

# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) Portland Care and Rehabilitation Centre, Inc.	
Address (No. & Street, City, State, Zip Code) 333 Main Street, Portland CT 06480	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH 871-C	RHNS	(Specify)	Medicare Provider 075217
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Medicaid Provider Numbers:	CCNH 8714	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

## General Information

Name of Facility (as licensed) Portland Care and Rehabilitation Centre, Inc.	License No. 871-C	Report for Year Ended 9/30/2021	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 Portland Care and Rehabilitation Centre, Inc. [facility name], for the cost report period beginning October 1, 2020 and ending September 30, 2021, 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) Gerald Yuska		Printed Name (Owner) Gerald Yuska	
Subscribed and Sworn to before me:	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public			

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>				Page 1A	of 37
Name of Facility Portland Care and Rehabilitation Centre, Inc.	Period Covered:		From 10/1/2020	To 9/30/2021	
Address of Facility 333 Main Street, Portland CT 06480					
Report Prepared By Ryan Turko	Phone Number 860-342-0370		Date 2/7/2022		
Item	Total	CCNH	RHNS	(Specify)	
1. Dietary wages paid	\$ 305,083	305,083			
2. Laundry wages paid	\$ 106,029	106,029			
3. Housekeeping wages paid	\$ 125,391	125,391			
4. Nursing wages paid	\$ 2,678,540	2,678,540			
5. All other wages paid	\$ 1,374,427	1,374,427			
<b>6. Total Wages Paid</b>	<b>\$ 4,589,470</b>	<b>4,589,470</b>			
7. Total salaries paid	\$				
<b>8. Total Wages and Salaries Paid (As per page 10 of Report)</b>	<b>\$ 4,589,470</b>	<b>4,589,470</b>			

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 860-342-0370	Report for Year Ended 9/30/2021	Page 2
Name of Facility (as shown on license) Portland Care and Rehabilitation Centre, Inc.		Address (No. & Street, City, State, Zip ) 333 Main Street, Portland CT 06480	
License Numbers:	CCNH 871-C	RHNS	(Specify)
Medicare Provider No. 075217			
Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> 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.
<b>Administrator</b>			
Name of Administrator Gerald Yuska		Nursing Home Administrator's License No.:	001765
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name		License No.:	

## **General Information and Questionnaire Partners/Members**

# **General Information and Questionnaire**

## **Corporate Owners**

# **General Information and Questionnaire**

## **Individual Proprietorship**

Name of Facility Portland Care and Rehabilitation Centre, Inc.	License No. 871-C	Report for Year Ended 9/30/2021	Page 3B	of 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

## General Information and Questionnaire

### Related Parties\*

Name of Facility Portland Care and Rehabilitation Centre, Inc.	License No. 871-C	Report for Year Ended 9/30/2021			Page 4	of 37	
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input type="radio"/> Yes <input checked="" type="radio"/> 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 type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," provide the following information:			
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**			
		<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.

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

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility Portland Care and Rehabilitation Centre, Inc.	License No. 871-C	Report for Year Ended 9/30/2021	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

### Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

⊕ No

Total \*\*\*

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

\*\* Attach copies of newly acquired leases.

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

## General Information and Questionnaire

### Accounting Basis

Name of Facility Portland Care and Rehabilitation C	License No. 871-C	Report for Year Ended 9/30/2021	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     Yes    If "No," explain.  
previous period?     No

#### Independent Accounting Firm

Name of Accounting Firm 1 Accavallo & Company LLC 2 Health Financial Systems 3 4	Address (No. & Street, City, State, Zip Code) 1000 Bridgeport Ave, Suite Shelton CT 06484 Florida
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Services Provided by This Firm (*describe fully*)

1 HUD Audit	\$ 15,381
2 Medicare Cost Report Software	\$ 475
3	\$
4	\$
	Charge for Services Provided \$ 15,856

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

Yes     No

#### Legal Services Information

Name of Legal Firm or Independent Attorney 1 Haile, Shaw & Pfaffenberger, PA 2 Gordon & Rees LLP 3 4 5	Telephone Number 860-494-7511
---	----------------------------------

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

1 660 US Hwy One, Third Floor, North Palm Fl 2 95 Glastonbury Boulvard, Glastonbury CT 3 4 5	
--	--

Services Provided by This Firm (*describe fully*)

1 Consulting Self Disallow	\$ 4,395
2 Collection on Medicaid, Settlement, Lawsuit	\$ 19,407
3	\$
4	\$
5	\$
	Charge for Services Provided \$ 23,802

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

Yes     No

## Schedule of Resident Statistics

Name of Facility Portland Care and Rehabilitation Centre, Inc.			License No. 871-C				Report for Year Ended 9/30/2021				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					65	65						
A. On last day of PREVIOUS report period	65	65										
B. On last day of THIS report period	65	65							65	65		
2. Number of Residents					60	60						
A. As of midnight of PREVIOUS report period	60	60										
B. As of midnight of THIS report period	56	56							56	56		
3. Total Number of Days Care Provided During Period					2,490	2,490			863	863		
A. Medicare	3,353	3,353										
B. Medicaid (Conn.)	12,712	12,712			9,415	9,415			3,297	3,297		
C. Medicaid (other states)												
D. Private Pay	5,495	5,495			4,053	4,053			1,442	1,442		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	21,560	21,560			15,958	15,958			5,602	5,602		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. <b>Total Resident Days (3G + 4A + 4B)</b>	<b>21,560</b>	<b>21,560</b>			<b>15,958</b>	<b>15,958</b>			<b>5,602</b>	<b>5,602</b>		

## Schedule of Resident Statistics (Cont'd)

Name of Facility Portland Care and Rehabilitation Centre, Inc.	License No. 871-C	Report for Year Ended 9/30/2021	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?

 Yes No

If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change	
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)		
				(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.

1st change	Change in Resident Days			CCNH	RHNS	(Specify)
	CCNH	RHNS	(Specify)	CCNH	RHNS	(Specify)
2nd change						
3rd change						
4th change						

6. Number of Residents and Rates on September 30 of Cost Year

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	7	33		16				
Per Diem Rate								
a. One bed rm.	Various	237.65		456.00				
b. Two bed rms.	Various	238.00		410.434				
c. Three or more bed rms.	N/A	N/A		N/A				

7. Total Number of Physical Therapy Treatments

TOTAL CCNH RHNS (Specify)

A. Medicare - Part B		68	68	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
<b>D. Total Physical Therapy Treatments</b>		68	68	

8. Total Number of Speech Therapy Treatments

TOTAL CCNH RHNS (Specify)

A. Medicare - Part B		77	77	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
<b>D. Total Speech Therapy Treatments</b>		77	77	

9. Total Number of Occupational Therapy Treatments

TOTAL CCNH RHNS (Specify)

A. Medicare - Part B		63	63	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
<b>D. Total Occupational Therapy Treatments</b>		63	63	

## Report of Expenditures - Salaries &amp; Wages

Name of Facility Portland Care and Rehabilitation Centre, Inc.	License No. 871-C	Report for Year Ended 9/30/2021		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)	156,858	2,120				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	272,054	8,680				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	305,083	17,932				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	125,391	8,584				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	160,559	6,884				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	106,028	6,482				
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	156,619	2,476				
b. RN						
1. Direct Care	738,956	18,175				
2. Administrative**	98,398	1,783				
c. LPN						
1. Direct Care	386,178	12,035				
2. Administrative**						
d. Aides and Attendants	1,298,388	62,236				
e. Physical Therapists	314,070	6,382				
f. Speech Therapists						
g. Occupational Therapists	197,125	5,417				
h. Recreation Workers	158,074	5,019				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	64,612	2,140				
n. Marketing						
o. Other (Specify) See Attached Schedule	51,077					
<i>A-13. Total Salary Expenditures</i>	4,589,470	166,345				

\* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

\*\* Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and

Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

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

**Schedule of Other Salaries and Wages (Page 10)**

**Schedule of Other Fees (Page 13)**

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

Name of Facility Portland Care and Rehabilitation Centre, Inc.			License No. 871-C		Report for Year Ended 9/30/2021			Page 11	of 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)							
<b>Section I - Operators/Owners</b>										
Gerald Yuska	156,858				Administrator	2,120		N/A		
<b>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).</b>										
Constance Yuska	106,450				Recreation/ Social Services	2,120		N/A		

\* 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.

State of Connecticut

**Annual Report of Long-Term Care Facility**

CSP-12 Rev. 10/2005

**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
Portland Care and Rehabilitation Centre, Inc.				871-C		9/30/2021			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)							
<b>Section III - Administrators***</b>										
Gerald Yuska	156,858				Administrator	2,120	A2	N/A		
<b>Section IV - Assistant Administrators</b>										

\*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 Portland Care and Rehabilitation Centre, Inc.	License No. 871-C	Report for Year Ended 9/30/2021		Page 13	of 37
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>					
1. Dietitian	18,425	308			
2. Dentist	2,820	20			
3. Pharmacist					
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	21,600	350			
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**					
d. Administrative Services facility					
1. Infection Control Committee (Quarterly meetings)					
2. Pharmaceutical Committee (Quarterly meetings)					
3. Staff Development Committee (Once annually)					
e. Other (Specify)					
9. Speech Therapist					
a. Resident Care					
b. Other					
10. Occupational Therapist					
a. Resident Care					
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care					
2. Administrative***					
b. LPN					
1. Direct Care					
2. Administrative***					
c. Aides					
d. Other					
12. Other (Specify)					
See Attached Schedule					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	42,845	678			

\* 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\***

\* 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
		9/30/2021		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	106,646	106,646		
2. Disability Insurance	\$				
3. Unemployment Insurance	\$	72,626	72,626		
4. Social Security (F.I.C.A.)	\$	334,832	334,832		
5. Health Insurance	\$	262,960	262,960		
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$				
8. Uniform Allowance	\$				
9. Other (Specify) See Attached Schedule	\$	4,658	4,658		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$				
d. Accounting and Auditing	\$	15,856	15,856		
e. Legal (Services should be fully described on Page 7)	\$	23,802	23,802		
f. Insurance on Lives of Owners and Operators (Specify)*	\$				
g. Office Supplies	\$	36,592	36,592		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	12,154	12,154		
2. Cellular Phones	\$				
i. Appraisal (Specify purpose and attach copy)*	\$				
j. Corporation Business Taxes (franchise tax)	\$				
k. Other Taxes (Not related to property - See Page 22)					
1. Income*	\$				
2. Other (Specify) See Attached Schedule	\$				
3. Resident Day User Fee	\$	384,163	384,163		
<b>Subtotal</b>		<b>\$ 1,254,289</b>	<b>1,254,289</b>		

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

(Carry Subtotals forward to next page)

**\*\*\* DO NOT Include Holiday Parties / Awards / Gifts to Staff**

Attachment Page 15

## **Schedule of Other Employee Benefits**

### Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
<b>Total</b>	\$ -	\$ -	\$ -

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

Name of Facility Portland Care and Rehabilitation Centre, Inc.	License No. 871-C	Report for Year Ended 9/30/2021		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
<b><i>Subtotals Brought Forward:</i></b>		1,254,289	1,254,289		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	7,351	7,351		
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$				
5. Education Expenses Related to Seminars and Conventions	\$	2,543	2,543		
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> )	\$	9,142	9,142		
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$	798	798		
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	\$	1,709	1,709		
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$				
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract ( <i>Specify and Complete     Schedule C-2, Page 21 for each firm or individual</i> )	\$	28,775	28,775		
12. Administrative Management Services**	\$				
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	91,383	91,383		
<b><i>C-14 Total Administrative &amp; General Expenditures</i></b>	\$	1,395,990	1,395,990		

\* 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)
<b>Total Other Travel and Entertainment</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
<b>Total Other Advertising</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
<b>Total Dues</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
<b>Total Contributions</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
Bank Service Charges	\$ 1,095		
Computer Services	\$ 42,640		
Gas for Trucks	\$ 6,718		
Marketing	\$ 1,815		
Licesnes and Permits	\$ 1,759		
Payroll Services	\$ 17,724		
Penalties	\$ 1,122		
Other Travel and Ent	\$ 18,510		
<b>Total Other Administrative and General</b>	<b>\$ 91,383</b>	<b>\$ -</b>	<b>\$ -</b>

State of Connecticut

**Annual Report of Long-Term Care Facility**

CSP-17 Rev. 10/97

**Schedule C-1 - Management Services\***

Name of Facility Portland Care and Rehabilitation Centre, Inc.	License No. 871-C	Report for Year Ended 9/30/2021	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	License No.	Report for Year Ended		Page of
	871-C	9/30/2021		18   37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 226,228	226,228		
2. Non-Food Supplies	\$ 35,153	35,153		
3. Other (Specify) _____	\$ _____			
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ _____			
c. Other (Specify) _____	\$ _____			
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 261,381</b>	<b>261,381</b>		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*				
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 Portland Care and Rehabilitation Centre, Inc.	License No. 871-C	Report for Year Ended 9/30/2021		Page of 19   37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$			
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> ) (Complete Schedule C-2 att. Page 21)	\$	12,299	12,299	
c. Other (Specify)	\$			
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	\$	12,299	12,299	
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
Portland Care and Rehabilitation Centre, Inc.	871-C	9/30/2021		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 31,589	31,589		
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )					
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> )	\$				
<b>4D. Total Housekeeping Expenditures (4a + b + c )</b>	\$	<b>31,589</b>	<b>31,589</b>		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from ValueRX	\$	123,918	123,918		
b. Medicine Cabinet Drugs	\$	17,527	17,527		
c. Medical and Therapeutic Supplies	\$	135,568	135,568		
d. Ambulance/Limousine***	\$	6,336	6,336		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	9,530	9,530		
f. X-rays and Related Radiological Procedures***	\$	3,103	3,103		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$	5,849	5,849		
i. Recreation	\$	5,060	5,060		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other ( <i>Specify</i> )**** See Attached Schedule	\$	21,515	21,515		
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	<b>328,406</b>	<b>328,406</b>		

\* 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**

## Report of Expenditures

\* 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 Portland Care and Rehabilitation Centre, Inc.	License No. 871-C	Report for Year Ended 9/30/2021			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 150,016	150,016				
b. Heat	\$ 17,653	17,653				
c. Light & Power	\$ 83,408	83,408				
d. Water	\$ 75,322	75,322				
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$					
f. Other <i>(itemize)</i>	\$ 47,615	47,615				
See Attached Schedule						
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$ 374,014	374,014				
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$ 27,286	27,286				
b. Building & Building Improvements	\$ 68,249	68,249				
c. Non-Movable Equipment	\$ 14,671	14,671				
d. Movable Equipment	\$ 38,689	38,689				
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$ 148,895	148,895				
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$ 4,174	4,174				
c. Leasehold Improvements	\$					
d. Other <i>(Specify)</i>	\$					
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$ 4,174	4,174				
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	\$ 55,864	55,864				
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$ 6,912	6,912				
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$ 215,845	215,845				

\* 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)
Oil of Generator	\$ 2,058		
Cable TV	\$ 10,635		
Exterminating	\$ 1,158		
Hazard Waste Disposal	\$ 553		
Elevator Services	\$ 3,456		
Rubbish Removal	\$ 12,323		
Snow Removal	\$ 2,116		
Truck Expense	\$ 15,316		
<b>Total Other Repairs and Maintenance</b>	<b>\$ 47,615</b>	<b>\$ -</b>	<b>\$ -</b>

## Depreciation Schedule

Name of Facility Portland Care and Rehabilitation Centre, Inc.				License No. 871-C			Report for Year Ended 9/30/2021				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		
<b>A. Land Improvements</b>													
1. Acquired prior to this report period				666,455		666,455	525,699	Straight Line	Various	27,286			
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
<b>A-4. Subtotal</b>											27,286		
<b>B. Building and Building Improvements</b>													
1. Acquired prior to this report period				3,736,439		3,765,049	1,916,662	Straight Line	Various	66,683			
2. Disposals (attach schedule)				27,182				Straight Line	40	1,511			
3. Acquired during this report period (attach schedule)				4,428						55			
<b>B-4. Subtotal</b>											68,249		
<b>C. Non-Movable Equipment</b>													
1. Acquired prior to this report period				192,033		227,985	129,020	Straight Line	Various	13,173			
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)				35,952						1,498			
<b>C-4. Subtotal</b>											14,671		
	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									
<b>D. Movable Equipment</b>													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a. 2009 Chevy Truck, Tractor, F-250 D	X				36,360	54,420	44,260	40,806	Straight Line	5	3,455		
b. 2018 Dodge Journey, F-350	X				56,698		56,698		Straight Line	5	10,177		
c. 2020 F-250	X		2	21	53,754		53,754		Straight Line	5	7,167		
d. 2020 F-150	X		1	21	65,336		65,336		Straight Line	5	9,800		
2. Movable Equipment													
a. Acquired prior to this report period					430,943			397,163	Straight Line	Various	7,564		
b. Disposals (attach schedule)					3,564								
c. Acquired during this report period (attach schedule)					7,019						526		
<b>D-3. Subtotal</b>												38,689	
<b>E. Total Depreciation</b>												148,895	

**Schedule of Land Improvements Acquired during this report period**

\*Ties to Page 23, Line A3

\*\*Ties to Page 23, Line A2

**Schedule of Building Improvements Acquired during this report period**

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

**Schedule of Non-Movable Equipment Acquired during this report period**

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

\*\*Ties to Page 23, Line C3

**Schedule of Movable Equipment Acquired during this report period**

\*Ties to Page 23, Line D2c

\*\*Ties to Page 23, Line D2b

**Schedule of Leasehold Improvements Acquired during this report period**

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

## Amortization Schedule\*

Name of Facility Portland Care and Rehabilitation Centre, Inc.			License No. 871-C		Report for Year Ended 9/30/2021			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. Capitalized Financing Costs	9	2006	40	166,941				4,174	
2.									
3.									
B-4. Subtotal									4,174
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									4,174

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

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

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

Name of Facility Portland Care and Rehabilitation Cent	License No. 871-C	Report for Year Ended 9/30/2021	Page 25	of 37
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#### 11. Property Questionnaire

##### Part A

Is the property either owned by the Facility  
or leased from a Related Party?\*

Yes

No

If "Yes," complete Part B.  
If "No," complete Part C.

\*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total			
1. Date Land Purchased	01/01/69			
2. Date Structure Completed	09/30/71			
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure	01/01/71			
5. Total Licensed Bed Capacity	65			
6. Square Footage	40,000			
7. Acquisition Cost				
a. Land	1,815,050			
b. Building	946,061			

##### Part B - Owner and Related Parties

1st Mortgage 2nd Mortgage 3rd Mortgage 4th Mortgage

1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	06/23/05			
c. Interest Rate for the Cost Year	4.00%			
d. Term of Mortgage (number of years)	40			
e. Amount of Principal Borrowed	4,080,500			
f. Principal balance outstanding as of _____	3,377,963			

##### 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 9/30/2021			Page 26	of 37
Item		Total	CCNH	RHNS	(Specify)	
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage		\$				
Name of Lender	Rate					
Berkadia Commercial Mortgage	3.65%					
Address of Lender						
118 Welsh Road Horsham, PA 19044-2207						
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		\$ 124,896	124,896	124,896		
12 B7. <b>Total Building Interest Expense (A1 - A4 + B5)</b>		\$ 124,896	124,896	124,896		

(Carry Subtotals forward to next page )

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

Name of Facility Portland Care and Rehabilitation Ce	License No. 871-C	Report for Year Ended 9/30/2021			Page 27	of 37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:			124,896	124,896		
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						
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)			\$			
12. D. Other Interest Expense (Specify)			\$			
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)			\$ 124,896	124,896		
14. Insurance						
a. Insurance on Property (buildings only)			\$ 10,703	10,703		
b. Insurance on Automobiles			\$ 8,899	8,899		
c. Insurance other than Property (as specified above)						
1. Umbrella ( <i>Blanket Coverage</i> )			\$			
2. Fire and Extended Coverage			\$			
3. Other (Specify)			\$ 178,523	178,523		
GL Insurance=164,673 HUD MIP =13850						
14d. <b>Total Insurance Expenditures</b> (14a + b + c)			\$ 198,125	198,125		
15. <b>Total All Expenditures</b> (A-13 thru C-14)			\$ 7,574,860	7,574,860		

## **D. Adjustments to Statement of Expenditures**

Name of Facility Portland Care and Rehabilitation Centre, Inc.			License No. 871-C	Report for Year Ended 9/30/2021		Page 28   of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS (Specify)
<b><i>Page 10 - Salaries and Wages</i></b>						
1.			Outpatient Service Costs	\$ 1,200	1,200	
2.			Salaries not related to Resident Care	\$		
3.			Occupational Therapy	\$ 197,125	197,125	
4.			Other - See attached Schedule	\$ 143,842	143,842	
<b><i>Page 13 - Professional Fees</i></b>						
5.			Resident Care Physicians **	\$		
6.			Occupational Therapy	\$		
7.			Other - See attached Schedule	\$		
<b><i>Pages 15 &amp; 16 - Administrative and General</i></b>						
8.			Discriminatory Benefits	\$		
9.			Bad Debts	\$		
10.			Accounting	\$		
10a.			Legal	\$ 4,395	4,395	
11.			Telephone	\$ 10,635	10,635	
12.			Cellular Telephone	\$		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$		
14.			Gifts, flowers and coffee shops	\$		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$		
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$ 18,510	18,510	
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	\$ 17,767	17,767	
<b><i>Page 18 - Dietary Expenditures</i></b>						
24.			Meals to employees, guests and others who are not residents	\$		
<b><i>Page 19 - Laundry Expenditures</i></b>						
25.			Laundry services to employees, guests and others who are not residents	\$		
<b><i>Page 20 - Housekeeping Expenditures</i></b>						
26.			Housekeeping services to employees, guests and others who are not residents	\$		
Subtotal (Items 1 - 26)			\$ 393,474	\$ 393,474		

\* 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)
10	A2	Gerald Yuska (Related Party) Admin Salary	\$ 76,349		
10	A12H	Constance Yuska (Recreation/ Social Service)	\$ 67,493		
<b>Total Other Salaries Adjustment</b>			\$ 143,842	\$ -	\$ -

**Schedule of Fees Adjustments**

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

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	2	Holiday Staff Parties	\$ 7,351		
16	AG	Penalties	\$ 1,122		
15	Attachment	Delete	\$ 9,294		
<b>Total Other A&amp;G Adjustments</b>			\$ 17,767	\$ -	\$ -

State of Connecticut

**Annual Report of Long-Term Care Facility**

CSP-29 Rev. 9/2018

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

Name of Facility			License No.	Report for Year Ended		Page of	
Portland Care and Rehabilitation Centre, Inc.			871-C	9/30/2021		29   37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 393,474	393,474		
<b>Page 20 - Resident Care Supplies***</b>							
27.			Prescription Drugs	\$ 123,918	123,918		
28.			Ambulance/Limousine	\$ 6,336	6,336		
29.			X-rays, etc	\$ 3,103	3,103		
30.			Laboratory	\$ 5,849	5,849		
31.			Medical Supplies	\$ 18,129	18,129		
32.			Oxygen (non emergency)	\$ 9,530	9,530		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 3,386	3,386		
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$ 19,978	19,978		
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 5,448	5,448		
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$ 13,850	13,850		
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 603,001	603,001		

\*\*\* 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)
20	L	PT Supplies	\$ 3,386		
<b>Total Other Ancillary Costs</b>			\$ 3,386	\$ -	\$ -

**Schedule of Excess Movable Equipment Depreciation**

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

**Schedule of Other Property Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Pg 27	14b	Car Insurance	\$ 5,448		
<b>Total Other Property Adjustments</b>			\$ 5,448	\$ -	\$ -

### **Schedule of Other - Indirect Adjustments**

Attachment Page 29

### **Schedule of Other - Miscellaneous Administrative Adjustments**

### **Schedule of Other - Direct Adjustments**

## Schedule of Unallowable Building Interest

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended		Page of
		9/30/2021		30   37
Item		Total	CCNH	RHNS
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>				(Specify)
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 3,187,650	3,187,650		
b. Medicaid Room and Board Contractual Allowance **	\$			
2. a. Medicaid ( <i>All other states</i> )	\$			
b. Other States Room and Board Contractual Allowance **	\$			
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 1,044,697	1,044,697		
b. Medicare Room and Board Contractual Allowance **	\$			
4. a. Private-Pay Residents and Other	\$			
b. Private-Pay Room and Board Contractual Allowance **	\$ 2,274,173	2,274,173		
<b>II. Other Resident Revenue</b>				
1. a. Prescription Drugs - Medicare	\$			
b. Prescription Drugs - Medicare Contractual Allowance **	\$			
c. Prescription Drugs - Non-Medicare	\$			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$			
2. a. Medical Supplies - Medicare	\$			
b. Medical Supplies - Medicare Contractual Allowance **	\$			
c. Medical Supplies - Non-Medicare	\$			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$			
3. a. Physical Therapy - Medicare	\$ 10,725	10,725		
b. Physical Therapy - Medicare Contractual Allowance **	\$			
c. Physical Therapy - Non-Medicare	\$			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$			
4. a. Speech Therapy - Medicare	\$			
b. Speech Therapy - Medicare Contractual Allowance **	\$			
c. Speech Therapy - Non-Medicare	\$			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$			
5. a. Occupational Therapy - Medicare	\$			
b. Occupational Therapy - Medicare Contractual Allowance **	\$			
c. Occupational Therapy - Non-Medicare	\$			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$			
6. a. Other ( <i>Specify</i> ) - Medicare	\$			
b. Other ( <i>Specify</i> ) - Non-Medicare	\$			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 6,517,245	6,517,245		
<b>IV. Other Revenue*</b>				
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> )	\$ 1,915,029	1,915,029		
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 1,915,029	1,915,029		
<b>VI. Total All Revenue</b> (III +V)	\$ 8,432,274	8,432,274		

\* 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)
<b>Total Other Resident Revenue - Medicare</b>		\$ -	\$ -	\$ -

**Schedule of Other Non-Medicare Resident Revenue**

## Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Resident Revenue</b>		\$ -	\$ -	\$ -

## Interest Income

## Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
<b>Total Interest Income</b>		\$ -	\$ -	\$ -	

### Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30	Private Insurance	\$ 820,271		
30	Interest Income	\$ 1,730		
30	Dividend Income	\$ 154		
30	HHS and Grant Money	\$ 281,652		
30	Grant Money	\$ 7,000		
30	CRF Grant	\$ 50,269		
30	Gain/ Loss of Disposal od Asset	\$ 453		
30	Payroll Protection Preceeds	\$ 753,500		
<b>Total Other Revenue</b>		<b>\$ 1,915,029</b>	<b>\$ -</b>	<b>\$ -</b>

**G. Balance Sheet**

Name of Facility	License No.	Report for Year Ended	Page of
		9/30/2021	31   37
Account			Amount
<b>Assets</b>			
A. Current Assets			
1. Cash ( <i>on hand and in banks</i> )			\$ 478,533
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 283,964
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$
4. Inventories			\$
5. Prepaid Expenses			\$ 199,846
a. Prepaid Property Taxes			10,949
b. Prepaid Building Insurance			168,880
c. Prepaid Mtg Insurance			16,158
d. See Schedule			3,859
6. Interest Receivable			\$
7. Medicare Final Settlement Receivable			\$
8. Other Current Assets ( <i>itemize</i> )			\$ 32,485
State Owed Money			425
See Schedule			32,060
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$ 994,828
B. Fixed Assets			
1. Land			\$ 181,505
2. Land Improvements	*Historical Cost	666,455	\$ 113,470
	Accum. Depreciation	552,985	Net
3. Buildings	*Historical Cost	3,768,049	\$ 1,783,138
	Accum. Depreciation	1,984,911	Net
4. Leasehold Improvements	*Historical Cost		\$
	Accum. Depreciation		Net
5. Non-Movable Equipment	*Historical Cost	227,985	\$ 84,294
	Accum. Depreciation	143,691	Net
6. Movable Equipment	*Historical Cost	441,526	\$ 36,273
	Accum. Depreciation	405,253	Net
7. Motor Vehicles	*Historical Cost	212,148	\$ 140,743
	Accum. Depreciation	71,405	Net
8. Minor Equipment-Not Depreciable			\$
9. Other Fixed Assets ( <i>itemize</i> )			\$ 102,948
See Schedule		102,948	
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$ 2,442,371

\* 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**

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

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

**Schedule of Other Assets Page 32 Line D7**

Page Ref	Line Ref	Description	
<b>Total Other Assets</b>			\$ -

**Schedule of Notes Payable (Itemize) Page 33 Line A2**

Page Ref	Line Ref	Description	
<b>Total Notes Payable</b>			\$ -

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

Page Ref	Line Ref	Description	
33	A12	Gerald Payable	\$ 2,596
33	A12	Sales Tax Payable	\$ (7,305)
33	A12	Deferred Revenue	\$ 161,398
33	A12	User Fee Payable	99614
<b>Total Other Current Liabilities (Itemize)</b>			\$ 256,303

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

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			\$ -

## G. Balance Sheet (cont'd)

Name of Facility Portland Care and Rehabilitation Centre	License No. 871-C	Report for Year Ended 9/30/2021	Page 32	of 37
Account		Amount		
		Total Brought Forward:		\$ 3,437,199
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				\$
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>				\$
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> )				\$
See Schedule				
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>				\$
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>				\$ 3,437,199

\* 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	License No.	Report for Year Ended	Page	of										
Portland Care and Rehabilitation Centre, Inc.	871-C	9/30/2021	33	37										
Account				Amount										
<b>Liabilities</b>														
A. Current Liabilities														
1. Trade Accounts Payable				\$ 190,419										
2. Notes Payable ( <i>itemize</i> )				\$ 19,804										
Capital One				403										
Home Depot Card				1,182										
Bank of America Card				18,219										
See Schedule														
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$										
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Name of Lender</th> <th style="text-align: left;">Purpose</th> <th style="text-align: left;">Amount</th> <th style="text-align: left;">Date Due</th> <th></th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td></td></tr> </tbody> </table>					Name of Lender	Purpose	Amount	Date Due						
Name of Lender	Purpose	Amount	Date Due											
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$ 66,130										
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$										
6. Accrued Payroll Taxes Payable				\$ 5,378										
7. Medicare Final Settlement Payable				\$ 1,036										
8. Medicare Current Financing Payable				\$										
9. Mortgage Payable ( <i>Current Portion</i> )				\$ 83,461										
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$										
11. Accrued Income Taxes*				\$										
12. Other Current Liabilities ( <i>itemize</i> )				\$ 605,920										
401K Accrual				2,892 Water and Sewer Accura 20,357										
State Loan Payable				49,122 PTO Accrual 245,303										
Unum Payable				1,273 Resident Account 33,024										
Resident Fund Accrual				(2,354) See Schedule 256,303										
<b>A-13. Total Current Liabilities</b> (Lines A1 thru 12)				<b>\$ 972,148</b>										

\* 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 Portland Care and Rehabilitation Centre, Inc	License No. 871-C	Report for Year Ended 9/30/2021	Page 34	of 37
Account				Amount
Total Brought Forward:				972,148
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$ 3,294,506
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> )				\$
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 3,294,506
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 4,266,654

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

Name of Facility Portland Care and Rehabilitation Centr	License No. 871-C	Report for Year Ended 9/30/2021	Page 35	of 37
Account			Amount	
<b>A. Reserves</b>				
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>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	39,000
3. Paid-in Surplus			\$	631,000
4. Treasury Stock			\$	(1,269,567)
5. Cumulated Earnings			\$	(1,087,301)
6. Gain or Loss for Period	10/1/2020	thru	9/30/2021	\$ 857,413
7. Total Net Worth			\$	(829,455)
<b>C. Total Reserves and Net Worth</b>			\$	(829,455)
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	3,437,199

## **H. Changes in Total Net Worth**

## I. Preparer's/Reviewer's Certification

Name of Facility Portland Care and Rehabilitation Centre,	License No. 871-C	Report for Year Ended 9/30/2021	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

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed
Printed Name of Preparer		
Ryan Turko		
Address		Phone Number
333 Main Street, Portland CT 06480		860-342-0370
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number
Ryan Turko		860-342-0370
Contact Email Address		
ryan87t@gmail.com		