State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2015

Name of Facility (as licensed) Milford Health Care Center, Inc.		
Address (No. & Street, City, State, Zip Code) 195 Platt Street, Milford,CT 06460		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	1056-C			75064

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID

For Department Use Only

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

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General Information

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Milford Health Care Center, Inc	1056-C	9/30/2015	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Bloomfield Health [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, 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.

Milford Health Care Ctr. Inc.

Signed (Administrator)		Date	Signed (Owner)	Date
Joanne Wallak		2/6/16		02/09/2016
Printed Name (Administrator) Joanne Wallak			Printed Name (Owner) Marvin Ostreicher	
Subscribed and Sworn to before me:	State of N.Y.	Date 2/8/16	Signed (Notary Public)	Comm. Expires 7/01/18
Address of Notary Public				

(Notary Seal)

GLORIA G. ALARIO
NOTARY PUBLIC STATE OF NEW YORK
NO. 01AL6077129 NASSAU COUNTY
TERM EXPIRES JULY 01, 2018

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Milford Health Care Center, Inc.	Period Covered:		From 10/1/2014	To 9/30/2015
Address of Facility 195 Platt Street, Milford,CT 06460				
Report Prepared By Blum Shapiro & Co.	Phone Number 860-561-4000		Date 2/8/2016	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$				
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$				
5. All other wages paid	$				
6. ***Total Wages Paid***	$				
7. Total salaries paid	$				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-878-5958	9/30/2015	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Milford Health Care Center, Inc.	195 Platt Street, Milford,CT 06460

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	1056-C			75064

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

○ Proprietorship ○ LLC ○ Partnership ⊙ Profit Corp. ○ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ⊙ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Joanne Wallak	001787

Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Milford Health Care Center, Inc.	195 Platt Street, Milford,CT 06460	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Agnes Zitter	9 Dogwood Lane, Lawrence, NY 11559	President	50
Marvin Ostreicher	184 Wildacre Ave, Lawrence, NY 11559	Secretary	50
Names of Stockholders Owning at Least 10% of Shares			
Agnes Zitter	9 Dogwood Lane, Lawrence, NY 11559	President	50
Marvin Ostreicher	184 Wildacre Ave, Lawrence, NY 11559	Secretary	50

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	4	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	%**				
See attachment		⊙	○					
		○	⊙					
		○	⊙					
		○	⊙					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	4	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	%**					
Preferred Therapy Solutions	850 Silas Deane Highway, Wethersfield, CT 06109	☑	☐	26%	PT,OT,ST Services/Consulting	13	5a,9a,10a,12	1,013,819	963,895
Milford Health Care Realty	46 Stauderman Ave, Lynbrook, NY 11563	☐	☑		Rental of Landing Building and Equipment	22	9	650,716	650,716
National Health Care Associates - Aetna	850 Silas Deane Highway, Wethersfield, CT 06109	☐	☑		Health Insurance Trust***	15	1a5	796,295	796,295
NOA Diagnostics	6851 Jericho Turnpike, Suite 150 Syosset, NY 11791	☑	☐	79%	Radiology	20	5f	22,446	20,615
Marlborough Health Care Center	85 Stage Harbor Road, Marlborough, CT 06447	☐	☑		Banking Transactions	16	13	3,426	3,426
National Health Care Associates	46 Stauderman Ave, Lynbrook, NY 11563	☐	☑		Banking Transactions	16	13	13,934	13,934
National Health Care Associates	46 Stauderman Ave, Lynbrook, NY 11563	☐	☑		Shared Expenses	16	12	422,503	422,503
Stauderman Realty	46 Stauderman Ave, Lynbrook, NY 11563	☐	☑		Shared Expenses	16	12	4,902	4,902
850 Silas Deane Realty	850 Silas Deane Highway, Wethersfield, CT 06109	☐	☑		Shared Expenses	16	12	1,577	1,577
Regency House Wallingford	181 East Main Street, Wallingford, CT 06492	☐	☑		Shared Employees-Admissions	16	13	2,075	2,075
Procare LTC Pharmacy of CT	1492 Highland Ave., Cheshire CT 06410	☑	☐	83%	Drugs/OTC's/Supplies/Consulting	20/13/16	5a2,b,c/B12	507,404	476,222

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

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General Information and Questionnaire
Basis for Allocation of Costs

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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (*See listing page 13*)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

The preparer of this report must answer the following questions applicable to the cost information provided.

1. In the preparation of this Report, were all costs allocated as required? ⊙ Yes ○ No If "No," explain fully why such allocation was not made.

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

Shared expenses, allocated by bed size. See page 17 attachment.

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

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

N/A

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Reliable Health Systems, Nostrand Ave, Brooklyn, NY 11230	○	⊙	Computer Equipment	10/01/08 / Ongoing	60 months	5,904	5,904
Leaf, P.O. Box 644006, Cincinnati, OH 45264	○	⊙	Copier	04/11/13	39 months	2,425	2,425
Toshiba #501862 P.O. Box 41602, Philadelphia, PA, 19101	○	⊙	Copiers	01/21/12	36 months	5,447	1,361
DE Lage Landen #501862 P.O. Box 41602, Philadelphia, PA, 19101	○	⊙	Copiers	01/21/15	36 months	4,550	3,457
Lexus Financial, P.O. Box 17187, Baltimore, MD,	○	⊙	Auto Lease	12/13/13	36 months	11,976	11,976
	○	⊙					
	○	○					
	○	○					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total ***** 25,123

* 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.

de lage landen

Lease Agreement

 # FTN31003T-001

LESSEE		
Full Legal Name MILFORD HEALTH CARE CENTER, INC.		Phone Number 2038785958
Billing Address 195 PLATT STREET, MILFORD, CT, 06460		Purchase Order Requisition Number
Equipment Location (if not same as above)		Send Invoice to Attention of

EQUIPMENT INFORMATION	Equipment Make	Model Number	Serial Number	Quantity	Description (Attach separate Schedule A if Necessary)
	Toshiba e-Studio457		Copier w/MR3028 RADF/MJ1107 Finisher/KD1026 LCF (1 ea)		
	Toshibae-Studio657		Copier w/MJ1027 Finisher (1 ea)		

PAYMENT INFORMATION	Number of Lease Payments	Lease Payment (PLUS)	Applicable Sales Tax (EQUALS)	Total Lease Payment	Term of Lease in Months	End of Lease Option	Payment Frequency
	39	356.55 +	22.64 =	379.19	39	Fair Market Value	Monthly
						End of Lease Purchase Option shall be FMV unless another option is indicated.	
		+	=		Security Deposit (PLUS)	First Period Payment (PLUS) Other	(EQUALS) Total Payment Enclosed
		+	=		+	+	=

TERMS AND CONDITIONS

1. Lease: You (the "Lessee") agree to lease from us (the "Lessor") the Equipment listed above and on any attached schedule (the "Lease"). You authorize us to adjust the Lease payments by up to 15% if the cost of the Equipment or taxes differs from the supplier's estimate. This lease is effective on the date that it is accepted and signed by us, and the term of this Lease begins on that date or any later date that we designate (the "Commencement Date") and continues thereafter for the number of months indicated above. Lease payments are due as invoiced by us. As you will have possession of the Equipment from the date of its delivery, if we accept and sign this Lease you will pay us interim rent for the period from the date the Equipment is delivered to you until the Commencement Date, as reasonably calculated by us based on the Lease payment, the number of days in that period, and a month of 30 days. Your Lease obligations are absolute, unconditional and are not subject to cancellation, reduction, setoff or counterclaim. You agree to pay us a fee of $75 to reimburse our expenses for preparing financing statements, other documentation costs and all ongoing administration costs during the term of this Lease. Security deposits are non-interest-bearing and may be applied to cure a Lease default. If you are not in default, we will return the deposit to you when the Lease is terminated. If a payment is not made when due, you will to pay us a late charge of 10% of the payment or $10, whichever is greater. We will charge you a fee of $25 for any check that is returned. ONLY WE ARE AUTHORIZED TO WAIVE OR CHANGE ANY TERM, PROVISION OR CONDITION OF THE LEASE.

2. Title: Unless you have a $1.00 purchase option, we will have title to the Equipment. If you have a $1.00 purchase option and/or the lease is deemed to be a security agreement, you grant us a security interest in the Equipment and all proceeds thereof. You authorize us to file Uniform Commercial Code ("UCC") financing statements on the equipment.

3. Equipment Use, Maintenance and Warranties: We are leasing the Equipment to you "AS-IS" AND MAKE NO WARRANTIES, EXPRESS OR IMPLIED, INCLUDING WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE. We transfer to you any manufacturer warranties. You are required at your cost to keep the Equipment in good working condition and to pay for all supplies and repairs. If the Lease Payment includes the cost of maintenance and/or service provided by a third party, you agree that we are not responsible to provide the maintenance or service and you will make all claims related to maintenance and service to the third party. You agree that any claims related to maintenance or service will not impact your obligation to pay all Lease Payments when due.

4. Assignment: You agree not to transfer, sell, sublease, assign, pledge or encumber either the Equipment or any rights under this Lease without our prior written consent. You agree that we may sell, assign, or transfer the Lease and the new owner will have the same rights and benefits we now have and will not have to perform any of our obligations and the rights of the new owner will not be subject to any claims, defenses, or setoffs that you may have against us or any supplier.

5. Risk of Loss and Insurance: You are responsible for all risks of loss or damage to the Equipment and if any loss occurs you are required to satisfy all of your Lease obligations. You will keep the Equipment insured against all risks of loss or damage for an amount equal to its replacement cost. You will list us as the sole loss payee for the insurance and give us written proof of the insurance. If you do not provide such insurance, you agree that we have the right, but not the obligation, to obtain such insurance, and add an insurance fee to the amount due from you, on which we may make a profit. We are not responsible for any losses or injuries caused by the Equipment and you will reimburse us and defend us against any such claims. This indemnity will continue after the termination of this Lease. You will obtain and maintain comprehensive public liability insurance naming us as an additional insured with coverages and amounts acceptable to us.

6. Taxes: You agree to pay when due, either directly or as reimbursement to us, all sales, use and personal property taxes and charges in connection with ownership and use of the Equipment. We may charge you a processing fee for administering property tax filings. You will indemnify us on an after-tax basis against the loss of any tax benefits anticipated at the Commencement Date arising out of your acts or omissions.

7. End of Lease: You will give us at least 60 days but not more than 120 days written notice (to our address below) before the expiration of the initial Lease term (or any renewal term) of your intention to purchase or return the Equipment. With proper notice you may: a) purchase all the Equipment as indicated above under "End of Lease Option"(fair market value purchase option amounts will be determined by us based on the Equipment's in place value); or b) return all the Equipment in good working condition at your cost in a timely manner, and to a location we designate. If you fail to notify us, or if you do not (i) purchase or (ii) return the Equipment as provided herein, this Lease will automatically renew at the same payment amount for consecutive 60-day periods.

8. Default and Remedies: You are in default on this Lease if: a) you fail to pay a Lease Payment or any other amount when due; or b) you breach any other obligation under the Lease or any other Lease with us. If you are in default on the Lease we may: (i) declare the entire balance of unpaid Lease Payments for the full Lease term immediately due and payable to us; (ii) sue you for and receive the total amount due on the Lease plus the Equipment's anticipated end of Lease fair market value or fixed price purchase option (the "Residual") with future Lease Payments and the Residual discounted to the date of default at the lesser of (A) a per annum interest rate equivalent to that of a U.S. Treasury constant maturity obligation (as reported by the U.S. Treasury Department) that would have a repayment term equal to the remaining Lease term, all as reasonably determined by us, or (B) 6% per annum, plus reasonable collection and legal costs; (iii) charge you interest on all monies due at the rate of 18% per year or the highest rate permitted by law from the date of default; and (iv) require that you immediately return the Equipment to us or we may peaceably repossess it. Any return or repossession will not be considered a termination or cancellation of the Lease. If the Equipment is returned or repossessed we will sell or re-rent the Equipment at terms we determine, at one or more public or private sales, with or without notice to you, and apply the net proceeds (after deducting any related expenses) to your obligations. You remain liable for any deficiency with any excess being retained by us.

9. Miscellaneous: You agree the Lease is a Finance Lease as defined in Article 2A of the "UCC". You acknowledge we have given you the name of the Equipment supplier and that you may have rights under the contract with the supplier and may contact the supplier for a description of these rights. If requested, you will sign a separate Equipment acceptance certificate. **This Lease was made in Pennsylvania ("PA"), is to be performed in PA and shall be governed and construed in accordance with the laws of PA. You consent to jurisdiction, personal or otherwise, in any state or federal court in PA and irrevocably waive a trial by jury.** You agree to waive any and all rights and remedies granted to you under Sections 2A-508 through 2A-522 of the UCC. You agree that the Equipment will only be used for business purposes and not for personal, family or household use and will not be moved from the above location without our consent. You agree that a facsimile copy of the Lease with facsimile signatures may be treated as an original and will be admissible as evidence of the Lease. We may inspect the Equipment during the Lease term.

LESSEE SIGNATURE

You agree that this is a non-cancelable lease. The Equipment is: ☐ NEW ☐ USED

Lessee (Full Legal Name)
MILFORD HEALTH CARE CENTER, INC.

Signature
X

Print Name
X MICHAEL BOKOW

Title
X MATERIALS MGR

Date
X 12/3/14

LESSOR

DE LAGE LANDEN FINANCIAL SERVICES, INC.
Lease Processing Center: 1111 Old Eagle School Road, Wayne, PA 19087-8608
PHONE: (800) 735-3273 • FAX: (800) 776-2329

Commencement Date

Lease Number

Accepted By

GUARANTY

I unconditionally guaranty prompt payment of all the Lessee's obligations. The Lessor is not required to proceed against the Lessee or the Equipment or enforce other remedies before proceeding against me. I waive notice of acceptance and all other notices or demands of any kind to which I may be entitled. I consent to any extensions or modification granted to the Lessee and the Lessee and the release and/or compromise of any obligations of the Lessee or any other guarantors without releasing me from my obligations. This is a continuing guaranty and will remain in effect in the event of my death and may be enforced by or for the benefit of any assignee or successor of the Lessor. **This guaranty is governed by and constituted in accordance with the Laws of the Commonwealth of Pennsylvania and I consent to non-exclusive jurisdiction in any state or federal court in Pennsylvania and waive trial by jury.**

Signature

Date

Print Name

ACCEPTANCE

The equipment has been received, put in use, is in good working order and is satisfactory and acceptable.

Signature
X

Date
X

Print Name
X

Title
X

Corporate Office
45 Corporate Avenue
Plainville, CT 06062
800-634-4810
P: 860-793-9994 F: 860-793-9954
www.theofficeworksinc.com

THE OFFICE WORKS

Branch Office
100 Mill Plain Road, 3rd Floor
Danbury, CT 06810
P: 203-942-2640

SALES ORDER

Date 11/11/2014 PO# _____ Terms _____

BILL TO Milford Health Care Center
Address 195 Platt Street
City Milford State CT 06460
Billing Contact _____
Billing Phone 203-878-5958

SHIP TO _____
Address _____
City _____ State ____ Zip _____
Ship to Phone _____
Ship to Fax _____

ITEM DESCRIPTION	SERIAL NUMBER	QTY	UNIT PRICE	EXTENDED PRICE
Toshiba e-Studio457 Digital Copier		1		39 Month Lease
MR3028 RADF		1		$356.55 per month
MJ1107 Finisher w/ Bridge Kit		1		Zero Down
KD1026 LCF		1		FMV Lease End Option
Power Filter 15 amp		1		
Toshiba e-Studio657 Digital Copier		1		
MJ1027 Finisher		1		
Power Filter 20 amp		1		

1) The Seller retains a security interest in all the equipment and supplies described in this Agreement until the purchase price is paid in full.
2) In the event Buyer makes default in payment the Buyer will be liable for the payment of any legal fees or costs incurred in sustaining or protecting the security interest or in enforcing the terms of the security agreement, and upon demand the Buyer agrees to make the equipment available to the Seller at a location to be determined by seller.
3) If there is a third party associated with this transaction, the lessee shall abide by the terms of the lease agreement. The Office Works, Inc. shall in no way be held responsible if the lessee fails to fulfill any terms set forth in the associated lease agreement.

	Make/Model	Equip. ID# & Serial Number	End Meter
Returned Equipment	Toshiba e-Studio455se & e-Studio655se	ID4897 SCQF142017/ID4894 SCCJ118137	

Hard-drive Options Upon Equipment Removal: Remove & Replace _____ Erase _____ Ignore _____

Notes / Provisions:

The Office Works Inc. will remove and return the Toshiba e-Studio455se & e-Studio655se to the leasing company at no charge.

Customer Authorization

Authorized Signature [signature]
Print Name /Title MICHAEL BOKOW MATERIALS MGMT
Date 12/3/14

The Office Works, Inc. Authorization

Accepted By _____
Print Name _____
Title _____

Revised 10/24/11

THE OFFICE WORKS

MASTER MAINTENANCE AGREEMENT

The Office Works, Inc.
Farmington Valley Corporate Park
45 Corporate Avenue
Plainville, CT 06062
800-634-4810
P: 860-793-9994 F: 860-793-9954
www.theofficeworksinc.com

BILLING INFORMATION

BILL TO Milford Health Care Center
Address 195 Platt Street
City Milford State CT Zip 06460
Billing Contact 860-621-2501
Lease Billed By De Lage Landen
PO # ☐
Machine ID # ☐
Serial # ☐
Make/Model Toshiba e-Studio457 & e-Studio657

EQUIPMENT LOCATION

SHIP TO _____
Address _____
City _____ State ___ Zip _____
Meter Contact _____
*Please Select Preferred Method of Contact Below
Meter Contact E-mail _____
Meter Contact Fax _____
Meter Contact Phone _____

ALL INCLUSIVE SERVICE MAINTENANCE AGREEMENT	X	Includes labor, travel, parts & supplies, excludes paper, staples and freight.
FULL SERVICE MAINTENANCE AGREEMENT		Includes labor, travel and parts, excludes supplies and freight.

Notes **State sales tax will be applied when applicable.**

Start Meter _____
Contract Effective Dates _____ to _____

Base Charge _____ M (A S Q M*)
Overage Billed _____ (A S Q M*) *A= annually, S= semi-annually, Q= quarterly, M= monthly

COPIES

Black Copy Allowance _____
Color Copy Allowance _____
Overage Rates 0.0065 (BLACK) _____ (COLOR)

PRINTS

Black Print Allowance _____
Color Print Allowance _____
Overage Rates _____ (BLACK) _____ (COLOR)

FOR THE FIXED CHARGES THAT ARE SUBJECT TO THE TERMS SET FORTH IN THIS AGREEMENT THE OFFICE WORKS, INC'S FIELD SERVICE DEPARTMENT WILL PROVIDE TECHNICAL REPAIR SERVICE IN ORDER TO MAINTAIN THE ABOVE "EQUIPMENT" IN PROPER OPERATING CONDITION. CUSTOMER ACKNOWLEDGES TO HAVE READ AND UNDERSTOOD THE TERMS AND CONDITIONS OF THIS AGREEMENT WHICH ARE CONTAINED ON BOTH SIDES OF THIS DOCUMENT AND WHICH CONSTITUTES THE ENTIRE AGREEMENT BETWEEN THE PARTIES. THERE ARE NO ORAL UNDERSTANDINGS, TERMS OR CONDITIONS; AND THE PARTIES MAY NOT RELY UPON ANY REPRESENTATIONS, EXPRESSED OR IMPLIED, NOT CONTAINED IN THIS AGREEMENT. THIS AGREEMENT IS NOT VALID UNTIL ACCEPTED BY THE OFFICE WORKS, INC.

CUSTOMER AUTHORIZATION

Authorized Signature X _____ Title _____
Print Name MICHAEL TOKOS Date _____
At this time I decline Maintenance Agreement Coverage _____ Intials

THE OFFICE WORKS, INC AUTHORIZATION

Authorized Signature _____ Title _____
Print Name _____ Date _____

Revised 10/6/11

TERMS AND CONDITIONS

EFFECTIVE DATE OF AGREEMENT: The undersigned hereby requests that the equipment listed on the reverse side hereof, be placed under maintenance agreement and billed according to the terms and conditions of this agreement. The term of this agreement shall commence upon the date indicated on the front of this agreement and The Office Works, Inc.'s acceptance of the contract. This agreement will automatically renew for successive (1) year terms and number of copy/prints allowance proportional and subject to the receipt by The Office Works, Inc. of the maintenance charge in effect at the renewal date, provided the customer is not then in default. This agreement will be coterminous with the equipment lease, if applicable.

GENERAL SCOPE OF COVERAGE: This agreement covers labor and all parts for adjustments and repairs as required by normal use of the equipment except as hereinafter provided. Damage to the equipment or its parts arising from misuse, abuse, negligence, or causes beyond The Office Works, Inc.'s control are not covered. The Office Works, Inc. may terminate this agreement in the event the equipment is modified, damaged, altered or serviced by personnel other than those employed by The Office Works, Inc., or if parts, accessories or components not authorized by The Office Works, Inc. are fitted to the equipment.

No change, alteration or amendment of the terms or conditions of this agreement are authorized or effective unless they have been agreed to in writing by an officer of the The Office Works, Inc. No course of dealing of any other customer shall constitute an amendment to the terms hereof or alter any of the terms of this agreement.

No terms or warranties are authorized unless they appear on the original of this agreement. The Office Works, Inc. disclaims all warranties, expressed or implied, including any implied warranties of merchantability, fitness for use, or fitness for particular purpose. The Office Works, Inc. shall not be responsible for direct, incidental or consequential damages, including but not limited to damages arising out of the use or performance of the equipment or the loss of use of the equipment.

Authorization to move equipment may be subject to the terms and conditions of lease contracts. Customer shall give The Office Works, Inc. thirty (30) days prior written notice if customer desires to move equipment covered under this agreement. The Office Works, Inc., at its option, may terminate service under this agreement in whole or in part in the event the equipment is moved without consent of The Office Works, Inc. The Office Works, Inc. reserves the right to increase the cost of this agreement for servicing equipment in a new location. A relocation, removal and/or reinstallation fee will be charged.

Reinstallation of drivers and/or installation of connected devices due to changes in network operating systems or malfunction of devices other than listed on this contract are not covered and will be billed by The Office Works, Inc. at the current published hourly rates.

EXTENT OF SERVICES: Labor performed during a service call includes lubrication and cleaning of the equipment, adjustments and repair or replacement of parts required by wear and tear resulting from normal use. Replaced parts become the property of The Office Works, Inc. Unlimited service calls, including travel time and mileage under this agreement will be made during normal business hours at the customer's installation address. The Office Works, Inc.'s normal business hours for service are from 8:00 a.m. to 4:30 p.m., Monday through Friday, excluding holidays. Customer understands that alterations, attachments, specification changes, parts or service necessitated by negligence, accident, use of unsuitable supplies or unauthorized interference with the equipment will be charged the rates in effect at the time of service.

REPAIR AND REPLACEMENT OF PARTS: All parts necessary to the operation of the equipment, with the exception of the exclusions listed below and subject to the general scope of coverage will be furnished free of charge during a service call included in the maintenance service provided by this agreement. When and in its sole discretion The Office Works, Inc. determines a shop reconditioning is necessary as a direct result of expected materials wear and age factors caused by normal office environment usage, to keep the equipment in working condition, The Office Works, Inc. will remove equipment from customer environment and return to our shop for repair. If the customer does not authorize such reconditioning, The Office Works, Inc. may discontinue service of the equipment under this agreement or may refuse to renew this agreement upon its expiration. Thereafter The Office Works, Inc. will be available on a "Per Call" basis at current published rates.

EXCLUSIONS: This agreement does not cover connected devices that allow the equipment to interface with networks and communications systems. The Office Works, Inc. will troubleshoot network related issues and perform maintenance on connected devices on a time and material billable basis.

External electrical, telephone or cabling are not covered under this agreement. Any charges by an outside source for improvements or repairs made to external electrical, telephone or cabling are solely the customer's responsibility. All equipment is required to have electrical connections through a power surge protector approved by The Office Works, Inc.

This agreement does not cover service necessitated as a result of malfunction of equipment when unauthorized parts, attachments or supplies that are not approved by The Office Works, Inc. are used with the equipment. This agreement does not cover service required as a result of alterations or malfunctioning computer or network hardware or network operating system, application, and/or network operating software. If it is determined that such changes, alterations or malfunctions make it impractical for The Office Works, Inc. to continue service, The Office Works, Inc. reserves the right to terminate this agreement.

This agreement does not cover the cost to overhaul, rebuild, remove, relocate or return equipment. This agreement does not apply to any loss or damage to equipment through accident, abuse, misuse, theft, neglect, acts of third parties, fire, water, casualty or any other natural force, whether direct, indirect consequential or inconsequential. The cost of repairing equipment caused by lighting strikes on electrical or phone lines are excluded. Losses and damages occurring from any of the foregoing are specifically excluded from this agreement.

This agreement excludes the following services where applicable: paper, transparencies, staples and freight.

BILLING: Base Charges will be billed approximately one (1) month in advance of the base billing cycle indicated on the front page of this agreement. Overages will be billed in arrears within ten (10) days following end date of overage billing cycle indicated on the front of this agreement. Meter readings will be collected via auto-email, auto-fax or by phone when customer has requested. Auto-meter requests require customer to have internet connectivity. Meter readings for agreements with semi-annual or annual billing cycles will be obtained periodically during the contract effective dates to ensure customer has not exceeded copy/print allowance(s). The Office Works, Inc. will estimate meters when they are not provided. Estimates will be based on available customer usage data.

INVOICING: All payment(s) should be remitted to the address indicated on the invoice(s). Payment terms are thirty (30) days from the invoice date. **Base charge invoices for new agreements are due upon receipt**, except where the agreement has been incorporated into the purchase of the equipment.

DEFAULT: Customer will be considered in "default" if scheduled payment(s) are not received within fifteen (15) days from due date. Customer agrees that should they have any past due balances with The Office Works, Inc. for any reason, at the sole discretion of The Office Works, Inc., support under this agreement shall be suspended until such past due balances shall and have been satisfied. The Office Works, Inc. reserves the right to terminate or delay service and/or supplies for any or all equipment associated with customer until customers account is paid current. Customer agrees to pay The Office Works, Inc costs and expenses of collection including the maximum attorney's fee permitted by law.

RENEWAL/CANCELLATION: This agreement shall automatically renew at the end of the current term for a successive one (1) year term, upon no less than thirty (30) days notification from the Office Works, Inc. The agreement invoice shall be deemed as written notification of its intention to renew. Upon The Office Works, Inc's re-assessment of the agreement, new agreement terms may be issued, and cost may be adjusted annually at the beginning of a new agreement term.

Customer must provide written notification thirty (30) days prior to desired termination effective date, of its intent to cancel this agreement. This contract may not be transferred if equipment is sold or title is transferred. This agreement is non-refundable.

TRAINING: The Office Works, Inc., at no additional charge, will train a reasonable number of key-operators designated by the customer, in operation of the equipment hardware. The Office Works, Inc. will train the customer for up to a total of two (2) hours on the installation and operation of software for up to two (2) workstations. Additional training and installation is available for an additional charge, at current published rates.

The customer will be responsible for daily care and cleaning of the top-glass, slit glass, dusting equipment, replenishing supplies and clearing jams. The customer shall adhere to manufacturer's specifications and/or operating manuals in operating equipment.

GOVERNING LAW: This agreement shall be governed by and construed according to the laws of the State of Connecticut, applicable to aggreement wholly negotiated, executed and performed in said state.

FORCE MAJEURE: The Office Works, Inc. shall not be liable for damages or delays in performance or failures to perform its obligations under this agreement caused by circumstances beyond its reasonable control including, but not limited to, delays or failure to perform caused by work stoppages, delays or losses in shipping, acts of governments, delay in manufacturing, including but not limited to bad weather, import and the governmental restrictions, accidents and delays or failure to perform by its suppliers.

INDEMNIFICATION: Not withstanding anything to the contrary herein, The Office Works, Inc. indemnity is limited to acts or omissions of gross negligence by The Office Works, Inc. and in no event shall The Office Works, Inc. be liable, in aggregate, for more the Fair Market Value of the Agreement ("Aggregate Indemnification Cap"). It is understood that the Aggregate Indemnification Cap is in fact an aggregate indemnification obligation, and not on a "per occurrence" basis indemnification obligation. It is further understood that any indemnification obligation by The Office Works, Inc. may have under this agreement shall be satisfied by recourse to insurance funds available under The Office Works, Inc. Comprehensive General Liability Insurance Policy.

NON-DISCRIMINATION: The Office Works, Inc. agrees and warrants that in the performance of this agreement, it will not discriminate or permit discrimination against any person or group or persons on the grounds of race, creed, color, age, religion or national origin in any manner prohibited by the laws of the United States or of the State of Connecticut, Massachusetts or New York.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	7	37

The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

Is the accounting basis for this period the same as for the previous period? ⊙ Yes ○ No — If "No," explain.

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Blum Shapiro	29 S. Main St., West Hartford, CT 06127
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Compilation, preparation of Medicare and Medicaid cost reports, HUD audit, and year end tax services	$ 29,750
2		$
3		$
4		$
		Charge for Services Provided $ 29,750

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

⊙ Yes ○ No pg 15 1 d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Altus Global Trade Solutions	(800) 509-6060
2 Goldman, Gruder & Wood, LLC	(203) 899-8900
3	
4	
5	

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

1 2400 Veterans Boulevard Suite 300 Kenner, LA 70062
2 200 Connecticut Avenue Norwalk, CT 06854
3
4
5

Services Provided by This Firm (*describe fully*)

1	Collections	$ 128
2	Collections	$ 725
3		$
4		$
5		$
		Charge for Services Provided $ 853

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

⊙ Yes ○ No pg 15 1 e

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	120	120			120	120			120	120		
B. On last day of THIS report period	120	120			120	120			120	120		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	114	114			114	114			118	118		
B. As of midnight of THIS report period	114	114			118	118			114	114		
3. Total Number of Days Care Provided During Period												
A. Medicare	10,402	10,402			7,611	7,611			2,791	2,791		
B. Medicaid (Conn.)	27,510	27,510			20,712	20,712			6,798	6,798		
C. Medicaid (other states)												
D. Private Pay	1,694	1,694			1,439	1,439			255	255		
E. State SSI for RCH												
F. Other (Specify)	1,608	1,608			1,194	1,194			414	414		
G. Total Care Days During Period (3A thru F)	41,214	41,214			30,956	30,956			10,258	10,258		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	73	73			53	53			20	20		
B. Other Bed Reserve Days	53	53			26	26			27	27		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	41,340	41,340			31,035	31,035			10,305	10,305		

2015 Cost Report - Page 8 attachment

Page 8, Line 3F: Total Number of Other Days Care Provided During the Period

Managed Care	771
Hospice	837
VA	-
	1,608

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	9	37

4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	15	72		27				
Per Diem Rate								
a. One bed rm.	PPS	240.76		505/655				
b. Two bed rms.	PPS	240.76		455/515				
c. Three or more bed rms.	PPS	240.76						

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	1,490	1,490		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	143	143		
C. Other	21,578	21,578		
D. ***Total Physical Therapy Treatments***	23,211	23,211		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	593	593		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	93	93		
C. Other	1,601	1,601		
D. ***Total Speech Therapy Treatments***	2,287	2,287		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,391	1,391		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	146	146		
C. Other	28,320	28,320		
D. ***Total Occupational Therapy Treatments***	29,857	29,857		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)	24,260	37				
2. Administrator(s) (Complete also Sec. III of Schedule A1)	159,473	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	223,488	11,387				
5. Dietary Service						
a. Head Dietitian	25,816	834				
b. Food Service Supervisor	72,152	2,080				
c. Dietary Workers	397,805	23,471				
6. Housekeeping Service						
a. Head Housekeeper	29,030	1,567				
b. Other Housekeeping Workers	386,080	23,596				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	54,634	1,845				
b. Other Maintenance Workers	97,992	3,846				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	128,831	7,434				
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	146,599	3,087				
b. RN						
1. Direct Care	694,432	17,321				
2. Administrative**	227,061	6,234				
c. LPN						
1. Direct Care	1,257,533	44,407				
2. Administrative**						
d. Aides and Attendants	1,921,198	120,491				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	109,988	2,080				
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	226,246	7,649				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	6,182,618	279,446				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Consulting Fees - Nursing	$ 9,383	Disallowed				
Consulting Fees - Rehab Therapy and Ancillary - PTS	$ 8,964	Disallowed				
Total	$ 18,347	-	$ -	-	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	11	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Marvin J. Ostreicher, 184 Wildacre Ave, Lawrence, NY 11559	24,260			Non-preferential	Supervises operations, deals with DNS & other patient care,	37	a1	See attached		
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

MARVIN J. OSTREICHER
TIME STUDY
Y/E SEPTEMBER 2015

	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	TOTAL
Augusta	3.00	8.50	7.00	4.00	7.50	7.50	1.50	4.50	7.50	5.50	4.50	6.50	**67.50**
Belair	5.00	5.50	7.00	3.00	5.50	4.50	2.50	2.00	3.00	5.00	6.50	5.00	**54.50**
Bloomfield	3.50	2.50	5.00	4.50	4.00	11.50	3.50	7.00	6.00	2.50	3.50	7.00	**60.50**
Brattleboro	5.50	4.00	3.00	4.00	4.50	4.50	1.00	3.50	8.00	3.00	4.50	7.00	**52.50**
Brentwood	2.50	9.50	2.50	7.00	3.00	7.00	7.50	3.50	3.00	4.00	2.50	4.00	**56.00**
Brewer	9.50	16.00	4.50	4.50	8.50	5.50	3.50	4.00	2.50	4.50	7.50	10.00	**80.50**
Bristol	3.50	2.00	4.50	12.50	6.50	3.00	3.50	6.50	8.50	4.00	1.00	4.50	**60.00**
Cambridge	5.50	4.00	5.00	16.00	5.00	6.00	1.50	7.00	4.50	3.00	3.50	8.50	**69.50**
Catskill	2.50	5.00	8.50	6.50	3.00	6.00	0.50	6.00	13.50	4.00	3.50	6.50	**65.50**
Cold Spring Hills	0.50	1.50	7.50	5.00	8.50	5.00	3.00	4.00	6.50	2.50	2.00	3.00	**49.00**
Colony	6.00	4.00	9.00	2.00	6.50	7.00	6.00	1.00	4.00	5.00	6.50	5.50	**62.50**
Country	7.00	8.50	3.00	7.00	3.50	6.00	4.00	6.50	9.00	5.00	5.50	10.50	**75.50**
Dover	2.00	0.50	9.50	5.00	2.50	4.00	2.00	1.00	4.50	6.00	1.50	3.50	**42.00**
Eastside	4.00	6.00	5.00	7.50	8.00	5.00	2.50	2.50	7.50	3.50	4.00	3.00	**58.50**
Eliot	0.50	5.00	9.00	4.50	2.00	2.00	2.50	2.50	6.50	1.50	4.50	2.50	**43.00**
Glen Falls	7.50	2.50	4.50	4.50	6.50	7.50	8.50	2.50	7.50	3.50	1.00	6.00	**62.00**
Hudson	1.00	7.00	12.50	2.50	6.00	1.50	4.00	0.50	12.00	4.50	2.50	5.50	**59.50**
Huntington	3.00	1.00	4.50	3.50	3.50	3.50	4.50	0.50	4.50	2.50	2.50	1.00	**34.50**
Kennebunk	1.00	6.50	6.50	2.00	2.00	7.50	3.00	0.50	5.50	2.50	12.00	0.00	**49.00**
Ludlowe	6.00	6.00	6.00	3.50	3.50	0.50	3.00	3.00	6.50	5.50	7.00	5.00	**55.50**
Maple View	4.50	5.50	9.50	3.00	6.00	7.50	6.50	5.50	2.00	9.00	3.50	5.00	**67.50**
Marlborough	0.50	1.00	3.00	5.50	2.00	2.50	3.50	0.50	3.00	4.00	1.00	2.00	**28.50**
Maywood	6.00	3.00	5.50	4.50	3.50	3.00	2.50	3.50	5.50	3.50	0.00	5.00	**45.50**
Milford	2.50	2.50	3.00	0.50	4.00	7.00	4.00	1.00	2.00	2.50	1.00	7.00	**37.00**
Newton Wellseley	4.50	4.50	3.00	4.00	3.00	7.50	2.50	0.00	2.00	3.00	0.00	1.50	**35.50**
Norway	5.50	2.00	2.50	2.00	3.50	5.50	5.00	3.50	1.50	5.00	5.50	4.50	**46.00**
Poughkeepsie	8.50	11.00	3.50	4.00	3.50	7.00	5.50	4.00	14.00	9.00	2.50	9.00	**81.50**
Regency	1.00	3.50	5.50	1.50	3.50	5.50	4.50	1.50	1.50	2.50	1.00	2.50	**34.00**
Reservoir	3.00	3.00	6.00	0.50	1.00	3.50	9.00	3.00	3.50	3.50	1.00	5.50	**42.50**
Riverside	3.00	6.50	4.50	1.50	5.50	2.00	5.50	4.00	4.00	4.50	7.00	2.00	**50.00**
Ross	7.00	5.50	3.50	5.50	6.00	5.00	6.50	6.50	4.00	2.50	4.50	2.00	**58.50**
Rutland	1.00	4.00	5.50	0.50	3.00	2.50	2.00	0.50	2.50	1.50	1.00	1.50	**25.50**
Sachem	4.50	2.50	5.00	4.00	2.50	7.00	2.50	2.50	2.00	3.00	5.50	2.50	**43.50**
Sands Point	0.50	3.00	4.00	0.50	6.50	7.00	6.50	0.50	2.50	2.50	2.50	2.50	**38.50**
Utica	2.00	4.50	3.50	4.50	4.50	6.00	3.00	0.50	6.00	6.50	2.50	4.00	**47.50**
Village Crest	0.50	3.00	4.50	3.50	4.50	7.00	9.50	3.00	2.50	5.00	4.00	0.50	**47.50**
Water's Edge	1.50	2.50	2.50	4.00	2.00	3.50	2.50	1.50	2.00	3.50	8.50	4.50	**38.50**
Westgate	1.00	2.00	3.50	7.50	4.50	3.00	3.50	0.00	1.00	0.00	2.00	4.50	**32.50**
Winship	5.50	4.50	9.50	4.00	4.00	3.00	4.00	1.00	3.50	4.00	1.50	11.00	**55.50**
Vacation	48.00	0.00	0.00	24.00	0.00	0.00	24.00	48.00	0.00	24.00	40.00	0.00	**208.00**
Sick	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
Personal	0.00	0.00	0.00	8.00	8.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**16.00**
Holiday	16.00	0.00	0.00	0.00	0.00	0.00	8.00	8.00	0.00	0.00	0.00	0.00	**32.00**
Total	**205.50**	**179.50**	**211.50**	**202.00**	**181.00**	**200.00**	**188.50**	**167.00**	**195.50**	**176.50**	**180.50**	**181.50**	**2269.00**

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Joanne Wallack (10/1/14-9/30/15) - on FMLA	125,204			Non-preferential	Management & supervision of healthcare facility	1,558	a2			
Eric D. Stein (3/6/15-6/5/15) - replacement while on FMLA	34,269			Non-preferential	Management & supervision of healthcare facility	522	a2			
Section IV - Assistant Administrators										

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

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

*** If more than one Administrator is reported, include dates of employment for each.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	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	193	6				
2. Dentist	3,349	Disallowed				
3. Pharmacist	17,507	36				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	406,996	9,084				
b. Other						
6. Social Worker	17,951	366				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	60,000	258				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	30,195	Disallowed				
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	82,191	1,566				
b. Other						
10. Occupational Therapist						
a. Resident Care	522,149	9,897				
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	18,347					
B-13 Total Fees Paid in Lieu of Salaries	1,158,878	21,213				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Melissa Alward, 56 Nashville Rd, Bethel CT 06801	Dietician	○	⊙	
United Dental Resources - 60 Waterbury Road, Prospect, CT 06712	Dental	○	⊙	
Procare LTC, 111 Executive Blvd Farmingdale NY 11735	Pharmacist , Consulting - Nursing	⊙	○	Common Ownership
Preferred Therapy Solutions, 809 Main Street, East Hartford, CT. 06108	PT, OT, ST, Consulting	⊙	○	Common Ownership
Regency House of Wallingford - 181 East Main St. Wallingford, CT 06492	Consultant, Social Worker	⊙	○	Common Ownership
Sheri Ganter, 125 Cinnamon Rd, Milford CT 06461-2795	Consultant, Social Worker	○	⊙	
Dr. Garumuni DeSilva, 15 Aldo Drive, Woodbridge, Ct., 16525	Medical Director	○	⊙	
Dr. Abisola Afolalu, 71 Harold St, West Haven, CT, 06516	Assistant Medical Director	○	⊙	
Amit Lahav, MD, 849 Boston Post Rd, Milford CT 06460	Physician Fees - Resident Care	○	⊙	
Chaatriwala Hatim, MD - 37 Wooster St. Naugatuck, CT 06770	Physician Fees - Resident Care	○	⊙	
Dr Lazaros Lazarides, 31 Heavenly Lane, Trumball, CT 06611	Physician Fees - Resident Care	○	⊙	
Health Drive Eye Care, 250 Pomeroy Ave, Meriden CT 06450	Physician Fees - Resident Care	○	⊙	
Orthopedic Specialty, 75 Kings Highway, Fairfield CT 06824	Physician Fees - Resident Care	○	⊙	
Swallowing Diagnostics - P.O. Box 484 Avon, CT 06001	Speech Evaluation	○	⊙	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	265,219	265,219		
2. Disability Insurance	$				
3. Unemployment Insurance	$	110,192	110,192		
4. Social Security (F.I.C.A.)	$	457,349	457,349		
5. Health Insurance	$	796,295	796,295		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	64,189	64,189		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	29,750	29,750		
e. Legal (*Services should be fully described on Page 7)*	$	853	853		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	20,841	20,841		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	25,626	25,626		
2. Cellular Phones	$	3,051	3,051		
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	$	650,317	650,317		
Subtotal	$	2,423,682	2,423,682		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,423,682	2,423,682		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	2,980	2,980		
3. Gifts to Staff and Residents	$	4,899	4,899		
4. Employee Travel	$	2,669	2,669		
5. Education Expenses Related to Seminars and Conventions	$	5,892	5,892		
6. Automobile Expense (*not purchase or depreciation*)	$	401	401		
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	1,076	1,076		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	26,133	26,133		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	6,448	6,448		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	8,374	8,374		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	269	269		
9. Subscriptions	$				
10. Contributions***	$	250	250		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$	428,982	428,982		
13. Other (*Specify*)	$	87,297	87,297		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,999,352	2,999,352		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Advertising Promotional - Marketing	$ 26,133		
Total Other Advertising	$ 26,133	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 8,264		
Costco	$ 110		
Total Dues	$ 8,374	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Political Contributions - Administration	$ 250		
Total Contributions	$ 250	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
IT Services - Administration	$ 3,921		
Consulting Fees - Fiscal Operations	$ 1,165		
Computer License Fee - Administration	$ 856		
Purch Services - Fiscal Operations	$ 38,103		
Licenses and Permits - Administration	$ 680		
Bank Charges - Administration	$ 28,976		
Background Check - Security	$ 32		
Background Check - Administration	$ 2,958		
Crime Insurance - Administration	$ 815		
Miscellaneous Expense - Administration	$ 9,771		
Penalties - Administration	$ 20		
Total Other Administrative and General	$ 87,297	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Milford Health Care Center, Inc.	1056-C	9/30/2015	17 | 37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
National Healthcare	428,982	See Attached	page 16, line M12

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

NHCA Manage

Report Date :10/1/2014 - 09/30/2015

		120 Bloomfield	132 Bristol	160 Cambridge	144 Ludlowe	120 Maple View Manor	120 Marlborough	120 Milford	95 New Milford	130 Regency	345 Riverside	150 Water's Edge
	Intercompany adjustments (Troy)	(2,575.61)	(2,832.59)	(3,433.76)	(3,090.74)	(2,575.61)	(2,575.61)	(2,575.61)	(2,039.27)	(2,790.15)	(7,405.04)	(3,219.22)
310000-0000-00-000-0	Prior Period-National Healthcare Management- - -	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
400000-0000-00-000-0	Salary-National Healthcare Management- - -	282,655.95	310,874.90	376,848.26	339,185.53	282,655.95	282,655.95	282,655.95	225,193.75	306,200.82	812,641.54	353,304.40
400010-0000-00-000-0	Vacation-NY-Nat. Mgmt.- - -	1,567.09	1,722.79	2,088.64	1,880.49	1,567.09	1,567.09	1,567.09	1,241.08	1,697.60	4,505.76	1,958.10
401000-0000-04-000-0	FICA-National Healthcare Management-Fiscal Ope- -	18,621.21	20,480.28	24,826.55	22,345.41	18,621.21	18,621.21	18,621.21	14,742.89	20,172.35	53,536.57	23,275.64
401100-0000-04-000-0	FUI-National Healthcare Management-Fiscal Oper- -	454.22	499.51	605.53	545.03	454.22	454.22	454.22	359.66	492.04	1,305.89	567.74
401101-0000-00-000-0	FUI - NY-National Healthcare Management- - -	(3.74)	(4.11)	(4.99)	(4.49)	(3.74)	(3.74)	(3.74)	(2.96)	(4.05)	(10.75)	(4.68)
401200-0000-04-000-0	SUI-National Healthcare Management-Fiscal Oper- -	1,653.60	1,818.56	2,204.44	1,984.27	1,653.60	1,653.60	1,653.60	1,309.24	1,791.30	4,754.08	2,066.78
401202-0000-00-000-0	SUI - CT-National Healthcare Management- - -	(102.62)	(112.86)	(136.81)	(123.15)	(102.62)	(102.62)	(102.62)	(81.25)	(111.17)	(295.05)	(128.27)
401250-0000-00-000-0	NY MTA Tax-Nat. Mgmt.- - -	518.54	570.35	691.33	622.33	518.54	518.54	518.54	410.56	561.75	1,490.90	648.13
401300-0000-04-000-0	Health Insurance-National Healthcare-Fiscal Op- -	22,866.50	25,147.97	30,485.17	27,439.83	22,866.50	22,866.50	22,866.50	18,104.85	24,771.16	65,742.55	28,580.53
401400-0000-04-000-0	Workers Compensation-National Health-Fiscal Op- -	20.84	22.93	27.79	25.01	20.84	20.84	20.84	16.50	22.59	59.94	26.05
401600-0000-04-000-0	Disability Expense-National Healthca-Fiscal Op- -	502.39	552.47	669.75	602.81	502.39	502.39	502.39	397.73	544.21	1,444.30	627.88
401700-0000-04-000-0	Pension-National Healthcare Manageme-Fiscal Op- -	4,667.41	5,133.07	6,222.49	5,600.86	4,667.41	4,667.41	4,667.41	3,695.46	5,056.17	13,419.02	5,833.72
401800-0000-04-000-0	Employee Benefits - Other-National H-Fiscal Op- -	682.30	750.45	909.66	818.76	682.30	682.30	682.30	540.18	739.16	1,961.70	852.91
402000-0000-04-000-0	Holiday Expense-National Healthcare -Fiscal Op- -	1,473.35	1,620.36	1,964.25	1,768.02	1,473.35	1,473.35	1,473.35	1,166.53	1,596.08	4,235.95	1,841.54
410000-0000-04-000-0	Supplies-National Healthcare Managem-Fiscal Op- -	3,105.44	3,415.57	4,140.54	3,726.84	3,105.44	3,105.44	3,105.44	2,459.03	3,364.44	8,929.00	3,881.87
410000-0000-08-000-0	Supplies-National Healthcare Managem-Maintenan- -	15.27	16.78	20.36	18.33	15.27	15.27	15.27	12.09	16.54	43.90	19.09
410000-0000-09-000-0	Supplies-National Healthcare Managem-Housekeep- -	33.37	36.69	44.48	40.04	33.37	33.37	33.37	26.44	36.15	95.94	41.70
410000-0000-12-000-0	Supplies-National Healthcare Manageme-Security- -	2.53	2.79	3.38	3.04	2.53	2.53	2.53	2.01	2.74	7.28	3.17
411000-0000-04-000-0	Food-National Healthcare Management-Fiscal Ope- -	19.64	21.61	26.19	23.57	19.64	19.64	19.64	15.55	21.28	56.46	24.55
431000-0000-03-000-0	Consulting Fees-National Healthcare -Administr- -	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
431000-0000-04-000-0	Consulting Fees-National Healthcare -Fiscal Op- -	7,030.70	7,732.13	9,373.07	8,436.78	7,030.70	7,030.70	7,030.70	5,566.63	7,616.30	20,213.47	8,787.48
432000-0000-03-000-0	Accounting Fees-National Healthcare -Administr- -	2,283.74	2,511.85	3,044.88	2,740.45	2,283.74	2,283.74	2,283.74	1,807.96	2,473.99	6,565.68	2,854.65
433000-0000-03-000-0	Legal Fees-National Healthcare Manag-Administr- -	1,771.23	1,947.98	2,361.37	2,125.50	1,771.23	1,771.23	1,771.23	1,402.38	1,918.79	5,092.41	2,213.88
433100-0000-03-000-0	Legal Fees - Labor-National Healthca-Administr- -	(611.80)	(672.84)	(815.64)	(734.16)	(611.80)	(611.80)	(611.80)	(484.40)	(662.76)	(1,758.96)	(764.68)
440000-0000-03-000-0	Purch Services-National Healthcare M-Administr- -	8,257.92	9,082.05	11,009.45	9,909.64	8,257.92	8,257.92	8,257.92	6,538.34	8,946.10	23,742.37	10,321.68
440000-0000-08-000-0	Purch Services-National Healthcare M-Maintenan- -	688.71	757.44	918.16	826.58	688.71	688.71	688.71	545.29	746.15	1,980.08	860.81
440000-0000-09-000-0	Purch Services-National Healthcare M-Housekeep- -	900.89	990.69	1,200.92	1,080.87	900.89	900.89	900.89	713.22	975.72	2,589.66	1,125.86
440000-0000-12-000-0	Purch Services-National Healthcare Ma-Security- -	53.36	58.71	71.17	64.05	53.36	53.36	53.36	42.29	57.83	153.47	66.73
440001-0000-08-000-0	Ground Services-Nat. Mgmt.-Maintenance- -	366.53	403.10	488.63	439.78	366.53	366.53	366.53	290.28	397.06	1,053.73	458.14
441000-0000-03-000-0	Computer Expense-National Healthcare-Administr- -	5,676.21	6,242.55	7,567.30	6,811.14	5,676.21	5,676.21	5,676.21	4,494.20	6,148.82	16,319.02	7,094.38
442000-0000-08-000-0	Pest Control-Nat. Mgmt.-Maintenance- -	20.00	21.95	26.65	23.98	20.00	20.00	20.00	15.81	21.62	57.43	24.95
452000-0000-25-000-0	Equipment Rental-National Healthcare-Fiscal Op- -	2,706.81	2,976.72	3,608.72	3,248.36	2,706.81	2,706.81	2,706.81	2,143.04	2,932.26	7,782.25	3,383.22
452100-0000-25-000-0	Equipment Rental - Interes-National -Fiscal Op- -	(1,194.52)	(1,313.70)	(1,592.51)	(1,433.42)	(1,194.52)	(1,194.52)	(1,194.52)	(945.77)	(1,294.02)	(3,434.31)	(1,493.01)
461000-0000-03-000-0	Telephone-National Healthcare Manage-Administr- -	2,712.85	2,983.31	3,616.64	3,255.35	2,712.85	2,712.85	2,712.85	2,147.76	2,938.63	7,799.37	3,390.65
461100-0000-03-000-0	Telephone - Cell-National Healthcare-Administr- -	2,006.26	2,206.37	2,674.65	2,407.48	2,006.26	2,006.26	2,006.26	1,588.40	2,173.30	5,767.96	2,507.54
462000-0000-25-000-0	Electric-National Healthcare Manageme-Property- -	1,529.87	1,682.44	2,039.55	1,835.81	1,529.87	1,529.87	1,529.87	1,211.25	1,657.25	4,398.44	1,912.13
463000-0000-25-000-0	Gas-National Healthcare Management-Property- -	443.34	487.58	591.08	532.03	443.34	443.34	443.34	351.02	480.27	1,274.68	554.15
466000-0000-25-000-0	Water-National Healthcare Management-Property- -	72.43	79.68	96.60	86.95	72.43	72.43	72.43	57.36	78.50	208.30	90.55
471000-0000-25-000-0	Rent-National Healthcare Management-Property- -	6,469.09	7,114.48	8,624.40	7,762.81	6,469.09	6,469.09	6,469.09	5,121.91	7,007.84	18,598.85	8,085.55
472000-0000-25-000-0	Personal Property Taxes-National Hea-Fiscal Op- -	516.53	567.96	688.58	619.75	516.53	516.53	516.53	408.91	559.46	1,484.89	645.51
473000-0000-04-000-0	Real Estate Taxes-National Healthcar-Fiscal Op- -	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
473000-0000-25-000-0	Real Estate Taxes-National Healthcar-Fiscal Op- -	3,426.41	3,768.25	4,568.02	4,111.67	3,426.41	3,426.41	3,426.41	2,712.89	3,711.81	9,851.10	4,282.62
484000-0000-04-000-0	Amort Exp - LHI-National Healthcare -Fiscal Op- -	1,327.68	1,460.13	1,770.03	1,593.23	1,327.68	1,327.68	1,327.68	1,051.22	1,438.25	3,817.12	1,659.43
484100-0000-04-000-0	Amortization Exp- LHI ALL-Nat. Mgmt.-Fiscal Op- -	13.35	14.69	17.82	16.04	13.35	13.35	13.35	10.59	14.51	38.39	16.71
486000-0000-04-000-0	Dep Exp - Moveable Equip-National He-Fiscal Op- -	7,709.31	8,478.48	10,277.90	9,251.17	7,709.31	7,709.31	7,709.31	6,103.96	8,351.46	22,164.73	9,635.76
491000-0000-03-000-0	Dues and Subscriptions-National Heal-Administr- -	257.10	282.74	342.75	308.54	257.10	257.10	257.10	203.56	278.48	739.13	321.30
500000-0000-03-000-0	Licenses and Permits-National Health-Administr- -	21.32	23.43	28.41	25.57	21.32	21.32	21.32	16.88	23.08	61.27	26.63
501000-0000-03-000-0	Advertising Employment-National Heal-Administr- -	8,395.23	9,232.87	11,192.42	10,074.37	8,395.23	8,395.23	8,395.23	6,647.11	9,094.54	24,136.88	10,493.18
501100-0000-03-000-0	Advertising Promotional-National Hea-Administr- -	7,253.58	7,977.65	9,670.79	8,704.30	7,253.58	7,253.58	7,253.58	5,742.94	7,857.89	20,854.26	9,066.65
503000-0000-03-000-0	Interest-National Healthcare Managem-Administr- -	403.92	470.31	570.07	513.28	403.92	403.92	403.92	338.59	463.27	1,229.67	534.49
503500-0000-03-000-0	Penalties-National Healthcare Manage-Administr- -	3.16	133.97	162.47	146.25	3.16	3.16	3.16	96.41	131.87	350.19	152.24
503600-0000-03-000-0	Bank Charges-Nat. Mgmt.-Administration- -	931.40	1,024.35	1,241.72	1,117.67	931.40	931.40	931.40	737.43	1,008.96	2,677.79	1,164.16
504000-0000-03-000-0	Postage-National Healthcare Manageme-Administr- -	984.22	1,082.49	1,312.19	1,181.11	984.22	984.22	984.22	779.28	1,066.23	2,829.69	1,230.12
509000-0000-03-000-0	Seminars-National Healthcare Managem-Administr- -	2,053.89	2,258.79	2,738.16	2,464.68	2,053.89	2,053.89	2,053.89	1,626.20	2,224.99	5,905.05	2,567.16
510000-0000-03-000-0	Liability Insurance-National Healthc-Administr- -	2,748.78	3,022.96	3,664.56	3,298.53	2,748.78	2,748.78	2,748.78	2,176.33	2,977.70	7,902.80	3,435.67
511000-0000-03-000-0	Auto Insurance-National Healthcare M-Administr- -	963.25	1,059.28	1,284.11	1,155.92	963.25	963.25	963.25	762.68	1,043.51	2,769.34	1,203.91
512000-0000-03-000-0	Umbrella Insurance-National Healthca-Administr- -	790.75	869.69	1,054.24	948.94	790.75	790.75	790.75	626.14	856.65	2,273.52	988.38
513000-0000-03-000-0	Crime Insurance-National Healthcare -Administr- -	23.14	25.48	30.93	27.80	23.14	23.14	23.14	18.37	25.12	66.63	28.94
517000-0000-03-000-0	Wor`kmans Comp Insurance-National	391.28	430.37	521.69	469.60	391.28	391.28	391.28	309.82	423.89	1,125.10	489.10
520000-0000-03-000-0	Auto Expense-National Healthcare Man-Administr- -	38.53	42.39	51.40	46.24	38.53	38.53	38.53	30.50	41.81	110.77	48.10
520100-0000-03-000-0	Auto Lease Expense-National Healthca-Administr- -	2,696.65	2,965.51	3,595.01	3,235.78	2,696.65	2,696.65	2,696.65	2,134.84	2,921.04	7,752.31	3,369.97
521000-0000-03-000-0	Travel Expense-National Healthcare M-Administr- -	4,708.93	5,179.26	6,278.29	5,650.74	4,708.93	4,708.93	4,708.93	3,728.03	5,101.27	13,538.39	5,885.96
522000-0000-03-000-0	Hotel Expense-National Healthcare Ma-Administr- -	4,686.54	5,154.73	6,248.54	5,623.81	4,686.54	4,686.54	4,686.54	3,710.28	5,076.90	13,473.77	5,858.17
540000-0000-31-000-0	Donations-National Healthcare Manage-Misc. Exp- -	54.63	60.08	72.83	65.55	54.63	54.63	54.63	43.25	59.18	157.05	68.28
541000-0000-03-000-0	Misc. Expense-Nat. Mgmt.-Administration- -	136.48	150.07	181.96	163.77	136.48	136.48	136.48	108.05	147.83	392.41	170.59
541000-0000-31-000-0	Misc. Expense-National Healthcare Ma-Misc. Exp- -	594.10	653.34	792.13	712.97	594.10	594.10	594.10	470.42	643.67	1,708.20	742.55
541001-0000-03-000-0	Political Contributions-Nat. Mgmt.-Administrat- -	5.46	6.01	7.28	6.56	5.46	5.46	5.46	4.33	5.92	15.71	6.83
542000-0000-31-000-0	Corporate Tax - State-National Healt-Misc. Exp- -	199.40	219.30	265.85	239.31	199.40	199.40	199.40	157.90	216.00	573.31	249.23
543000-0000-31-000-0	Corporate Tax - Federal-National Hea-Misc. Exp- -	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
544000-0000-25-000-0	Sales Tax - Conn.-National Healthcar-Fiscal Op- -	285.82	6,189.53	7,502.39	6,752.24	285.82	285.82	285.82	4,454.53	6,095.81	16,176.78	7,033.01
	Sum	428,982.14	477,834.12	579,240.88	521,357.16	428,982.14	428,982.14	428,982.14	345,388.48	470,655.76	1,249,100.09	543,050.94
	Page 16 line m12 on Cost Report	428,982.00	477,834.00	579,241.00	521,357.00	428,982.00	428,982.00	428,982.00	345,388.00	470,656.00	1,249,100.00	543,051.00
	Variances	0.14	0.12	(0.12)	0.16	0.14	0.14	0.14	0.48	(0.24)	0.09	(0.06)

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

Name of Facility	License No.	Report for Year Ended	Page of
Milford Health Care Center, Inc.	1056-C	9/30/2015	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	305,792	305,792		
2. Non-Food Supplies	$	33,920	33,920		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	15,288	15,288		
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	355,000	355,000		

2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals:	Total no. of meals served per day:*				

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Milford Health Care Center, Inc.	1056-C	9/30/2015	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. $	984	984		
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)*	$	5,422	5,422		
c. Management Services**	$				
d. Other (*Specify*) Supplies $8,971 & Diapers $56,999	$	65,970	65,970		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	72,376	72,376		

3F.	Laundry Questionnaire			
G.	Is cost of employee laundry included in 3E?	○ Yes	⊙ No	If yes, specify cost.
H.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report?			(Page/Line Item)
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	○ Yes	⊙ No	If yes, specify cost.
K.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
L.	Where is the revenue received reported in the Cost Report?			(Page/Line Item)

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3E.

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

*** Pounds of Laundry only required for multi-level facilities.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	47,239	47,239		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	47,239	47,239		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from PCA		$	435,797	435,797		
b. Medicine Cabinet Drugs		$	27,972	27,972		
c. Medical and Therapeutic Supplies		$	164,383	164,383		
d. Ambulance/Limousine***		$	2,186	2,186		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	26,287	26,287		
f. X-rays and Related Radiological Procedures***		$	34,283	34,283		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	48,955	48,955		
i. Recreation		$	31,980	31,980		
j. Other (Specify)**** See Attached Schedule		$	64,590	64,590		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	836,433	836,433		

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

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
IV Therapy Supplies - Rehabilitation Therapy and Ancillary	$ 8,947		
Purchased services - Nursing	$ 1,985		
Equipment Rental - Nursing	$ 15,679		
Equipment Rental - Rehabilitation Therapy and Ancillary	$ 15,326		
Medical Services - Flu Vaccine	$ 22,653		
Total Other Resident Care	$ 64,590	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
ADM Environmental Group	1370 Coney Island Ave. Brooklyn, NY 11230	○	⊙		Waste Services/Monthly Recycling Services	24,488			22	6F
Milford Quality Landscaping	P.o. Box 329 Milford, CT 06460	○	⊙		Landscaping	18,711			22	6F
ADP	P.O. Box 842875 Boston, MA 02284	○	⊙		Payroll Service	14,227			16	M13
Becroft Landscape SVC	583 Anderson Ave. Milford, CT 06460	○	⊙		Landscaping/Snow Removal	12,155			22	6F
Simplex Grinnel	Dept CH 10320 Palentine, IL, 60055	○	⊙		Alarm Maintenance	13,682			22	6A
MJ Daly	110 Mattatuck HTS, Waterbury CT 06705	○	⊙		HVAC	23,139			22	6a
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Milford Health Care Center, Inc.	1056-C	9/30/2015	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	56,982	56,982		
b. Heat	$	68,440	68,440		
c. Light & Power	$	130,190	130,190		
d. Water	$	20,327	20,327		
e. Equipment Lease (*Provide detail on page 6*)	$	25,123	25,123		
f. Other (*itemize*)	$	125,076	125,076		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	426,138	426,138		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$				
d. Movable Equipment	$	38,711	38,711		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	38,711	38,711		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	79,910	79,910		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	79,910	79,910		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	650,716	650,716		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	155,230	155,230		
c. Personal property taxes	$	8,732	8,732		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	933,299	933,299		

* Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 24.

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Supplies - Maintenance	$ 34,976		
Purchased Services - Maintenance	$ 86,225		
Purchased Services - Security	$ 1,557		
Pest Control - Maintenance	$ 1,750		
Short Term Lease - Postage Machine	$ 568		
Total Other Repairs and Maintenance	$ 125,076	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					761,503		761,503	577,596	SL		34,113	
b. Disposals (attach schedule)					(155,591)			(155,590)	SL			
c. Acquired during this report period (attach schedule)					44,659		44,659		SL		4,598	
D-3. Subtotal												38,711
E. ***Total Depreciation***												38,711

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Schedule of Land Improvements Acquired during this report period

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

***Ties to Page 23, Line A3**
****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

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

***Ties to Page 23, Line B3**
****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Non-Movable Equipment		$ -		$ -	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

***Ties to Page 23, Line C3**
****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
11/20/2014	Hysteam Gas Streamer	$ 13,240	5	$ 2,428	
11/18/2014	Electric Bed	$ 1,840	12	$ 141	
11/30/2014	Circulator Pumps	$ 924	10	$ 85	
1/31/2015	LD TV's	$ 1,985	5	$ 298	
2/28/2015	Dual Bedside Phone Station	$ 2,675	5	$ 357	
2/28/2015	PC's	$ 931	5	$ 124	
2/28/2015	Monitors	$ 212	5	$ 28	
3/31/2015	PC's	$ 950	5	$ 111	
3/31/2015	Monitors	$ 216	5	$ 25	
4/7/2015	Electric Bed	$ 938	12	$ 39	
4/30/2015	Support Mattress	$ 472	5	$ 47	
4/30/2015	Support Mattress	$ 829	5	$ 83	
4/30/2015	Low Coolant Block Heater	$ 1,079	10	$ 54	
4/30/2015	Circulator Pumps	$ 611	10	$ 31	
4/30/2015	Circulator Pumps	$ 809	10	$ 40	
4/30/2015	Kit BP	$ 2,046	10	$ 85	
4/30/2015	Clocks	$ 2,536	5	$ 254	
5/31/2015	Kit BP	$ 2,046	10	$ 85	
5/31/2015	Reliant Lift Charger	$ 722	10	$ 24	
6/30/2015	Monitors	$ 262	5	$ 17	
6/30/2015	PC's	$ 809	5	$ 54	
6/30/2015	Support Mattress	$ 829	5	$ 55	
7/31/2015	Support Mattress	$ 632	5	$ 32	
8/31/2015	Headboard/Footboard	$ 478	5	$ 16	
9/30/2015	Electric Bed	$ 1,746	12	$ 12	
9/30/2015	PC's	$ 810	5	$ 14	
9/30/2015	Clocks	$ 1,925	5	$ 32	
9/30/2015	Vacuum	$ 1,193	8	$ 12	
9/30/2015	Scanner	$ 914	5	$ 15	
Total additions for Movable Equipment		$ 44,659		$ 4,598	*
Deletions:					
9/30/2015	Shelving	$ 1,376	5	$ -	
9/30/2015	Reclining Wheelchair	$ 610	5	$ -	
9/30/2015	Chair Alarms	$ 761	5	$ -	
9/30/2015	Recliners	$ 967	5	$ -	
9/30/2015	Refrigerator	$ 472	5	$ -	
9/30/2015	Install Ran System	$ 1,344	5	$ -	
9/30/2015	Informers	$ 1,043	5	$ -	
9/30/2015	Informers	$ 1,388	5	$ -	
9/30/2015	Refrigerator	$ 954	5	$ -	
9/30/2015	Sentra Wheelchairs	$ 709	5	$ -	
9/30/2015	Informers	$ 1,827	5	$ -	
9/30/2015	Informers	$ 690	5	$ -	
9/30/2015	Informers	$ 926	5	$ -	
9/30/2015	Informers	$ 2,081	5	$ -	
9/30/2015	Informers	$ 685	5	$ -	
9/30/2015	Informers	$ 630	5	$ -	
9/30/2015	Informers & Bed Alarms	$ 1,869	5	$ -	
9/30/2015	Informers	$ 684	5	$ -	
9/30/2015	Informers	$ 1,044	5	$ -	
9/30/2015	Marisa Complete W/J/B	$ 3,353	5	$ -	
9/30/2015	Informers Bed Sensors	$ 647	5	$ -	
9/30/2015	Chair Alarm With Sensors	$ 1,170	5	$ -	
9/30/2015	Chair Alarm Pads	$ 553	5	$ -	
9/30/2015	Chair Alarm With Sensors	$ 2,356	5	$ -	
9/30/2015	Microzone II Controller	$ 923	5	$ -	
9/30/2015	Bed Alarms	$ 750	5	$ -	
9/30/2015	Informers	$ 1,482	5	$ -	
9/30/2015	Bed Alarms	$ 793	5	$ -	
9/30/2015	Informers	$ 1,515	5	$ -	
9/30/2015	Informers	$ 1,973	5	$ -	
9/30/2015	Timeclock	$ 1,855	5	$ -	

9/30/2015	Informers	$	1,636	5	$ -
9/30/2015	Informers, Bed Sensors, Alarms	$	569	5	$ -
9/30/2015	Informers, Bed Sensors, Alarms	$	3,145	5	$ -
9/30/2015	Informers, Bed Sensors, Alarms	$	1,934	5	$ -
9/30/2015	MME 1996 5 Year Life	$	1,454	5	$ -
9/30/2015	MME 1996 10 Year Life	$	20,676	10	$ -
9/30/2015	MME 1997 5 Year Life	$	646	5	$ -
9/30/2015	MME 1997 10 Year Life	$	5,495	10	$ -
9/30/2015	MME 1998 10 Year Life	$	33,135	10	$ -
9/30/2015	MME 1999 10 Year Life	$	43,205	10	$ -
9/30/2015	License Fee	$	2,994	10	$ -
9/30/2015	Micro Tech Informer	$	1,466	5	$ -
9/30/2015	12 CAT Plenum Data Drops	$	1,749	5	$ -
9/30/2015	Tax on #310	$	57	5	$ -
Total deletions for Movable Equipment		$	155,591		$ - **

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

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/31/2014	Wall Coverings	$ 940	5	$ 444
10/31/2014	Wall Coverings	$ 2,217	5	$ 188
11/30/2014	Valance Rods	$ 149	10	$ 14
11/30/2014	Valance Rods	$ 123	10	$ 11
12/31/2014	Steel Doors	$ 1,667	20	$ 70
12/31/2014	Slop Sink Closet	$ 832	20	$ 35
2/28/2015	Hot Water Pipe	$ 2,210	10	$ 147
2/28/2015	Ceiling Tiles	$ 585	10	$ 39
2/28/2015	Hot Water Pipe	$ 2,299	10	$ 153
3/28/2015	Fire Exit Device	$ 2,349	10	$ 137
4/30/2015	Hot Water Valve	$ 606	10	$ 30
4/30/2015	Tiles	$ 5,637	10	$ 282
5/28/2015	Wall Paper	$ 2,331	5	$ 194
5/28/2015	Wall Paper	$ 2,247	5	$ 187
5/28/2015	Wall Paper	$ 2,534	5	$ 211
5/28/2015	Expansion Tanks	$ 3,599	10	$ 150
6/12/2015	Wooden Doors	$ 2,090	15	$ 46
6/30/2015	Outlet and Cable TV Jacks	$ 1,457	10	$ 49
6/30/2015	Tiles	$ 527	10	$ 18
6/30/2015	Smoke Detectors	$ 1,139	10	$ 38
6/30/2015	Trane Compressor	$ 4,244	10	$ 141
6/30/2015	Push Button Lock	$ 599	10	$ 20
7/31/2015	Heat Pump	$ 5,208	10	$ 130
8/6/2015	Fire Door	$ 773	15	$ 9
8/6/2015	Smoke Fire Doors	$ 869	10	$ 14
8/30/2015	Wall Guard	$ 1,381	5	$ 46
8/31/2015	Control Board	$ 1,341	10	$ 34
8/31/2015	Control Board	$ 1,099	10	$ 27
9/30/2015	Ceiling Lights	$ 984	10	$ 8
9/30/2015	Mixing Valve	$ 983	25	$ 3
9/30/2015	Sprinkler	$ 1,956	25	$ 7
9/30/2015	Control Board	$ 1,099	10	$ 9
9/30/2015	HVAC Motor & Blade	$ 2,021	10	$ 17
9/30/2015	2 Ton Split Unit	$ 5,213	5	$ 87
9/30/2015	2 Ton Split Unit	$ 5,213	5	$ 87
9/30/2015	Fan Motor	$ 616	15	$ 3
9/30/2015	2 Ton Split Unit	$ 2,558	5	$ 43
9/30/2015	Valve	$ 823	10	$ 7
Total additions for Leasehold Improvement		$ 72,518		$ 3,135 *
Deletions:				

Total deletions for Leasehold Improvement		$ -		$ -	**

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

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period				1,020,754	530,320	SL		76,775	
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)				72,518		SL		3,135	
C-4. Subtotal									79,910
D. ***Total Amortization***									79,910

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Milford Health Care Center, Inc.	1056-C	9/30/2015	25 | 37

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	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	120
6. Square Footage	59,396
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	07/29/04			
c. Interest Rate for the Cost Year	6.39%			
d. Term of Mortgage (number of years)	40			
e. Amount of Principal Borrowed	9,387,600			
f. Principal balance outstanding as of 9/30/15	8,788,075			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Milford Health Care Center, Inc.	1056-C	9/30/2015	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*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Milford Health Care Center, Inc.	1056-C	9/30/2015	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*) $	340	340		
Property - $99, Admin - $241				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	340	340		
14. Insurance				
a. Insurance on Property (buildings only) $	14,348	14,348		
b. Insurance on Automobiles $	3,593	3,593		
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	7,999	7,999		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $	75,367	75,367		
Liability $31,122, Mortgage $44,245				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	101,307	101,307		
15. ***Total All Expenditures (A-13 thru C-14)*** $	13,112,980	13,112,980		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Milford Health Care Center, Inc.	1056-C	9/30/2015	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.	10	12M	Salaries not related to Resident Care $	14,992	14,992		
3.			Occupational Therapy $				
4.			Other - See attached Schedule $	14,000	14,000		
Page 13 - Professional Fees							
5.	13	8c	Resident Care Physicians ** $	30,195	30,195		
6.	13	10a	Occupational Therapy $	522,149	522,149		
7.			Other - See attached Schedule $	40,700	40,700		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $				
10.	15	1e	Accounting & Legal $	6,053	6,053		
11.			Telephone $				
12.	15	1h2	Cellular Telephone $	1,611	1,611		
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.	16	m3	Unallowable Advertising * $	26,133	26,133		
19.			Income Tax / Corporate Business Tax $				
20.	16	m10	Fund Raising / Contributions $	250	250		
21.	15	1d r	Unallowable Management Fees $	148,724	148,724		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	48,966	48,966		
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) $	853,773	853,773		

* 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	a12m	Unallowable expense - Social Service	$ 14,000		
Total Other Salaries Adjustment			$ 14,000	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B2	Dentist	$ 3,349		
13	B12	Consulting Fees - Nursing	$ 9,383		
13	B12	Consulting Fees - Rehab Therapy and Ancillary - PTS	$ 8,964		
13	B8a	Medical Director (over the limit)	$ 19,004		
Total Other Fees Adjustments			$ 40,700	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	L3	Gifts to residents & staff	$ 4,899		
16	M13	Miscellaneous expenses	$ 9,771		
16	M13	Bank charges	$ 28,976		
16	M13	Penalties	$ 20		
16	M13	Crime Insurance	$ 815		
16	M8	Dues - COSTCO	$ 110		
16	M9	Dues - Chamber of Commerce	$ 269		
16	1a	Benefits on salaries not related to resident care	$ 4,106		
Total Other A&G Adjustments			$ 48,966	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Milford Health Care Center, Inc.	1056-C	9/30/2015	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	853,773	853,773		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $	435,797	435,797		
28.	20	5d	Ambulance/Limousine $	2,186	2,186		
29.	20	5f	X-rays, etc $	34,283	34,283		
30.	20	5h	Laboratory $	48,955	48,955		
31.	20	5c	Medical Supplies $	10,180	10,180		
32.	20	5e2	Oxygen (non emergency) $	26,287	26,287		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	72,718	72,718		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.			Depreciation on Unallowable Motor Vehicles $				
37.	22	10c	Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $	20,073	20,073		
Page 27 - Insurance							
40.	27	14c3	Mortgage Insurance $	44,245	44,245		
41.			Property Insurance $				
Other - Miscellaneous							
42.			Research or Experimental Activities $				
43.			Radio and Television Revenue $				
44.			Vending Machine Revenue $				
45.			Purchase Discounts and Allowances $				
46.			Duplications of functions or services $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest $				
48.			Interest Income on Accounts Rec $				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $	5,635	5,635		
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.			***Total Amount of Decrease (Items 1 - 50)*** $	1,554,132	1,554,132		

*** Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Attachment Page 29

Milford Health Care Center, Inc.
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Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Flu Vaccine	$ 22,653		
20	5j	IV Therapy Supplies	$ 8,947		
20	5j	Purchased Services-Nursing	$ 1,025		
20	5j	Equipment Rental-Nursing	$ 15,679		
20	5j	Equipment Rental Rehab Therapy & Ancillary	$ 15,326		
20	Misc	Procare disallowed price markup	$ 1,882		
20	5i	Cable TV Expense - Resident Rooms	$ 7,206		
Total Other Ancillary Costs			$ 72,718	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	6e	Auto Leases	$ 11,976		
27	14b	Auto Insurance	$ 3,593		
22	7d	Depreciation on Mattresses	$ 2,456		
22	7d	Depreciation on TV's	$ 2,048		
Total Other Property Adjustments			$ 20,073	$ -	$ -

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30	IV8	Misc Income - Rebates	$ 3,354		
30	IV8	Misc Income - Medical Records	$ 1,015		
30	IV8	Misc Income - Other	$ 266		
27	12D	Other interest expense	$ 241		
30	IV5	Interest Income	$ 759		
Total Other Adjustments			$ 5,635	$ -	$ -

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Milford Health Care Center, Inc.	1056-C	9/30/2015	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	12,710,186	12,710,186		
b. Medicaid Room and Board Contractual Allowance **	$	(6,003,326)	(6,003,326)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	5,412,876	5,412,876		
b. Medicare Room and Board Contractual Allowance **	$	(57,665)	(57,665)		
4. a. Private-Pay Residents and Other	$	1,755,636	1,755,636		
b. Private-Pay Room and Board Contractual Allowance **	$	(525,576)	(525,576)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	218,430	218,430		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(218,430)	(218,430)		
c. Prescription Drugs - Non-Medicare	$	168,410	168,410		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(168,410)	(168,410)		
2. a. Medical Supplies - Medicare	$	12,789	12,789		
b. Medical Supplies - Medicare Contractual Allowance **	$	(12,789)	(12,789)		
c. Medical Supplies - Non-Medicare	$	299	299		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	474,935	474,935		
b. Physical Therapy - Medicare Contractual Allowance **	$	(437,028)	(437,028)		
c. Physical Therapy - Non-Medicare	$	351,287	351,287		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(351,287)	(351,287)		
4. a. Speech Therapy - Medicare	$	105,175	105,175		
b. Speech Therapy - Medicare Contractual Allowance **	$	(67,383)	(67,383)		
c. Speech Therapy - Non-Medicare	$	60,666	60,666		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(60,666)	(60,666)		
5. a. Occupational Therapy - Medicare	$	643,790	643,790		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(605,743)	(605,743)		
c. Occupational Therapy - Non-Medicare	$	469,390	469,390		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(469,390)	(469,390)		
6. a. Other *(Specify)* - Medicare	$	1,717	1,717		
b. Other *(Specify)* - Non-Medicare	$	(299)	(299)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	13,407,594	13,407,594		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	759	759		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	(15,821)	(15,821)		
V. Total Other Revenue (1 thru 8)	$	(15,062)	(15,062)		
VI. Total All Revenue (III +V)	$	13,392,532	13,392,532		

* *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)
Pg 30 line II6a	Medicare Part A Contra Other	$ (47,833)		
Pg 30 line II6a	Medicare Part A Lab	$ 27,352		
Pg 30 line II6a	Medicare Part A X-Ray	$ 19,899		
Pg 30 line II6a	Medicare Pt B Prior Period	$ (1,537)		
Pg 30 line II6a	Medicare Pt B Flu/Pneumonia	$ 3,254		
Pg 30 line II6a	Medicare Pt A Ambulance	$ 582		
Total Other Resident Revenue - Medicare		$ 1,717	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
Pg 30 line II6b	Comm Ins Contra Other	$ (33,446)		
Pg 30 line II6b	Comm Ins Lab	$ 20,225		
Pg 30 line II6b	Comm Ins X-Ray	$ 12,922		
Pg 30 line II6b	Medicaid Contra Other	$ (25)		
Pg 30 line II6b	Medicaid Lab	$ 25		
Total Other Resident Revenue		$ (299)	$ -	$ -

Interest Income

Page Ref	Description	CCNH	RHNS	(Specify)
Pg 30 line IV5	Interest income	$ 759		
Total Interest Income		$ 759	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
Pg 30 line IV8	Miscellaneous Other Income - ($1,015 Medical Records; $3,354 Rebates $266 other)	$ 4,635		
Pg 30 line IV8	Prior Period Other	$ (20,230)		
Pg 30 line IV8	Sales Tax- Property	$ (226)		
Total Other Revenue		$ (15,821)	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 761,822
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 2,208,786
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 39,422
5. Prepaid Expenses				$ 224,419
a. Taxes (personal property, real estate, corp)		135,502		
b. Management fees		48,267		
c. Insurance		17,615		
d. Prepaid Expenses Other		23,035		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 1,365,427
Patient Funds		37,566		
Escrow deposits		161,448		
Due from Related Party		1,166,413		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 4,599,876
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	1,093,272		$ 483,042
	Accum. Depreciation	610,230	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	650,571		$ 189,854
	Accum. Depreciation	460,717	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 672,896

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	32	37

Account				Amount
			Total Brought Forward:	$ 5,272,772
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 166,376
Security Deposits		11,500		
Reserve for Replacement		154,876		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 166,376
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 5,439,148

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 1,885,976
	2. Notes Payable (*itemize*)				$
	3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
	Name of Lender	Purpose	Amount	Date Due	
	4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 471,713
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$
	7. Medicare Final Settlement Payable				$
	8. Medicare Current Financing Payable				$
	9. Mortgage Payable (*Current Portion*)				$
	10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
	11. Accrued Income Taxes*				$
	12. Other Current Liabilities (*itemize*)				$ 1,100,714
	Accrued expenses	73,349	CT User Fee	157,944	
	Patient funds	37,566	Accounting Fee	32,100	
	Due to Third Party	15,033	Due to Related Party	750,297	
	Due to Realty	34,425			
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 3,458,403

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	34	37

Account	Amount
Total Brought Forward:	3,458,403
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 3,458,403

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

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	35	37

Account	Amount
A. **Reserves**	
1. Reserve for value of leased land	$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
3. Reserve for depreciation value of leased personal property (*Equity)*	$
4. Reserve for leasehold real properties on which fair rental value is based	$
5. Reserve for funds set aside as donor restricted	$
6. Total Reserves	$
B. **Net Worth**	
1. Owner's Capital	$
2. Capital Stock	$ 1,000
3. Paid-in Surplus	$
4. Treasury Stock	$
5. Cumulated Earnings	$ 1,700,193
6. Gain or Loss for Period 10/1/2014 thru 9/30/2015	$ 279,552
7. Total Net Worth	$ 1,980,745
C. ***Total Reserves and Net Worth***	$ 1,980,745
D. ***Total Liabilities, Reserves, and Net Worth***	$ 5,439,148

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2014			$ 2,442,159
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 13,392,532
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 13,112,980
D.	Net Income or Deficit			$ 279,552
E.	Balance			$ 2,721,711
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	State Tax Refund	4,034		
	2. Other (*itemize*)			
F-3.	Total Additions			$ 4,034
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$ 680,000
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	Marvin Ostreicher, 184 Wildacre Ave, Lawrence, NY 11559	President	340,000	
	Agnes Zitter, 9 Dogwood Lane, Lawrence, NY 11559	Secretary	340,000	
	2. Other Withdrawings *(Specify)*			$ 66,000
	Purpose		Amount	
	State Taxes		66,000	
	3. Total Deductions			$ 746,000
H.	***Balance at End of Period*** 09/30/15			$ 1,979,745

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Milford Health Care Center, Inc.	1056-C	9/30/2015	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
Blum, Shapiro & Company, P.C.		2/5/16

Printed Name of Preparer
Blum Shapiro & Co

Address: Address	Phone Number
29 South Main Street, West Hartford, CT 06127	860-561-4000