain or Loss for Period			\$	(302,980)
	10/1/2021	thru	9/30/2022	
7. Total Net Worth			\$	(1,897,354)
C. Total Reserves and Net Worth			\$	(1,867,792)
D. Total Liabilities, Reserves, and Net Worth			\$	2,750,085

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2022	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2021			\$	(1,807,215)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	6,497,819
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	6,800,799
D. Net Income or Deficit			\$	(302,980)
E. Balance			\$	(2,110,195)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period			\$	(2,110,195)
				09/30/22

I. Preparer's/Reviewer's Certification

Name of Facility Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2022	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				
Orange Health Care Center				
Address Address			Phone Number	
225 Boston Post Road, Orange, CT 06477			203-795-0835	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Jason Moore			203-795-0835	
Contact Email Address				
jmoore@orange-healthcare.com				