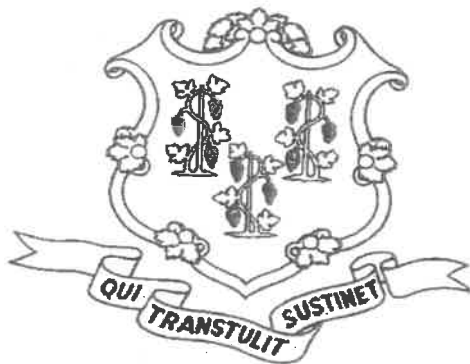


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2018

Name of Facility (as licensed) Orchard Grove Specialty Care Center	
Address (No. & Street, City, State, Zip Code) 5 Richard Brown Drive Uncasville, CT 06382	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)
<input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018

License Numbers:	CCNH 2306-C	RHNS	(Specify)	Medicare Provider 07-5438
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Medicaid Provider Numbers:	CCNH 21064	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) Orchard Grove Specialty Care Center	License No. 2306-C	Report for Year Ended 9/30/2018	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 Orchard Grove Specialty Care Center [facility name], for the cost report period beginning October 1, 2017 and ending September 30, 2018, 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) Peter Allen			Printed Name (Owner) Brian J. Foley		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Orchard Grove Specialty Care Center		Period Covered:	From 10/1/2017	To 9/30/2018
Address of Facility 5 Richard Brown Drive Uncasville, CT 06382				
Report Prepared By Apple Health Care, Inc.		Phone Number (860) 678-9755	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 (860) 678-9755	Report for Year Ended 9/30/2018	Page 2	of 37
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Name of Facility (as shown on license) Orchard Grove Specialty Care Center	Address (No. & Street, City, State, Zip) 5 Richard Brown Drive Uncasville, CT 06382
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License Numbers: CCNH 2306-C	RHNS (Specify)	Medicare Provider No. 07-5438
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Type of Facility (Check appropriate box(es))		
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)

Type of Ownership (Check appropriate box)						
<input type="radio"/> Proprietorship	<input type="radio"/> LLC	<input type="radio"/> Partnership	<input checked="" type="radio"/> Profit Corp.	<input type="radio"/> Non-Profit Corp.	<input type="radio"/> Government	<input type="radio"/> Trust

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

Has there been any change in ownership or operation during this report year?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," explain fully.
---	---------------------------	-------------------------------------	--------------------------

Administrator

Name of Administrator Peter Allen	Nursing Home Administrator's License No.:	1442CT
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Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name	License No.:

**General Information and Questionnaire
 Corporate Owners**

Name of Facility Orchard Grove Specialty Care Center	License No. 2306-C	Report for Year Ended 9/30/2018	Page 3A	of 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		
Orchard Grove Specialty Care Center	5 Richard Brown Drive Uncasville, CT 06382	Connecticut		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Brian J. Foley	21 Waterville Road Avon, CT 06001	President	100	
Ryan Vess	21 Waterville Road Avon, CT 06001	Secretary		
Names of Stockholders Owning at Least 10% of Shares				
Brian J. Foley	21 Waterville Road Avon, CT 06001	President	100	

**General Information and Questionnaire
 Related Parties***

Name of Facility Orchard Grove Specialty Care Center	License No. 2306-C	Report for Year Ended 9/30/2018	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 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	%**				
Brian J. Foley	21 Waterville Road Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Real Estate Rental	Pg. 22 Line 9	924,000	924,000
Apple Health Care	21 Waterville Road Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Management & Accounting Services	Pg. 16 Line m12	417,100	417,100
Corporate Employees	21 Waterville Road Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	149,518	149,518
Employees @ Various Apple Facilities		<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	10,749	10,749
Apple Health Care	21 Waterville Road Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Pension Plan (401K)	Pg. 15 Line 1a7	24,220	24,220
Aetna	PO Box 88860 Chicago, IL 60695	<input checked="" type="radio"/>	<input type="radio"/>		Group Medical	Pg. 15 Line 1a5	598,674	
Delta Dental	PO Box 222 Parsippany, NJ 07054	<input checked="" type="radio"/>	<input type="radio"/>		Group Dental	Pg. 15 Line 1a5	38,609	
Aetna Ancillary	PO Box 88860 Chicago, IL 60695	<input checked="" type="radio"/>	<input type="radio"/>		Group Life & Disability	Pg. 15 Line 1a6	37,354	
Marsh	PO Box 846015 Dallas, TX 75284	<input checked="" type="radio"/>	<input type="radio"/>		Property, Liability, & Umbrella Insurance	Pg. 27 Line 14a	128,100	

* Use additional sheets if necessary.
 ** Provide the percentage amount of revenue received from non-related parties.

**General Information and Questionnaire
Related Parties***

Name of Facility Orchard Grove Specialty Care Center	License No. 2306-C	Report for Year Ended 9/30/2018	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 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	%**				
AIG	PO Box 10472 Newark, NJ	✘			Worker's Compensation	Pg. 15 1a1	249,269	
Swallowing Diagnostics	21 Waterville Road Avon, CT	✘		83%	Diagnostic Services	Pg 20 5f	3,030	2,857
Ryan Vess	21 Waterville Road Avon, CT		✘			##		

* Use additional sheets if necessary.
 ** Provide the percentage amount of revenue received from non-related parties.
 ## Related expense has been disallowed on Pg. 28 Line 23

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility Orchard Grove Specialty Care Center	License No. 2306-C	Report for Year Ended 9/30/2018	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 CCHH and RHNS as follows:

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

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

1. In the preparation of this Report, were all costs allocated as required? Yes No If "No," explain fully why such allocation was not made.
2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.
 The costs incurred by Apple Health Care, inc. (a related party), to provide Accounting and Managerial services to each facility owned by Brian J. Foley, are allocated on a per bed basis.
3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)
 Yes No If "No," explain fully why such allocation was not made.
- N/A

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 Orchard Grove Specialty Care Center			License No. 2306-C		Report for Year Ended 9/30/2018		Page 6	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input checked="" type="radio"/> Yes <input type="radio"/> No	Total ***

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

General Information and Questionnaire
Accounting Basis

Name of Facility Orchard Grove Specialty Care Cent	License No. 2306-C	Report for Year Ended 9/30/2018	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 1 Blum Shapiro & Co. PC 2 Brazee & Huban 3 4	Address (No. & Street, City, State, Zip Code) 29 South Main St. West Hartford, CT 06127 35 Wendell Ave. Pittsfield, MA 10202
--	--

Services Provided by This Firm (<i>describe fully</i>)	
1 Preparation of audited financials (disallow Pg.28)	\$ 13,472
2 Preparation of tax returns	\$ 2,206
3	\$
4	\$
	Charge for Services Provided
	\$ 15,678

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

Legal Services Information

Name of Legal Firm or Independent Attorney 1 2 3 4 5	Telephone Number
---	------------------

Address (*No. & Street, City, State, Zip Code*)
 1
 2
 3
 4
 5

Services Provided by This Firm (<i>describe fully</i>)	
1	\$
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided
	\$

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

Schedule of Resident Statistics

Name of Facility Orchard Grove Specialty Care Center			License No. 2306-C		Report for Year Ended 9/30/2018				Page 8	of 37			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	130	130			130	130			130	130			
B. On last day of THIS report period	130	130			130	130			130	130			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	112	112			112	112			114	114			
B. As of midnight of THIS report period	114	114			114	114			114	114			
3. Total Number of Days Care Provided During Period													
A. Medicare	3,637	3,637			2,962	2,962			675	675			
B. Medicaid (Conn.)	35,230	35,230			26,636	26,636			8,594	8,594			
C. Medicaid (other states)													
D. Private Pay	3,266	3,266			2,104	2,104			1,162	1,162			
E. State SSI for RCH													
F. Other (Specify)													
G. Total Care Days During Period (3A thru F)	42,133	42,133			31,702	31,702			10,431	10,431			
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)	42,133	42,133			31,702	31,702			10,431	10,431			

Schedule of Resident Statistics (Cont'd)

Name of Facility Orchard Grove Specialty Care Center			License No. 2306-C			Report for Year Ended 9/30/2018			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days							CCNH	RHNS	(Specify)				
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	4		87		23								
Per Diem Rate													
a. One bed rm.					432.00								
b. Two bed rms.	RUGS III		225.00		410.00								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments							TOTAL	CCNH	RHNS	(Specify)			
A. Medicare - Part B							5,361	5,361					
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other							9,459	9,459					
D. Total Physical Therapy Treatments							14,820	14,820					
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B							942	942					
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other							1,301	1,301					
D. Total Speech Therapy Treatments							2,243	2,243					
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B							5,822	5,822					
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other							9,276	9,276					
D. Total Occupational Therapy Treatments							15,098	15,098					

Report of Expenditures - Salaries & Wages

Name of Facility Orchard Grove Specialty Care Center	License No. 2306-C	Report for Year Ended 9/30/2018	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	140,276	2,126				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	63,800	3,873				
5. Dietary Service						
a. Head Dietitian	45,662	1,444				
b. Food Service Supervisor	53,601	2,475				
c. Dietary Workers	359,984	26,545				
6. Housekeeping Service						
a. Head Housekeeper	14,182	760				
b. Other Housekeeping Workers	179,469	14,051				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	103,443	5,298				
8. Laundry Service						
a. Supervisor	39,415	1,868				
b. Other Laundry Workers	50,162	3,919				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants	152,654	6,059				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	168,946	3,550				
b. RN						
1. Direct Care	583,989	15,692				
2. Administrative**	243,311	7,165				
c. LPN						
1. Direct Care	856,080	30,548				
2. Administrative**						
d. Aides and Attendants	1,437,327	87,591				
e. Physical Therapists	319,194	9,232				
f. Speech Therapists	61,860	1,746				
g. Occupational Therapists	172,374	4,593				
h. Recreation Workers	106,681	5,423				
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	170,387	5,417				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	5,322,798	239,373				

* 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 Orchard Grove Specialty Care Center				License No. 2306-C		Report for Year Ended 9/30/2018			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.

Annual Report of Long-Term Care Facility

**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	
Orchard Grove Specialty Care Center				2306-C	9/30/2018			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Peter Allen	140,276				Administrator 10/1/17-9/30/18	2,126	A2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Orchard Grove Specialty Care Center	2306-C	9/30/2018	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	13,518	136				
3. Pharmacist	7,301	61				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	78,631	154				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
Audiologist	136	3				
9. Speech Therapist						
a. Resident Care	3,030	67				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	23,946	232				
B-13 Total Fees Paid in Lieu of Salaries	126,563	653				

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

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

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

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

Name of Facility Orchard Grove Specialty Care Center		License No. 2306-C	Report for Year Ended 9/30/2018	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Joseph Allesandro PO Box 6 Pomfret Center, CT	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Phil Raiford PO Box 6 Pomfret Center, CT	Associate Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Pointright	Data Integrity Auditor	<input type="radio"/>	<input checked="" type="radio"/>		
Healthdrive Dental 1 Prestige Drive Meriden, CT	Dentist	<input type="radio"/>	<input checked="" type="radio"/>		
Neighborcare Pharmacy Dept 781668 PO Box 78000 Detroit, MI 48278	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>		
Patient Ping	Admissions/Discharge Fee	<input type="radio"/>	<input checked="" type="radio"/>		
CT Purchase Consultant	Purchase Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Celtic Consulting	MDS Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Sara Cassello	Social Work Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Swallowing Diagnostics	Speech Consultant	<input checked="" type="radio"/>	<input type="radio"/>	See Disclosure pg 4	
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Orchard Grove Specialty Care Center	2306-C	9/30/2018		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 249,269	249,269			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 97,240	97,240			
4. Social Security (F.I.C.A.)	\$ 381,901	381,901			
5. Health Insurance	\$ 488,499	488,499			
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 37,354	37,354			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 24,220	24,220			
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*	\$ 420,224	420,224			
d. Accounting and Auditing	\$ 15,678	15,678			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$				
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 31,874	31,874			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 17,956	17,956			
2. Cellular Phones	\$				
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$				
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	\$ 796,690	796,690			
Subtotal	\$ 2,560,904	2,560,904			

* 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
Orchard Grove Specialty Care Center	2306-C	9/30/2018	16	37
Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	2,560,904	2,560,904		
1. Travel and Entertainment				
1. Resident Travel and Entertainment	\$ 27,122	27,122		
2. Holiday Parties for Staff	\$ 4,612	4,612		
3. Gifts to Staff and Residents	\$ 9,790	9,790		
4. Employee Travel	\$ 10,312	10,312		
5. Education Expenses Related to Seminars and Conventions	\$ 3,680	3,680		
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>)	\$ 1,095	1,095		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$			
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 21,519	21,519		
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	\$ 725	725		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 9,350	9,350		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 456	456		
9. Subscriptions	\$ 360	360		
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>)	\$			
12. Administrative Management Services**	\$ 417,100	417,100		
13. Other (<i>Specify</i>) See Attached Schedule	\$ 185,606	185,606		
C-14 Total Administrative & General Expenditures	\$ 3,252,631	3,252,631		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Advertising - Public Relations	\$ 21,519		
Total Other Advertising	\$ 21,519	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF Dues	\$ 9,350		
Total Dues	\$ 9,350	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Corporate Fees Non Reimbursable	\$ 80,825		
Licenses & Fees	\$ (10,907)		
Pre Employment Screenings	\$ 16,119		
Point Click Care Fees	\$ 16,601		
Bank Charges, Penalties, Fees	\$ 53,584		
Legal Fees - Collections, Probate, Conservator	\$ 1,896		
Resident Expenses	\$ 1,017		
Account W/O	\$ -		
CMS Penalty	\$ 25,010		
Interpreter	\$ 1,460		
Total Other Administrative and General	\$ 185,606	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Orchard Grove Specialty Care Center	License No. 2306-C	Report for Year Ended 9/30/2018	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 #
Apple Health Care, Inc.	417,100	Accounting & Management Services	Pg. 16 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		License No.	Report for Year Ended		Page	of
Orchard Grove Specialty Care Center		2306-C	9/30/2018		18	37
Item	Total	CCNH	RHNS	(Specify)		
2. Dietary						
a. In-House Preparation & Service						
1. Raw Food	\$ 283,106	283,106				
2. Non-Food Supplies	\$ 45,597	45,597				
3. Other (Specify) _____	\$ _____					
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)						
	\$ 2,056	2,056				
c. Other (Specify) _____						
	\$ _____					
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 330,759	330,759				
2F. Dietary Questionnaire						
G. Resident Meals:	Total no. of meals served per day:*	346	346			
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.

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

Name of Facility		License No.	Report for Year Ended	Page	of
Orchard Grove Specialty Care Center		2306-C	9/30/2018	19	37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*		Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$	6,566	6,566	
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. \$	10,480	10,480	
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)		\$	17,046	17,046	
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.

*** 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 Orchard Grove Specialty Care Center		License No. 2306-C	Report for Year Ended 9/30/2018		Page 20	of 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. \$	32,700	32,700		
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$				
	C. Other (<i>Specify</i>)	\$				
4D.	Total Housekeeping Expenditures (4a + b + c)	\$	32,700	32,700		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from West River/Neighborcare	\$	194,820	194,820		
b.	Medicine Cabinet Drugs	\$				
c.	Medical and Therapeutic Supplies	\$	238,680	238,680		
d.	Ambulance/Limousine***	\$				
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	62,739	62,739		
f.	X-rays and Related Radiological Procedures***	\$	10,711	10,711		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	17,097	17,097		
i.	Recreation	\$	54,363	54,363		
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	46,135	46,135		
5M.	Total Resident Care Expenditures (5a - 5j)	\$	624,545	624,545		

* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
 ** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.
 *** Facility should self-disallow the expense on Page 29 of the Cost Report.
 **** ICFMR's should provide a detailed schedule of all Day Program Costs.

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

Name of Facility Orchard Grove Specialty Care Center			License No. 2306-C	Report for Year Ended 9/30/2018	Page of 21 37						
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***					
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line	
Jon's Quality Landscaping	150 Meridian Street Groton, CT	<input type="radio"/>	<input checked="" type="radio"/>		Landscaping & Snow Removal	23,361				22	6a
CWPM	25 Norton Place Plainville, CT	<input type="radio"/>	<input checked="" type="radio"/>		Refuse Removal	19,462				22	6f
Proline	P.O. Box 150473 Hartford, CT	<input type="radio"/>	<input checked="" type="radio"/>		Dietary Equipment Maintenance	14,312				22	6a
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Orchard Grove Specialty Care Center	2306-C	9/30/2018			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 173,136	173,136				
b. Heat	\$ 59,911	59,911				
c. Light & Power	\$ 90,993	90,993				
d. Water	\$ 61,815	61,815				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$					
f. Other (<i>itemize</i>)	\$ 22,433	22,433				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 408,287	408,287				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$ 1,197	1,197				
d. Movable Equipment	\$ 29,748	29,748				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 30,946	30,946				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 53,073	53,073				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 53,073	53,073				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 924,000	924,000				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 65,251	65,251				
c. Personal property taxes	\$ 6,578	6,578				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,079,848	1,079,848				

* 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)
Refuse Removal	\$ 22,433		
Total Other Repairs and Maintenance	\$ 22,433	\$ -	\$ -

Depreciation Schedule

Name of Facility Orchard Grove Specialty Care Center		License No. 2306-C			Report for Year Ended 9/30/2018			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													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal													
B. Building and Building Improvements													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal													
C. Non-Movable Equipment													
1. Acquired prior to this report period		17,421			8,238	SL	Variable	1,197					
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)						SL	Variable						
C-4. Subtotal									1,197				
		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						390,104		390,104	297,014	SL	Variable	27,648	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)						24,917						2,101	
D-3. Subtotal													29,748
E. Total Depreciation													30,946

Orchard Grove Specialty Care Center
9/30/2018

Schedule of Land Improvements Acquired during this report period

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

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

Schedule of Building Improvements Acquired during this report period

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

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

Schedule of Non-Movable Equipment Acquired during this report period

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/26/2017	Deposit Dressers	\$ 4,690	15	\$ 391
11/1/2017	Dishwasher Booster Replacement	\$ 4,000	5	\$ 1,000
12/5/2017	Balance Due Dressers	4,437.50	15	369.77
2/23/2018	New Dressers	9,411.97	15	221.62
7/2/2018	5 Wireless AP Units	2,376.92	5	118.20
Total additions for Movable Equipment		\$ 24,917		\$ 2,101 *
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:				
12/6/2017	Vinyl Flooring	\$ 2,379	10	\$ 297
12/29/2017	Replace Hot Water Tank	\$ 17,909	20	\$ 1,119
2/13/2018	New Floors	9,486.65	10	339.73
3/29/2018	12 pendant sprinklers	1,065.10	25	14.27
8/2/2018	Wood Fire Doors	3,137.33	15	41.42
1/30/2017	historical just approved/ Flooring	7,519.75	10	939.93
Total additions for Leasehold Improvement		\$ 41,497		\$ 2,752 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Orchard Grove Specialty Care Center			License No. 2306-C		Report for Year Ended 9/30/2018			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period				778,137	262,967	A		50,321	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				41,497		A		2,752	
C-4. Subtotal									53,073
D. Total Amortization									53,073

* 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 Orchard Grove Specialty Care Center	License No. 2306-C	Report for Year Ended 9/30/2018	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input 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				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	130			
6. Square Footage	36,318			
7. Acquisition Cost				
a. Land				
b. Building				
Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Variable			
b. Date Mortgage Obtained	12/07/16			
c. Interest Rate for the Cost Year	4.48%			
d. Term of Mortgage (number of years)	5			
e. Amount of Principal Borrowed	10,034,175			
f. Principal balance outstanding as of	9,582,637			
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
Orchard Grove Specialty Care Center		2306-C	9/30/2018		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended			Page	of
Orchard Grove Specialty Care Cer		2306-C		9/30/2018			27	37
Item				Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:								
12. C. Movable Equipment								
1. Automotive Equipment				\$				
A. Item		Rate	Amount					
Lender								
Address of Lender								
2. Other (Specify)				\$				
A. Item		Rate	Amount					
Lender								
Address of Lender								
B. Item		Rate	Amount					
Lender								
Address of Lender								
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$				
12. D. Other Interest Expense (Specify)				\$				
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$				
14. Insurance								
a. Insurance on Property (buildings only)				\$ 128,100	128,100			
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)				\$ 128,100	128,100			
15. Total All Expenditures (A-13 thru C-14)				\$ 11,323,277	11,323,277			

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Orchard Grove Specialty Care Center			2306-C	9/30/2018	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.	10	A12g	Occupational Therapy	\$ 172,374	172,374		
4.			Other - See attached Schedule	\$ 21,177	21,177		
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 420,224	420,224		
10.	15/16	1d/m	Accounting	\$ 15,368	15,368		
10a.			Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m2/3	Unallowable Advertising *	\$ 21,519	21,519		
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m10	Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 170,716	170,716		
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)				\$ 821,378	821,378		

* 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)
VAR	VAR	Social Service - Marketing	\$ 21,177		
Total Other Salaries Adjustment			\$ 21,177	\$ -	\$ -

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)
16	m13	Corp Fee- Non-reimbursable	\$ 80,825		
16	1.3	Employee Recognition/Gifts/Parties	\$ 9,790		
16	8a	Chamber of Commerce	\$ 456		
16	m13	Bank Charges, penalties, fines	\$ 53,584		
16	m13	Resident Expenses	\$ 1,017		
16	m13	Account W/O	\$ -		
16	m13	CMS Penalty	\$ 25,010		
30	IV8	Rebates	\$ 34		
Total Other A&G Adjustments			\$ 170,716	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
Orchard Grove Specialty Care Center				2306-C	9/30/2018	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 821,378	821,378		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 186,128	186,128		
28.	16	L1	Ambulance/Limousine	\$ 27,122	27,122		
29.	20	h	X-rays, etc	\$ 10,711	10,711		
30.	20	f	Laboratory	\$ 17,097	17,097		
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 37,989	37,989		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 39,954	39,954		
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	\$			
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)				\$ 1,140,379	1,140,379		

*** 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.

Orchard Grove Specialty Care Center
 9/30/2018

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV Therapy Supplies	\$ 26,344		
20	5j	Rehab Service Supplies	\$ 13,437		
30	IV8	Medical Supply Refund	\$ 173		
Total Other Ancillary Costs			\$ 39,954	\$ -	\$ -

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)
27	12D	Interest	\$ -		
Total Other Adjustments			\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Orchard Grove Specialty Care Center	2306-C	9/30/2018			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 7,607,589	7,607,589				
b. Medicaid Room and Board Contractual Allowance **	\$					
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,437,667	1,437,667				
b. Medicare Room and Board Contractual Allowance **	\$ 554,289	554,289				
4. a. Private-Pay Residents and Other	\$ 1,368,738	1,368,738				
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 125,575	125,575				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (125,575)	(125,575)				
c. Prescription Drugs - Non-Medicare	\$ 65,947	65,947				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (70,590)	(70,590)				
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	\$ 450,349	450,349				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (291,631)	(291,631)				
c. Physical Therapy - Non-Medicare	\$ 68,342	68,342				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (65,732)	(65,732)				
4. a. Speech Therapy - Medicare	\$ 94,143	94,143				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (58,284)	(58,284)				
c. Speech Therapy - Non-Medicare	\$ 6,795	6,795				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (6,120)	(6,120)				
5. a. Occupational Therapy - Medicare	\$ 593,734	593,734				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (372,121)	(372,121)				
c. Occupational Therapy - Non-Medicare	\$ 85,680	85,680				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (82,395)	(82,395)				
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 11,386,400	11,386,400				
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 206	206				
V. Total Other Revenue (1 thru 8)	\$ 206	206				
VI. Total All Revenue (III +V)	\$ 11,386,606	11,386,606				

* 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 on Accounts Receivable	2,991,280	\$ -		
Total Interest Income			\$ -	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV8	Medical Supply refund	\$ 173		
30 IV8	Rebates	\$ 34		
Total Other Revenue		\$ 206	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Orchard Grove Specialty Care Center	2306-C	9/30/2018	31	37
Account		Amount		
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,991,280
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	24,576
5. Prepaid Expenses			\$	21,249
a. _____				
b. _____				
c. _____				
d. See Schedule		21,249		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	206,933

See Schedule		206,933		
A-9. Total Current Assets (Lines A1 thru 8)			\$	3,244,037
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____ Net			
3. Buildings	*Historical Cost _____		\$	
	Accum. Depreciation _____ Net			
4. Leasehold Improvements	*Historical Cost <u>819,633</u>		\$	503,593
	Accum. Depreciation <u>316,040</u> Net			
5. Non-Movable Equipment	*Historical Cost <u>17,421</u>		\$	7,986
	Accum. Depreciation <u>9,435</u> Net			
6. Movable Equipment	*Historical Cost <u>415,021</u>		\$	88,258
	Accum. Depreciation <u>326,762</u> Net			
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____ Net			
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	19,010

See Schedule		19,010		
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	618,848

* 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
Orchard Grove Specialty Care Center	2306-C	9/30/2018	32	37
Account			Amount	
Total Brought Forward:			\$	3,862,885
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements			*Historical Cost _____	
			Accum. Depreciation _____	Net \$
3. Buildings			*Historical Cost _____	
			Accum. Depreciation _____	Net \$
4. Non-Movable Equipment			*Historical Cost _____	
			Accum. Depreciation _____	Net \$
5. Movable Equipment			*Historical Cost _____	
			Accum. Depreciation _____	Net \$
6. Motor Vehicles			*Historical Cost _____	
			Accum. Depreciation _____	Net \$
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense			*Historical Cost _____	
			Accum. Depreciation _____	Net \$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address		Amount	Loan Date	
_____		_____	_____	
7. Other Assets (<i>itemize</i>)			\$	

See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 3,862,885	

* 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
Orchard Grove Specialty Care Center		2306-C	9/30/2018	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	654,114
2. Notes Payable (<i>itemize</i>)				\$	

See Schedule					
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>)				\$	109,269
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	22,704
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>)				\$	669,921

See Schedule					669,921
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	1,456,007

* 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 Orchard Grove Specialty Care Center		License No. 2306-C	Report for Year Ended 9/30/2018	Page 34	of 37
Account				Amount	
Total Brought Forward:				1,456,007	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					
\$					
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$	
Name and Address of Lender	Amount	Loan Date			
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 2,305,727	

See Schedule				2,305,727	
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 2,305,727	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 3,761,733	

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	A5	Prepaid Insurance	\$ 0
31	A5	Prepaid Property Tax	\$ 21,098
31	A5	Prepaid Other	\$ 150
Total Prepaid Expenses			\$ 21,249

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

Page Ref	Line Ref	Description	
31	A8	Payroll W/H	\$ 12,676
31	A8	Due Affiliate -Corporate	\$ 194,117
31	A8	A/P Patient Exchange	\$ 139
Total Other Current Assets (Itemize)			\$ 206,933

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

Page Ref	Line Ref	Description	
31	B9	Fixed Asset Clearing Account	\$ 19,010
31	B9	Construction in Progress	\$ -
Total Other Other Fixed Assets (Itemize)			\$ 19,010

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Loans Rec. - Officers/Owners	\$ -
		Capitalized Refinance	\$ -
		Leasehold Deposits	\$ -
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	
33	A12	Accrued PTO	\$ 170,171
33	A12	Accrued Pension	\$ 1,163
33	A12	Accrued Worker's Comp	\$ 160,687
33	A12	Accrued Expense Other	323,385.75
33	A12	Accrued Professional Fees	11,009.52
33	A12	Payroll W/H	2,711.75
33	A12	Due Affiliate (Credit Balance)	
33	A12	Gemino Revolving Loan	0.00
33	A12	Exchange	792.00
Total Other Current Liabilities (Itemize)			\$ 669,921

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

Page Ref	Line Ref	Description	
34	B4	A/P Other	\$ 2,305,727
Total Other Current Liabilities (Itemize)			\$ 2,305,727

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

Name of Facility	License No.	Report for Year Ended	Page	of
Orchard Grove Specialty Care Center	2306-C	9/30/2018	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>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	(5,460,666)
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	5,498,488
6. Gain or Loss for Period			\$	63,329
	10/1/2017	thru 9/30/2018		
7. Total Net Worth			\$	101,152
C. Total Reserves and Net Worth			\$	101,152
D. Total Liabilities, Reserves, and Net Worth			\$	3,862,885

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Orchard Grove Specialty Care Center	2306-C	9/30/2018	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2017			\$	896,012
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	11,386,606
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	11,323,277
D. Net Income or Deficit			\$	63,329
E. Balance			\$	959,341
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	858,189
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount	
Brian Foley		President	8,189	
Brian Foley		President	850,000	
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose		Amount		
3. Total Deductions			\$	858,189
H. Balance at End of Period			\$	101,152
				09/30/18

I. Preparer's/Reviewer's Certification

Name of Facility Orchard Grove Specialty Care Center	License No. 2306-C	Report for Year Ended 9/30/2018	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Robert Gwizdak				
Address Address			Phone Number	
21 Waterville Road Avon, CT 06001			(860) 678-9755	
Annual Report Contact			Phone Number	
Susan Southey			(860) 470-7542	
Annual Report Contact Email Address				
ssouthey@apple-rehab.com				