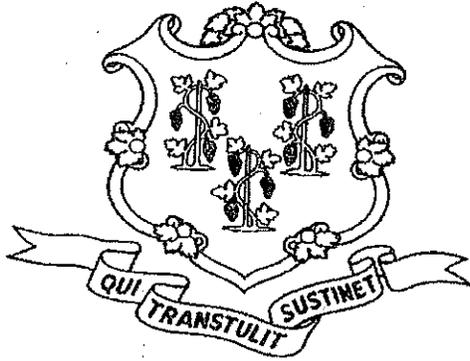


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2015

Name of Facility (as licensed) Orange Health Care Center	
Address (No. & Street, City, State, Zip Code) 225 Boston Post Road, Orange, CT 06477	
Type of Facility Chronic and Convalescent Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input checked="" type="checkbox"/> Supervision only <input type="checkbox"/> (Specify) (CCNH) (RHNS)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH 2361	RHNS 176-RH	(Specify)	Medicare Provider 070-5434
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Medicaid Provider Numbers:	CCNH 4978	RHNS 91769	ICF-IID
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For Department Use Only

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

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General Information

Name of Facility (as licensed) Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2015	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Orange Health Care Center [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.

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

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Orange Health Care Center	Period Covered:	From 10/1/2014	To 9/30/2015	
Address of Facility 225 Boston Post Road, Orange, CT 06477				
Report Prepared By Orange Health Care Center	Phone Number 203-795-0835	Date		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-795-0835		Report for Year Ended 9/30/2015		Page 2	of 37
Name of Facility (as shown on license) Orange Health Care Center			Address (No. & Street, City, State, Zip) 225 Boston Post Road, Orange, CT 06477		
License Numbers:	CCNH 2361	RHNS 176-RH	(Specify)	Medicare Provider No. 070-5434	
Type of Facility (Check appropriate box(es))					
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input type="checkbox"/> (Specify)	
Type of Ownership (Check appropriate box)					
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust					
If this facility opened or closed during report year provide:			Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.					
Administrator					
Name of Administrator			Nursing Home Administrator's License No.:		
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name Paul Knutsen			License No.:		1500

General Information and Questionnaire Related Parties*

Name of Facility Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2015	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No 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				
Integrity Health Care Management	33 Chesterfield Rd, Amston, CT 06231	<input type="radio"/>	<input checked="" type="radio"/>	Management Fee	P 16 L M12		
Andree Acampora	225 Boston Post Rd, Orange CT 06477	<input type="radio"/>	<input checked="" type="radio"/>	Note payable - Related Party	P 33 L A2		
Paul Knutsen	33 Chesterfield Rd, Amston, CT 06231	<input type="radio"/>	<input checked="" type="radio"/>	Note payable - Related Party	P 33 L A2		
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				

* Use additional sheets if necessary.

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

**General Information and Questionnaire
Basis for Allocation of Costs**

Name of Facility Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2015	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

All cost, unless they could be identified to a specific cost center, were allocated based accumulated statistics. See attached for allotation methods.

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

All related company expenses are allocated based on the same allocation explanation as stated directly above

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

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

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility		License No.	Report for Year Ended	Page	of	
Orange Health Care Center		2361	9/30/2015	6	37	
Name and Address of Lessor	Related * to Owners, Operators, Officers		Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No				
Leaf, P.O. Box 644006, Cincinnati, OH 45264-4006	<input type="radio"/>	<input checked="" type="radio"/>	08/25/11	36 months	2,688	1,724
US Bank Equipment Finance 1310 Madrid St.	<input type="radio"/>	<input checked="" type="radio"/>	01/06/15	36 months	2,760	1,323
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
	<input type="radio"/>	<input type="radio"/>				
Is a Mileage Log Book Maintained for All Leased Vehicles ?			<input type="radio"/> Yes	<input type="radio"/> No	Total ***	
					3,047	

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

General Information and Questionnaire
Accounting Basis

Name of Facility Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2015	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

- Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Medillo & Cziedzic, P.C.	1 Evergreen Ave., Hamden, CT 06518
2 Craig J Lubitski Consulting	225 Pitkin St. East Hartford, CT 06108
3	
4	

Services Provided by This Firm (*describe fully*)

1 Federal and state tax returns, various other tax forms.	\$ 1,600
2 Medicare cost reporting	\$ 2,850
3	\$
4	\$
	Charge for Services Provided
	\$ 4,450

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

- Yes No Page 15 Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Murtha Cullina LLP	860-240-6000
2	
3	
4	
5	

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

1 185 Asylum St Hartford, CT 06103
2
3
4
5

Services Provided by This Firm (*describe fully*)

1 DPH survey issues	\$ 2,907
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided
	\$ 2,907

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

- Yes No Page 15 Line 1e

Schedule of Resident Statistics (Cont'd)

Name of Facility Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2015	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? Yes No
 If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
7/1/2015	X	X			1		1				60		To become 100% skilled

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	4,384		
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	8		40		3				
Per Diem Rate									
a. One bed rm.	Various		191.15						
b. Two bed rms.	Various		191.15		375.00				
c. Three or more bed rms.			191.15						

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	2,052	2,052		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	166	166		
C. Other	5,119	5,119		
D. Total Physical Therapy Treatments	7,337	7,337		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	852	852		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	62	62		
C. Other	1,136	1,136		
D. Total Speech Therapy Treatments	2,050	2,050		

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	3,658	3,658		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	269	269		
C. Other	6,306	6,306		
D. Total Occupational Therapy Treatments	10,233	10,233		

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Orange Health Care Center	2361	9/30/2015	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	83,690	2,097	647	16		
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	50,080	3,304	387	25		
5. Dietary Service						
a. Head Dietitian	13,571	505	105	4		
b. Food Service Supervisor	61,057	2,382	472	18		
c. Dietary Workers	154,257	6,831	1,193	53		
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	185,574	5,587	1,113	34		
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	43,218	2,315	259	14		
b. Other Maintenance Workers						
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
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	89,394	2,261	586	15		
b. RN						
1. Direct Care	379,557	6,544	2,487	43		
2. Administrative**	72,656	2,150	476	14		
c. LPN						
1. Direct Care	298,436	5,715	1,956	37		
2. Administrative**						
d. Aides and Attendants	952,101	26,709	6,239	175		
e. Physical Therapists	65,386	901				
f. Speech Therapists	35,452	974				
g. Occupational Therapists	65,566	2,008				
h. Recreation Workers	38,225	2,248	296	17		
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	43,139	1,737	334	13		
n. Marketing						
o. Other (Specify)						
See Attached Schedule	11,861	757	92	6		
<i>A-13. Total Salary Expenditures</i>	<i>2,643,220</i>	<i>75,025</i>	<i>16,642</i>	<i>484</i>		

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

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

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

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

Name of Facility Orange Health Care Center		License No. 2361		Report for Year Ended 9/30/2015		Page 11	of 37		
Name	Salary Paid		Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS (Specify)							
Section I - Operators/Owners									
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).									

* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.
 ** Include all employment worked during the cost year.

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

Name of Facility (as licensed) Orange Health Care Center		License No. 2361		Report for Year Ended 9/30/2015		Page 12	of 37		
Name	Salary Paid		Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS (Specify)							
Section III - Administrators***									
Jessica Garcia	83,690	647	Group Life, health insurance	Administrator, day to day operations of the nursing home	2,113 AI				
Section IV - Assistant Administrators									

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Orange Health Care Center	2361	9/30/2015	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						
2. Dentist						
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	78,942					
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	18,061		139			
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	662					
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	35,566					
b. Other						
10. Occupational Therapist						
a. Resident Care	92,366					
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	16,382	769	107	3		
2. Administrative***	10,252					
b. LPN						
1. Direct Care	1,383	194	9	1		
2. Administrative***						
c. Aides	392	20	3	1		
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	254,006	983	258	5		

* 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.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2015	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 210,230	208,620	1,610	
2. Disability Insurance	\$ 29,163	28,940	223	
3. Unemployment Insurance	\$ 52,779	52,374	405	
4. Social Security (F.I.C.A.)	\$ 195,761	194,259	1,502	
5. Health Insurance	\$ 269,291	267,229	2,062	
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 106,865	106,047	818	
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 9,128	9,128		
d. Accounting and Auditing	\$ 4,450	4,416	34	
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 2,907	2,885	22	
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 26,293	26,092	201	
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 18,288	18,148	140	
2. Cellular Phones	\$ 701	695	6	
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 263	261	2	
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$			
2. Other (<i>Specify</i>) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 362,532	354,860	7,672	
Subtotal	\$ 1,288,651	1,273,954	14,697	

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

(Carry Subtotals forward to next page)

Annual Report of Long-Term Care Facility

CSP-16 Rev. 9/2002

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	9/30/2015	16	37
Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	1,288,651	1,273,954	14,697	
l. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$			
3. Gifts to Staff and Residents	\$			
4. Employee Travel	\$ 215	213	2	
5. Education Expenses Related to Seminars and Conventions	\$ 14,625	14,513	112	
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$			
7. Other (<i>Specify</i>) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$ 594	589	5	
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 557	553	4	
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	\$ 23	23		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 5,540	5,498	42	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 400	397	3	
9. Subscriptions	\$			
10. Contributions*** See Attached Schedule	\$			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 64,737	64,243	494	
12. Administrative Management Services**	\$ 297,512	295,239	2,273	
13. Other (<i>Specify</i>) See Attached Schedule	\$ 9,303	9,232	71	
C-14 Total Administrative & General Expenditures	\$ 1,682,157	1,664,454	17,703	

* 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)
Promotional	\$ 553	\$ 4	
Total Other Advertising	\$ 553	\$ 4	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CT Association of Health Care Facilities	\$ 4,063	\$ 31	
D.E.A.	\$ 725	\$ 6	
Treasurer State of CT	\$ 710	\$ 5	
Total Dues	\$ 5,498	\$ 42	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Charges	\$ 212	\$ 2	
Employee Physicals	\$ 149	\$ 1	
Penalties	\$ 8,778	\$ 67	
Miscellaneous	\$ 93	\$ 1	
Total Other Administrative and General	\$ 9,232	\$ 71	\$ -

Schedule C-1 - Management Services*

Name of Facility Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2015	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Integrity Health Care Management 33 Chesterfield Road Amston, CT 06231		To provide services with accounts receivable, accounts payable, payroll, admissions and marketing	P. 16 L. 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.

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

Name of Facility Orange Health Care Center		License No. 2361	Report for Year Ended 9/30/2015	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 113,665	112,793	872	
2.	Non-Food Supplies	\$ 17,142	17,010	132	
3.	Other (Specify) _____ Supplements	\$ 8,529	8,464	65	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$			
c. Management Services**		\$			
d. Other (Specify) _____		\$			
2E. Total Dietary Expenditures (2a + b + c + d)		\$ 139,336	138,267	1,069	
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G.	Resident Meals: Total no. of meals served per day:*	164	163	1	
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No					
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)					

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

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

Name of Facility Orange Health Care Center		License No. 2361	Report for Year Ended 9/30/2015	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. \$				
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)	\$	62,771	62,397	374	
c. Management Services**	\$				
d. Other (Specify)	\$				
3E. Total Laundry Expenditures (3a + b + c + d)	\$	62,771	62,397	374	
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
I. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
L. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3E.

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

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Orange Health Care Center		2361	9/30/2015		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	18,357	18,248	109	
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$	70,630	70,209	421	
c.	Management Services*	\$				
d.	Other (<i>Specify</i>)	\$				
4E.	Total Housekeeping Expenditures (4a + b + c + d)	\$	88,987	88,457	530	
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from Partners Pharmacy	\$	114,585	114,408	177	
b.	Medicine Cabinet Drugs	\$	4,935	4,897	38	
c.	Medical and Therapeutic Supplies	\$	72,392	71,839	553	
d.	Ambulance/Limousine***	\$	4,899	4,899		
e.	Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	13,330	13,330		
f.	X-rays and Related Radiological Procedures***	\$	10,609	10,609		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	7,480	7,480		
i.	Recreation	\$	7,669	7,610	59	
j.	Other (Specify)**** See Attached Schedule	\$	39,618	39,618		
5K.	Total Resident Care Expenditures (5a - 5j)	\$	275,517	274,690	827	

* 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.

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

Name of Facility	License No.	Report for Year Ended			Page	of
Orange Health Care Center	2361	9/30/2015			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 54,199	53,876	323			
b. Heat	\$ 18,076	17,969	107			
c. Light & Power	\$ 42,507	42,254	253			
d. Water	\$ 11,276	11,209	67			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 2,316	2,302	14			
f. Other (<i>itemize</i>)	\$					
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 128,374	127,610	764			
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$ 116	115	1			
b. Building & Building Improvements	\$ 18,092	17,984	108			
c. Non-Movable Equipment	\$ 2,085	2,073	12			
d. Movable Equipment	\$ 28,114	27,946	168			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 48,407	48,118	289			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$ 2,281	2,264	17			
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 2,281	2,264	17			
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	\$ 22,030	21,899	131			
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$ 2,451	2,436	15			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 75,169	74,717	452			

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

Depreciation Schedule

Name of Facility Orange Health Care Center		License No. 2361		Report for Year Ended 9/30/2015				Page 23	of 37
Property Item		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. Land Improvements									
1. Acquired prior to this report period		52,178		42,933	41,191	MACRS	15 Years	116	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
A-4. Subtotal									116
B. Building and Building Improvements									
1. Acquired prior to this report period		959,240		959,240	899,373	Various	Various	14,724	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)		47,911						3,368	
B-4. Subtotal									18,092
C. Non-Movable Equipment									
1. Acquired prior to this report period		32,450		32,450	18,735	Various	Various	1,455	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)		9,456						630	
C-4. Subtotal									2,085
D. Movable Equipment									
1. Motor Vehicles (Specify name, model and year of each vehicle)									
a. 2012 Porche Cayane		36,478		36,478	16,416	SL	5 Years	7,295	
b.									
c.									
d.									
2. Movable Equipment									
a. Acquired prior to this report period									
b. Disposals (attach schedule)		167,671		167,671	119,347	Various	Various	11,002	
c. Acquired during this report period (attach schedule)		49,086						9,817	
D-3. Subtotal									28,114
E. Total Depreciation									48,407

Orange Health Care Center
9/30/2015

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:				
12/29/2014	Architech - Building Renovations	\$ 5,228	10	\$ 523
9/30/2015	Building renovations (Rooms, flooring, PT area)	\$ 42,683	10	\$ 2,845
Total additions for Building Improvements		\$ 47,911		\$ 3,368 *
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:				
12/15/2014	Olympic Flooring	\$ 9,456	10	\$ 630
Total additions for Non-Movable Equipment		\$ 9,456		\$ 630 *
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:				
12/16/2014	Integrity Health Care MGMT	\$ 1,985	5	\$ 396
8/1/2015	Electric beds	\$ 30,399	5	\$ 6,080
9/4/2015	Copier	1150	5	230
11/13/2014	Computers	2772	5	555
7/1/2015	Cubicle curtains and tables	7628	5	1526
7/1/2015	Electric beds	5152	5	1030
Total additions for Movable Equipment		\$ 49,086		\$ 9,817
Deletions:				
Total deletions for Movable Equipment		\$ -		\$ -

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

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

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Orange Health Care Center	License No. 2361		Report for Year Ended 9/30/2015			Page 24	of 37		
	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
Month	Year								
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1. Loan cost	7	14	30 years	45,625	604	SL		2,281	
2.									
3.									
B-4. Subtotal									2,281
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									2,281

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2015	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*			<input type="radio"/> Yes	<input checked="" type="radio"/> No	
			If "Yes," complete Part B. If "No," complete Part C.		
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description	Total				
1. Date Land Purchased	09/30/75				
2. Date Structure Completed					
3. If NOT Original Owner, Date of Purchase	04/25/61				
4. Date of Initial Licensure	1948				
5. Total Licensed Bed Capacity	60				
6. Square Footage	16,500				
7. Acquisition Cost					
a. Land	25,000				
b. Building	36,400				
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)					
b. Date Mortgage Obtained					
c. Interest Rate for the Cost Year					
d. Term of Mortgage (number of years)					
e. Amount of Principal Borrowed					
f. Principal balance outstanding as of _____					
Complete if Mortgage was Refinanced During Current Cost Year					
g. Type of Financing (e.g., fixed, variable)					
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
l. Principal Outstanding on Note Paid-Off					
Part C - Arms-Length Leases for Real Property Improvements Only					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	

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

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

Name of Facility		License No.	Report for Year Ended			Page	of
Orange Health Care Center		2361	9/30/2015			26	37
Item			Total	CCNH	RHNS	(Specify)	
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage			\$ 81,385	80,766	619		
Name of Lender		Rate					
Farmers Insurance Group Federal Credit Union		5.50%					
Address of Lender							
9301 Corbin Ave. Suite 1200 Northridge, CA 91324							
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)			\$ 81,385	80,766	619		

(Carry Subtotals forward to next page)

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

Name of Facility Orange Health Care Center		License No. 2361		Report for Year Ended 9/30/2015			Page 27	of 37
Item				Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:				81,385	80,766	619		
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) Credit card, other				\$ 7,116	7,059	57		
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$ 88,501	87,825	676		
14. Insurance								
a. Insurance on Property (buildings only)				\$ 32,333	32,086	247		
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)				\$ 32,333	32,086	247		
15. Total All Expenditures (A-13 thru C-14)				\$ 5,487,271	5,447,729	39,542		

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Orange Health Care Center				2361	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.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians **	\$ 662	662		
6.	13	B10a	Occupational Therapy	\$ 92,366	92,366		
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 9,128	9,128		
10.	15	1d	Accounting & Legal	\$ 2,907	2,885	22	
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.	15	1f	Life insurance premiums on the life of Owners, Partners, Operators	\$ 1,621	1,607	14	
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	m2,m	Unallowable Advertising *	\$ 1,151	1,142	9	
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)				\$ 107,835	107,790	45	

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

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

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

Name of Facility Orange Health Care Center				License No. 2361	Report for Year Ended 9/30/2015	Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 107,835	107,790	45	
Page 20 - Resident Care Supplies***							
27.	20	5a	Prescription Drugs	\$ 114,585	114,408	177	
28.	20	5d	Ambulance/Limousine	\$ 4,899	4,899		
29.	20	5f	X-rays, etc	\$ 10,609	10,609		
30.	20	5h	Laboratory	\$ 7,480	7,480		
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 13,330	13,330		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$			
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.	22	7d	Depreciation on Unallowable Motor Vehicles	\$ 28,114	27,946	168	
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Research or Experimental Activities	\$			
43.	30	IV8	Radio and Television Revenue	\$ 2,240	2,240		
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	\$ 18,378	18,378		
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)				\$ 307,470	307,080	390	

*** 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.

Orange Health Care Center
9/30/2015

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)
Total Other Property Adjustments			\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30	IV 8	Prior year write offs	\$ 18,378		
Total Other Adjustments			\$ 18,378	\$ -	\$ -

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2015			Page 30	of 37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 5,852,100	5,798,550	53,550			
b. Medicaid Room and Board Contractual Allowance **	\$ (2,895,282)	(2,868,874)	(26,408)			
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 938,393	938,393				
b. Medicare Room and Board Contractual Allowance **	\$ 432,991	432,991				
4. a. Private-Pay Residents and Other	\$ 592,208	592,208				
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 118,535	118,535				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (115,078)	(115,078)				
c. Prescription Drugs - Non-Medicare	\$ 5,690	5,690				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (5,690)	(5,690)				
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	\$ 464,899	464,899				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (406,608)	(406,608)				
c. Physical Therapy - Non-Medicare	\$ 18,367	18,367				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (18,367)	(18,367)				
4. a. Speech Therapy - Medicare	\$ 259,104	259,104				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (208,371)	(208,371)				
c. Speech Therapy - Non-Medicare	\$ 25,103	25,103				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (25,103)	(25,103)				
5. a. Occupational Therapy - Medicare	\$ 671,255	671,255				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (571,451)	(571,451)				
c. Occupational Therapy - Non-Medicare	\$ 25,103	25,103				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (25,103)	(25,103)				
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 5,132,695	5,105,553	27,142			
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ 520	520				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 22,000	22,000				
V. Total Other Revenue (1 thru 8)	\$ 22,520	22,520				
VI. Total All Revenue (III +V)	\$ 5,155,215	5,128,073	27,142			

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

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

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2015	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	36,415
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	518,778
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	67,334
a. Prepaid insurance	40,903			
b. Deposits taxes	6,612			
c. Other	19,819			
d.				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	55,583
Property escrow	52,331			
Other	3,252			
A-9. Total Current Assets (Lines A1 thru 8)			\$	678,110
B. Fixed Assets				
1. Land			\$	40,600
2. Land Improvements	*Historical Cost	42,933		
	Accum. Depreciation	41,307	Net	1,626
3. Buildings	*Historical Cost	1,007,151		
	Accum. Depreciation	917,465	Net	89,686
4. Leasehold Improvements	*Historical Cost			
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	41,906		
	Accum. Depreciation	20,820	Net	21,086
6. Movable Equipment	*Historical Cost	216,757		
	Accum. Depreciation	140,166	Net	76,591
7. Motor Vehicles	*Historical Cost	36,478		
	Accum. Depreciation	23,711	Net	12,767
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	242,356

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

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Orange Health Care Center		2361	9/30/2015	32	37
Account				Amount	
Total Brought Forward:				\$	920,466
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 (<i>itemize</i>)				\$	
6. Loans to Owners or Related Parties (<i>itemize</i>)				\$	
Name and Address		Amount	Loan Date		
7. Other Assets (<i>itemize</i>)				\$ 42,736	
Loan cost		42,736			
D-8. Total Investments and Other Assets (Lines D1 thru 7)				\$ 42,736	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)				\$ 992,764	

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

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Orange Health Care Center		2361	9/30/2015	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	759,320
2. Notes Payable (<i>itemize</i>)				\$	287,373
Andree Acampora					29,000
Paul Knutsen					258,373
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	147,718
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	1,787
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	186,662
Provider fee payable					186,662
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	1,382,860

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Orange Health Care Center		License No. 2361	Report for Year Ended 9/30/2015	Page 34	of 37
Account				Amount	
Total Brought Forward:				1,382,860	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					
				\$	5,564
Name of Lender	Purpose	Amount	Date Due		
Auto	American Eagle	5,564	2/13/16		
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$	
Name and Address of Lender	Amount	Loan Date			
4. Other Long-Term Liabilities (<i>itemize</i>)				\$	1,465,157
Loan payable FIG		1,465,157			
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$	1,470,721
C. Total All Liabilities (Lines A-13 + B-5)				\$	2,853,581

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	9/30/2015	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 (<i>Equity</i>)			\$	29,562
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	29,562
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	45,410
3. Paid-in Surplus			\$	(28,565)
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(1,575,168)
6. Gain or Loss for Period			\$	(332,056)
7. Total Net Worth			\$	(1,890,379)
C. Total Reserves and Net Worth			\$	(1,860,817)
D. Total Liabilities, Reserves, and Net Worth			\$	992,764

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Orange Health Care Center	2361	9/30/2015	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2014			\$	(1,429,065)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	5,155,215
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	5,487,271
D. Net Income or Deficit			\$	(332,056)
E. Balance			\$	(1,761,121)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
Prior year expenses				(16,764)
F-3. Total Additions			\$	(16,764)
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	129,339
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
Andree Acampora		Owner	129,339	
Paul Knutsen		Owner		
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	129,339
H. Balance at End of Period		09/30/15	\$	(1,907,224)

I. Preparer's/Reviewer's Certification

Name of Facility Orange Health Care Center	License No. 2361	Report for Year Ended 9/30/2015	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Jason Moore				
Address Address			Phone Number	
225 Boston Post Road, Orange, CT 06477			203-795-0835	

Error Check

Level	Item	Reported as	
-	Page 35 - Total Liabilities, Reserves and Net Worth	992,764	Total Assets 992,764

