State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2020

Name of Facility (as licensed) Orange Health Care Center		
Address (No. & Street, City, State, Zip Code) 225 Boston Post Road, Orange, CT 06477		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020	

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	4978		

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2020	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Orange Health Care Center [facility name], for the cost report period beginning October 1, 2019 and ending September 30, 2020, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

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

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Orange Health Care Center	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 225 Boston Post Road, Orange, CT 06477				
Report Prepared By Orange Health Care Center	Phone Number 203-795-0835		Date 2/1/2021	

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
203-795-0835	9/30/2020	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Orange Health Care Center	225 Boston Post Road, Orange, CT 06477

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2361			070-5434

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (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.:
Andree Acampora	001280

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

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

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2020	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
Dawn-Ra Corporation	225 Boston Post Road Orange, CT 06477	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Linda Silberstein	225 Boston Post Road Orange, CT 06477	President	1
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⊙ No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

If "Yes," provide the following information:

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

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
CIT Bank	○	⊙	Xerox copier	10/16/18	63 months	5,588	6,589
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙				**Total** ***	6,589

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
** Attach copies of newly acquired leases.
*** Amount should agree to Page 22, Line 6e.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Simione Macca and Larrow	4130 Whitney Ave, Hamden, CT 06518
2 Craig Lubitski Consulting	225 Pitkin St. East Hartford, CT 06108
3	
4	

Services Provided by This Firm (*describe fully*)

1	Tax returns	$ 3,000
2	Medicare cost reporting	$ 2,300
3		$
4		$
		Charge for Services Provided $ 5,300

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

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 American Arbitration Association	
2 Jackson Lewis	914-872-8060
3 Jacobi, Case & Sperazini	203-874-7110
4	
5	

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

1
2 44 South Broadway, White Plains, NY 10601
3 57 Plains Rd. Milford, CT 06461
4
5

Services Provided by This Firm (*describe fully*)

1	Union grievance arbitrator	$ 325
2	Union contract negotions representation/workers comp lawsuit	$ 26,316
3	Collections case	$ 2,341
4		$
5		$
		Charge for Services Provided $ 28,982

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

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	60	60			60	60						
B. On last day of THIS report period	60	60							60	60		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	54	54			54	54						
B. As of midnight of THIS report period												
3. Total Number of Days Care Provided During Period												
A. Medicare	3,407	3,407			2,759	2,759			648	648		
B. Medicaid (Conn.)	13,033	13,033			9,712	9,712			3,321	3,321		
C. Medicaid (other states)												
D. Private Pay	1,812	1,812			1,350	1,350			462	462		
E. State SSI for RCH												
F. Other (Specify) Managed Care	32	32			27	27			5	5		
G. Total Care Days During Period (3A thru F)	18,284	18,284			13,848	13,848			4,436	4,436		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	18,284	18,284			13,848	13,848			4,436	4,436		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(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	9	34		7				
Per Diem Rate								
a. One bed rm.	Various	232.00		416.00				
b. Two bed rms.	Various	232.00		395.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	2,195	2,195		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	48	48		
C. Other	5,180	5,180		
D. ***Total Physical Therapy Treatments***	7,423	7,423		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	273	273		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	626	626		
D. ***Total Speech Therapy Treatments***	899	899		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	3,393	3,393		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	39	39		
C. Other	5,157	5,157		
D. ***Total Occupational Therapy Treatments***	8,589	8,589		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	103,851	2,056				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	92,943	3,478				
5. Dietary Service						
a. Head Dietitian	9,743	336				
b. Food Service Supervisor	47,463	2,040				
c. Dietary Workers	246,677	10,540				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	194,140	8,438				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	66,312	1,903				
b. Other Maintenance Workers						
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	53,012	2,308				
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	217,106	4,160				
b. RN						
1. Direct Care	382,714	10,756				
2. Administrative**	69,055	1,719				
c. LPN						
1. Direct Care	384,552	11,362				
2. Administrative**	69,070	1,696				
d. Aides and Attendants	1,092,924	50,205				
e. Physical Therapists	177,094	3,196				
f. Speech Therapists	38,153	693				
g. Occupational Therapists	231,302	4,993				
h. Recreation Workers	53,244	2,040				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
Companion	5,879	422				
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	57,878	1,632				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	3,687	99				
A-13. Total Salary Expenditures	3,596,799	124,072				

* 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**
Inhalation therapist	$ 3,687	99				
Total	$ 3,687	99	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Andree Acampora	103,851	Health insurance. Payroll	Day to day operations of the			2,056	A3			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	6,270	96				
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	352	7				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	17,883	161				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	278	6				
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	34,911	405				
2. Administrative***	2,400	24				
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides	15,319	279				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	77,413	978				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Qaiyum Mujtaba M.D., 750 Savin Avenue, West Haven, CT	Medical Director	○	⊙	
Health Drive Dental One Prestige Dr, Meriden, CT	Dental	○	⊙	
Dr. Hafsa Nawaz, 17 Carriage Hill Rd, Woodbridge, CT 06525	Medical Director	○	⊙	
The Nurse Network, PO Box 982, Southington, CT 06489	Nursing pool	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
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		○	⊙	
		○	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2020	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	155,879	155,879		
2. Disability Insurance	$				
3. Unemployment Insurance	$	39,348	39,348		
4. Social Security (F.I.C.A.)	$	244,496	244,496		
5. Health Insurance	$	518,667	518,667		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	35,543	35,543		
7. Pensions (Non-Discriminatory)	$	159,775	159,775		
(not-owners and not-operators)					
8. Uniform Allowance	$	3,003	3,003		
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	36,534	36,534		
d. Accounting and Auditing	$	5,300	5,300		
e. Legal (*Services should be fully described on Page 7)*	$	28,982	28,982		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	8,574	8,574		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	17,109	17,109		
2. Cellular Phones	$				
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$	14,520	14,520		
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	314,332	314,332		
Subtotal	$	1,582,062	1,582,062		

* 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
Orange Health Care Center	2361	9/30/2020	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,582,062	1,582,062		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	1,168	1,168		
3. Gifts to Staff and Residents	$				
4. Employee Travel	$				
5. Education Expenses Related to Seminars and Conventions	$	19,549	19,549		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	6	6		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$				
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$				
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	4,839	4,839		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	116,749	116,749		
12. Administrative Management Services**	$				
13. Other (*Specify*) See Attached Schedule	$	3,841	3,841		
C-14 Total Administrative & General Expenditures	$	1,728,214	1,728,214		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

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

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Ct Association of Health Care Facilities	$ 4,444		
Town of Orange - Food service license	$ 295		
Town of Orange Fire Marshall	$ 100		
Total Dues	$ 4,839	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
BANK CHARGES	$ 3,416		
EMPLOYEE PHYSICALS	$ 425		
Total Other Administrative and General	$ 3,841	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Orange Health Care Center	2361	9/30/2020	17 | 37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Orange Health Care Center	2361	9/30/2020	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	127,489	127,489		
2. Non-Food Supplies	$	31,189	31,189		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	158,678	158,678		

2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F. Resident Meals:	Total no. of meals served per day:*	156	156		

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

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

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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 Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2020		Page 19 | of 37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry a. In-House Processing* — Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.*** — Amt. $	5,529	5,529		
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.*** — Lbs.				
Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.*** — Lbs.				
Amt. $				
4. Repair and/or purchase of linens.*** — Lbs.				
Amt. $				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)* — $				
c. Other (*Specify*) — $				
3D. ***Total Laundry Expenditures*** (3a + b + c) — $	5,529	5,529		

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2020	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.	$	18,289	18,289		
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	18,289	18,289		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Partners/Pharmerica		$	115,258	115,258		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	154,494	154,494		
d. Ambulance/Limousine***		$	746	746		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	19,363	19,363		
f. X-rays and Related Radiological Procedures***		$	9,853	9,853		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	19,308	19,308		
i. Recreation		$	13,648	13,648		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$				
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	332,670	332,670		

* 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)
Total Other Resident Care	$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Paycom	Oklahoma City, OK 73142	○	⊙		Payroll processing				16	m11
Paul Knutsen	33 Chesterfield Dr, Amston, CT	○	⊙		Administrative consulting				16	m11
Point Click Care	Suite 4, Mississauga, ON, L5N 8E9	○	⊙		Computer services				16	m11
John's Refuse	PO Box 387, Guilford, CT 06437	○	⊙		Rubish Removal				22	6a
Data Titans	PO Box 127, Colchester, CT 06415	○	⊙		Computer IT Services				16	m11
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

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

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

Name of Facility	License No.	Report for Year Ended			Page of
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Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	54,446	54,446		
b. Heat	$	12,662	12,662		
c. Light & Power	$	39,215	39,215		
d. Water	$	25,173	25,173		
e. Equipment Lease (*Provide detail on page 6*)	$	7,021	7,021		
f. Other (*itemize*)	$				
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	138,517	138,517		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	21,250	21,250		
b. Building & Building Improvements	$	48,259	48,259		
c. Non-Movable Equipment	$	11,507	11,507		
d. Movable Equipment	$	29,277	29,277		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	110,293	110,293		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	5,282	5,282		
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	5,282	5,282		
9. Rental payments on leased real property less real estate taxes included in item 10b	$				
10. Property Taxes					
a. Real estate taxes paid by owner	$	34,992	34,992		
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	5,492	5,492		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	156,059	156,059		

* 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)
Total Other Repairs and Maintenance	$ -	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
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Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	223,597		214,352	87,085	S/L	Various	21,250	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								21,250
B. **Building and Building Improvements**								
1. Acquired prior to this report period	1,596,078		1,596,078	1,058,560	S/L	Various	48,259	
2. Disposals (attach schedule)	(31,244)			(31,244)				
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								48,259
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	140,842		140,842	52,482			11,507	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								11,507

	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					282,136		282,136	204,375	S/L	Various	29,277	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)												
D-3. Subtotal												29,277
E. ***Total Depreciation***												110,293

Schedule of Land Improvements Acquired during this report period

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

***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 Improvement		$ -		$ -	*
Deletions:					
9/30/2020	Building painting	$ (31,244)			
Total deletions for Building Improvement		$ (31,244)		$ -	**

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

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

Schedule of Non-Movable Equipment Acquired during this report peri

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

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

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

Schedule of Movable Equipment Acquired during this report peri

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

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

Schedule of Leasehold Improvements Acquired during this report peri

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

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
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Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1. Loan cost	7	14	30 years	45,625	20,553			5,282	
2.									
3.									
B-4. Subtotal									5,282
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									5,282

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
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11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ○ Yes ⊙ No

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

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

Description	Total
1. Date Land Purchased	09/30/75
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	04/25/61
4. Date of Initial Licensure	1948
5. Total Licensed Bed Capacity	60
6. Square Footage	16,500
7. Acquisition Cost	
a. Land	25,000
b. Building	36,400

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
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Item	Total	CCNH	RHNS	(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
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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*) $	192,166	192,166		
Purchase note / vendors				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	192,166	192,166		
14. Insurance				
a. Insurance on Property (buildings only) $	58,895	58,895		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $				
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	58,895	58,895		
15. ***Total All Expenditures (A-13 thru C-14)*** $	6,463,229	6,463,229		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
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Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.	10	A12g	Occupational Therapy $	231,302	231,302		
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians ** $	278	278		
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	36,534	36,534		
10.	15	1d	Accounting $	625	625		
10a.			Legal $	28,982	28,982		
11.			Telephone $				
12.			Cellular Telephone $				
13.	15	1a6	Life insurance premiums on the life of Owners, Partners, Operators $	2,923	2,923		
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.			Unallowable Advertising * $				
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $				
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $				
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	300,644	300,644		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

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

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

Name of Facility	License No.	Report for Year Ended	Page of
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Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	300,644	300,644		
Page 20 - Resident Care Supplies***								
27.	20	5a	Prescription Drugs	$	115,258	115,258		
28.	20	5d	Ambulance/Limousine	$	746	746		
29.	20	5f	X-rays, etc	$	9,853	9,853		
30.	20	5h	Laboratory	$	19,308	19,308		
31.	20	5c	Medical Supplies	$	23,174	23,174		
32.	20	5e2	Oxygen (non emergency)	$	19,363	19,363		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$				
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$				
36.			Depreciation on Unallowable Motor Vehicles	$				
37.			Unallowable Property and Real Estate Taxes	$				
38.			Rental of Building Space or Rooms	$				
39.			Other - See Attached Schedule	$	2,252	2,252		
Page 27 - Insurance								
40.			Mortgage Insurance	$				
41.			Property Insurance	$				
Other - Miscellaneous								
42.			Other - Indirect	$				
43.			Interest Income on Account Rec.	$				
44.			Other - Miscellaneous Administrative	$				
45.			Management Fees Direct	$				
46.			Management Fees Indirect	$				
47.			Other - Direct	$				
Not For Profit Providers Only								
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	$				
49.	***Total Amount of Decrease (Items 1 - 48)***			$	490,598	490,598		

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

Attachment Page 29

Schedule of Other Ancillary Costs

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

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	6a	Repairs and maintenance (offsets with rental income in misc income line)	$ 510		
22	6c	Electric (offsets with rental income in misc income line)	$ 582		
22	6b	Heating (offsets with rental income in misc income line)	$ 761		
22	6d	Water (offsets with rental income in misc income line)	$ 399		
Total Other Property Adjustments			$ 2,252	$ -	$ -

Schedule of Other - Indirect Adjustments

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

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
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Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	5,304,248	5,304,248		
b. Medicaid Room and Board Contractual Allowance **	$	(2,107,856)	(2,107,856)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	2,820,358	2,820,358		
b. Medicare Room and Board Contractual Allowance **	$	(903,656)	(903,656)		
4. a. Private-Pay Residents and Other	$	854,278	854,278		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$				
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$				
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	424,869	424,869		
b. Physical Therapy - Medicare Contractual Allowance **	$	(359,845)	(359,845)		
c. Physical Therapy - Non-Medicare	$	57,572	57,572		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(57,572)	(57,572)		
4. a. Speech Therapy - Medicare	$	129,477	129,477		
b. Speech Therapy - Medicare Contractual Allowance **	$	(104,762)	(104,762)		
c. Speech Therapy - Non-Medicare	$	14,545	14,545		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(14,545)	(14,545)		
5. a. Occupational Therapy - Medicare	$	517,697	517,697		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(412,911)	(412,911)		
c. Occupational Therapy - Non-Medicare	$	62,190	62,190		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(62,190)	(62,190)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	6,161,897	6,161,897		
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)*	$	150	150		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	179,927	179,927		
V. Total Other Revenue (1 thru 8)	$	180,077	180,077		
VI. Total All Revenue (III +V)	$	6,341,974	6,341,974		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30	Interest income		$ 150		
Total Interest Income			$ 150	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV8	Rental income	$ 40,633		
30 IV8	Miscellaneous	$ 2,922		
30 IV8	SBA Covid Grant - Payment of mortgage	$ 136,372		
Total Other Revenue		$ 179,927	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2020	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 1,327,974
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 773,690
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 33,948
a. Insurance		3,591		
b. Deposits - taxes		15,541		
c. Other		14,816		
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 79,429
Other deposits		3,252		
Due from 233 Boston Post Realty		76,177		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,215,041
B. Fixed Assets				
1. Land				$ 40,600
2. Land Improvements	*Historical Cost	214,352		$ 106,017
	Accum. Depreciation	108,335	Net	
3. Buildings	*Historical Cost	1,564,834		$ 489,259
	Accum. Depreciation	1,075,575	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	140,842		$ 76,853
	Accum. Depreciation	63,989	Net	
6. Movable Equipment	*Historical Cost	282,136		$ 48,484
	Accum. Depreciation	233,652	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 761,213

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			$ -

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

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

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

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

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

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2020	32	37

Account				Amount
			Total Brought Forward:	$ 2,976,254
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$ 20,317
2. Land Improvements	*Historical Cost	9,245		
	Accum. Depreciation		Net	$ 9,245
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$ 29,562
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 139,249
Deferred financing fees		139,249		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 139,249
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 3,145,065

* 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
Orange Health Care Center	2361	9/30/2020	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 363,678
2. Notes Payable (*itemize*)				$ 710,500
SBA PPP Loan	710,500			
See Schedule				
3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 220,643
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 7,931
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*)				$ 1,658,642
Accrued expenses	33,748			
Provider fee payable	77,606			
Due to owners	1,124,217			
Deferred revenue	423,071	See Schedule		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 2,961,394

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2020	34	37

Account	Amount
Total Brought Forward:	2,961,394
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ 2,733,841
Celtic Bank	2,733,841	
See Schedule		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 2,733,841
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 5,695,235

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

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2020	35	37

Account		Amount
A.	**Reserves**	
1.	Reserve for value of leased land	$
2.	Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
3.	Reserve for depreciation value of leased personal property (*Equity)*	$ 29,562
4.	Reserve for leasehold real properties on which fair rental value is based	$
5.	Reserve for funds set aside as donor restricted	$
6.	Total Reserves	$ 29,562
B.	**Net Worth**	
1.	Owner's Capital	$
2.	Capital Stock	$ 45,410
3.	Paid-in Surplus	$ 167,431
4.	Treasury Stock	$
5.	Cumulated Earnings	$ (2,671,318)
6.	Gain or Loss for Period 10/1/2019 thru 9/30/2020	$ (121,255)
7.	Total Net Worth	$ (2,579,732)
C.	***Total Reserves and Net Worth***	$ (2,550,170)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 3,145,065

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2020	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2019			$ (2,656,813)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 6,341,974
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 6,463,229
D.	Net Income or Deficit			$ (121,255)
E.	Balance			$ (2,778,068)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
	2019 Taxes			(14,505)
F-3.	Total Additions			$ (14,505)
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period***	09/30/20		$ (2,792,573)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2020	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. have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Orange Health Care Center

Addres Address	Phone Number
225 Boston Post Road	203-795-0835

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Jason Moore	203-795-0835

Contact Email Address
jmoore@orange-healthcare.com