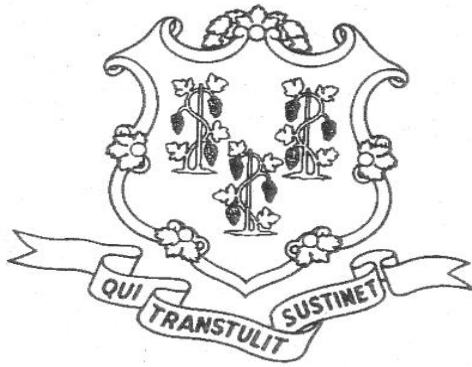


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2017

Name of Facility (as licensed) Portland Care and Rehabilitation Centre, Inc.	
Address (No. & Street, City, State, Zip Code) 333 Main Street, Portland CT 06480	
Type of Facility Chronic and Convalescent                      Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input type="checkbox"/> Supervision only <input type="checkbox"/> (Specify) (CCNH)    (RHNS)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH 871-C	RHNS	(Specify)	Medicare Provider 07-5214
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Medicaid Provider Numbers:	CCNH 8714	RHNS	ICF-IID
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**For Department Use Only**

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

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**General Information**

Name of Facility (as licensed) Portland Care and Rehabilitation Centre, Inc.	License No. 871-C	Report for Year Ended 9/30/2017	Page 1	of 37
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**Administrator's/Owner's Certification**

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Portland Care and Rehabilitation Centre, Inc. [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) Gerald Yuska			Printed Name (Owner) Gerald Yuska		
Subscribed and Sworn to before me:	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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Portland Care and Rehabilitation Centre, Inc.		Period Covered:	From 10/1/2016	To 9/30/2017
Address of Facility 333 Main Street, Portland CT 06480				
Report Prepared By Ryan Turko		Phone Number 860-342-0370	Date 2/10/2018	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$ 253,045	253,045		
2. Laundry wages paid	\$ 45,241	45,241		
3. Housekeeping wages paid	\$ 103,595	103,595		
4. Nursing wages paid	\$ 2,014,253	2,014,253		
5. All other wages paid	\$ 1,355,160	1,355,160		
6. <b>Total Wages Paid</b>	<b>\$ 3,771,294</b>	<b>3,771,294</b>		
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	<b>\$ 3,771,294</b>	<b>3,771,294</b>		

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

**General Information and Questionnaire**  
**Type of Facility - Organization Structure**

Phone No. of Facility 860-342-0370		Report for Year Ended 9/30/2017		Page 2	of 37
Name of Facility (as shown on license) Portland Care and Rehabilitation Centre, Inc.			Address (No. & Street, City, State, Zip) 333 Main Street, Portland CT 06480		
License Numbers:	CCNH 871-C	RHNS	(Specify)	Medicare Provider No. 07-5214	
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.					
<b>Administrator</b>					
Name of Administrator George Yuska			Nursing Home Administrator's License No.:	001892	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		









**General Information and Questionnaire  
Related Parties\***

Name of Facility Portland Care and Rehabilitation Centre, Inc.	License No. 871-C	Report for Year Ended 9/30/2017	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	%**				
		<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"/>					

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

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility Portland Care and Rehabilitation Centre, Inc.	License No. 871-C	Report for Year Ended 9/30/2017	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

## General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility Portland Care and Rehabilitation Centre, Inc.			License No. 871-C		Report for Year Ended 9/30/2017		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						
N/A	<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	<b>Total ***</b>

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

\*\* Attach copies of newly acquired leases.

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

**General Information and Questionnaire**  
**Accounting Basis**

Name of Facility Portland Care and Rehabilitation C	License No. 871-C	Report for Year Ended 9/30/2017	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 Michaud Accavallo Woodbridge, Cusano LLC 2 KMPG 3 HR Block 4	Address (No. & Street, City, State, Zip Code) 158 Main St, Suite 301, Ansonia CT 06401 Florida
--	--

Services Provided by This Firm (*describe fully*)

1 HUD Audit and Consulting	\$ 13,090
2 Cost Report Software	\$ 526
3 Tax Program (Self Disallow)	\$ 104
4	\$
104 total disallowance on Page 28. This is for the Tax Program expense. No legal fees have been disallowed. The Litigation expense is being disallowed by Desk Review. Refer to WP B.7.	
Charge for Services Provided	
\$ 13,720	

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    Pg 15 Line 9

**Legal Services Information**

Name of Legal Firm or Independent Attorney 1 Gordon & Rees LLP 2 Joseph A. Vitale 3 Haile, Shaw & Pfaffenberger, P.A. 4 5	Telephone Number 860-278-7448 203-439-0602
--	--

Address ( <i>No. &amp; Street, City, State, Zip Code</i> ) 1 95 Glastonbury Blvd, Glastonbury CT 2 575 Hoghland ave, Cheshire CT 3 North Palm, FL 33408 4 5
--

Services Provided by This Firm (*describe fully*)

1 Litigation	\$ 19,326
2 HUD Consulting/Refi	\$ 2,766
3 Consulting	\$ 2,602
4	\$
5	\$
Charge for Services Provided	
\$ 24,694	

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    Page 15 Ln E

### Schedule of Resident Statistics

Name of Facility Portland Care and Rehabilitation Centre, Inc.			License No. 871-C		Report for Year Ended 9/30/2017				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	65	65			65	65			65	65		
B. On last day of THIS report period	65	65			65	65			65	65		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	60	60			60	60			60	60		
B. As of midnight of THIS report period	49	49			60	60			49	49		
3. Total Number of Days Care Provided During Period												
A. Medicare	3,248	3,248			2,542	2,542			706	706		
B. Medicaid (Conn.)	12,725	12,725			9,873	9,873			2,852	2,852		
C. Medicaid (other states)												
D. Private Pay	4,973	4,973			3,510	3,510			1,463	1,463		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	20,946	20,946			15,925	15,925			5,021	5,021		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. <b>Total Resident Days (3G + 4A + 4B)</b>	20,946	20,946			15,925	15,925			5,021	5,021		

### Schedule of Resident Statistics (Cont'd)

Name of Facility Portland Care and Rehabilitation Centre, Inc.	License No. 871-C	Report for Year Ended 9/30/2017	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)				

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	5	30		14				
Per Diem Rate								
a. One bed rm.	Various		223.53	398.00				
b. Two bed rms.	Various		223.53	365-387				
c. Three or more bed rms.	MN/A		N/A	N/A				

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	223	223		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	28	28		
<b>D. Total Physical Therapy Treatments</b>	<b>251</b>	<b>251</b>		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	173	173		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	39	39		
<b>D. Total Speech Therapy Treatments</b>	<b>212</b>	<b>212</b>		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	179	179		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	30	30		
<b>D. Total Occupational Therapy Treatments</b>	<b>209</b>	<b>209</b>		

### Report of Expenditures - Salaries & Wages

Name of Facility Portland Care and Rehabilitation Centre, Inc.	License No. 871-C	Report for Year Ended 9/30/2017	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
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	156,429	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	322,536	9,419				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	253,045	17,244				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	103,595	8,907				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	155,111	6,173				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	45,241	4,324				
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	132,292	2,305				
b. RN						
1. Direct Care	672,422	17,851				
2. Administrative**	77,224	2,027				
c. LPN						
1. Direct Care	328,372	10,383				
2. Administrative**						
d. Aides and Attendants	803,944	54,478				
e. Physical Therapists	299,514	6,333				
f. Speech Therapists						
g. Occupational Therapists	221,074	6,912				
h. Recreation Workers	158,841	4,168				
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	44,105	2,075				
n. Marketing						
o. Other (Specify) See Attached Schedule	-2,449					
<i>A-13. Total Salary Expenditures</i>	<i>3,771,296</i>	<i>154,677</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 of Other Salaries and Wages (Page 10)**

Position	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Paid Time off Accrual	\$ (2,449)					
<b>Total</b>	\$ (2,449)	-	\$ -	-	\$ -	-

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

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



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

Name of Facility				License No.	Report for Year Ended				Page	of
Portland Care and Rehabilitation Centre, Inc.				871-C	9/30/2017				11	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section I - Operators/Owners</b>										
George Yuska	156,429				Administrator	2,080	A2	N/A		
Gerald Yuska	156,429				Office Manager	2,080	A4	N/A		
<b>Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).</b>										
Constance Yuska	103,886				Recreation Director/Social Service	2,080	12H	N/A		

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended				Page	of
Portland Care and Rehabilitation Centre, Inc.				871-C	9/30/2017				12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section III - Administrators***</b>										
George Yuska	156,429				Administrator	2,080		N/A		
<b>Section IV - Assistant Administrators</b>										

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

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

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

**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended	Page	of		
Portland Care and Rehabilitation Centre, Inc.	871-C	9/30/2017	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian	15,554	259				
2. Dentist	2,820	60				
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	21,600	445				
b. Utilization Review (Title 18 and 19 only) monthly meeting	300	3				
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>40,274</b>	<b>767</b>				

\* 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 Portland Care and Rehabilitation Centre, Inc.		License No. 871-C		Report for Year Ended 9/30/2017	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Debra Weeks Jameson, Middlefield CT	Dietician	<input type="radio"/>	<input checked="" type="radio"/>			
LTC Management, Prospect CT 06712	Dental Consultant	<input type="radio"/>	<input checked="" type="radio"/>			
Dr Matthew Raider, Portland CT	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
Dr. Otto Weis, Portland CT	Utilization Review	<input type="radio"/>	<input checked="" 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"/>			
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		<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.  
 \*\* 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
Portland Care and Rehabilitation Centre, Inc.	871-C	9/30/2017		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 127,423	127,423			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 67,781	67,781			
4. Social Security (F.I.C.A.)	\$ 278,093	278,093			
5. Health Insurance	\$ 138,687	138,687			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$				
8. Uniform Allowance	\$				
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ (1,407)	(1,407)			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$				
d. Accounting and Auditing	\$ 14,020	14,020			
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 24,694	24,694			
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$				
g. Office Supplies	\$ 32,727	32,727			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 14,510	14,510			
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	\$ 384,771	384,771			
<b>Subtotal</b>	\$ 1,081,299	1,081,299			

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

(Carry Subtotals forward to next page)



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

Name of Facility	License No.	Report for Year Ended	Page	of
Portland Care and Rehabilitation Centre, Inc.	871-C	9/30/2017	16	37
Item	Total	CCNH	RHNS	(Specify)
<b>Subtotals Brought Forward:</b>	1,081,299	1,081,299		
1. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$ 5,244	5,244		
3. Gifts to Staff and Residents	\$			
4. Employee Travel	\$			
5. Education Expenses Related to Seminars and Conventions	\$ 2,358	2,358		
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$ 3,058	3,058		
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> )***	\$			
3. Advertising Other ( <i>Specify</i> )***	\$ 1,137	1,137		
See Attached Schedule				
4. Fund-Raising***	\$			
5. Medical Records	\$			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$			
7. Postage	\$ 2,772	2,772		
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> )	\$			
See Attached Schedule				
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$ 119	119		
10. Contributions***	\$ 222	222		
See Attached Schedule				
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$ 14,816	14,816		
12. Administrative Management Services**	\$			
13. Other ( <i>Specify</i> )	\$ 81,114	81,114		
See Attached Schedule				
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 1,192,139	1,192,139		

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

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

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

**Schedule of Other Travel and Entertainment**

Description	CCNH	RHNS	(Specify)
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
Advertising of Med Bags	\$ 399		
Marketing	\$ 738		
<b>Total Other Advertising</b>	\$ 1,137	\$ -	\$ -

**Schedule of Dues**

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

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
Great Path	\$ 50		
American Heart Assoc	\$ 172		
<b>Total Contributions</b>	\$ 222	\$ -	\$ -

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
Bank Service Charges	\$ 80		
Computer Services	\$ 29,478		
Gas for Truck	\$ 5,646		
Licenses and Permits	\$ 990		
Payroll Services	\$ 14,228		
Penalties	\$ 8,307		
Other Travel and Ent	\$ 22,385		
<b>Total Other Administrative and General</b>	\$ 81,114	\$ -	\$ -



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

Name of Facility Portland Care and Rehabilitation Centre, I	License No. 871-C	Report for Year Ended 9/30/2017	Page 17 of 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

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

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

Name of Facility Portland Care and Rehabilitation Centre, Inc.	License No. 871-C	Report for Year Ended 9/30/2017	Page 18	of 37
<b>Item</b>	<b>Total</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 209,569	209,569		
2. Non-Food Supplies	\$ 19,132	19,132		
3. Other (Specify) _____	\$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$			
c. Management Services**	\$			
d. Other (Specify) _____	\$			
<b>2E. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 228,701</b>	<b>228,701</b>		
<b>2F. Dietary Questionnaire</b>	<b>Total</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
G. Resident Meals: Total no. of meals served per day:*				
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 Portland Care and Rehabilitation Centre, Inc.		License No. 871-C	Report for Year Ended 9/30/2017	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)	\$			
	c. Management Services**	\$			
	d. Other (Specify) Purchased Linens	\$	8,107	8,107	
3E.	<b>Total Laundry Expenditures</b> (3a + b + c + d)	\$	8,107	8,107	
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	
Portland Care and Rehabilitation Centre, Inc.	871-C	9/30/2017	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. \$	11,118	11,118		
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. Management Services*		\$			
d. Other ( <i>Specify</i> )		\$			
<b>4E. Total Housekeeping Expenditures (4a + b + c + d)</b>		\$ 11,118	11,118		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Value RX Pharmacy	\$	86,411	86,411		
b. Medicine Cabinet Drugs	\$	7,369	7,369		
c. Medical and Therapeutic Supplies	\$	96,457	96,457		
d. Ambulance/Limousine***	\$	14,872	14,872		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	14,851	14,851		
f. X-rays and Related Radiological Procedures***	\$	4,343	4,343		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$	6,771	6,771		
i. Recreation	\$	8,421	8,421		
j. Other (Specify)**** See Attached Schedule	\$	18,966	18,966		
<b>5K. Total Resident Care Expenditures (5a - 5j)</b>		\$ 258,461	258,461		

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

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

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

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

**Schedule of Other Resident Care**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
PT Supplies	\$ 6,840		
Social Services Supplies	\$ 12		
Part B Medical Expenses (Self Disallow)	\$ 12,114		
<b>Total Other Resident Care</b>	\$ 18,966	\$ -	\$ -

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

Name of Facility Portland Care and Rehabilitation Centre, Inc.			License No. 871-C		Report for Year Ended 9/30/2017			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
Carol Jensen	20 Court Street, Cromwell CT 06416	<input type="radio"/>	<input checked="" type="radio"/>		MDS Consulting and Coverage	2,120				
A/R Solutions	Wallingford CT	<input type="radio"/>	<input checked="" type="radio"/>		Billing Services	1,499				
Portland Citgo	Portland CT	<input type="radio"/>	<input checked="" type="radio"/>		Storage Units rented by facility	3,203				
A&A Office Supplies	Middletown CT	<input type="radio"/>	<input checked="" type="radio"/>		Copier Service Contract- Charge per copy	4,777				
Act Group	Cromwell CT	<input type="radio"/>	<input checked="" type="radio"/>		Copier Service Contract- Charge per copy	3,217				
		<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"/>							

\* 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
Portland Care and Rehabilitation Centre, Inc.	871-C	9/30/2017			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 171,150	171,150				
b. Heat	\$ 15,094	15,094				
c. Light & Power	\$ 83,244	83,244				
d. Water	\$ 37,337	37,337				
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$					
f. Other ( <i>itemize</i> )	\$ 34,618	34,618				
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$ 341,443</b>	<b>341,443</b>				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$ 27,287	27,287				
b. Building & Building Improvements	\$ 63,081	63,081				
c. Non-Movable Equipment	\$ 13,865	13,865				
d. Movable Equipment	\$ 11,882	11,882				
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$ 116,115</b>	<b>116,115</b>				
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$ 4,174	4,174				
c. Leasehold Improvements	\$					
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$ 4,174</b>	<b>4,174</b>				
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	\$ 63,761	63,761				
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$					
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$ 184,050</b>	<b>184,050</b>				

\* 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**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
Cable for Residents (Self Disallow)	\$ 16,932		
Exterminating	\$ 627		
Hazardous Waste Disposal	\$ 277		
Elevator Services	\$ 5,106		
Rubbish Removal	\$ 10,023		
Snow Removal	\$ 1,657		
Plant Other	\$ (4)		
<b>Total Other Repairs and Maintenance</b>	\$ 34,618	\$ -	\$ -

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Portland Care and Rehabilitation Centre, Inc.  
9/30/2017

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

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

\*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
<b>Additions:</b>				
4/27/2017	Fire Alarm System	\$ 23,406	40	\$ 260
10/1/2016	Kitchen Doors	\$ 4,052	39	\$ 104
5/2/2017	Dynalock Doors	\$ 8,094	40	\$ 68
<b>Total additions for Building Improvements</b>		\$ 35,552		\$ 432 *
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
<b>Total additions for Non-Movable Equipment</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
4/19/2017	Nursing Station Computers	\$ 8,899		\$ 371
5/18/2017	Office Computers	\$ 6,407		\$ 214
<b>Total additions for Movable Equipment</b>		\$ 15,306		\$ 585 *
<b>Deletions:</b>				
<b>Total deletions for Movable Equipment</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
<b>Total additions for Leasehold Improvement</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Amortization Schedule\***

Name of Facility Portland Care and Rehabilitation Centre, Inc.			License No. 871-C		Report for Year Ended 9/30/2017			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							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1. Capitalized Financing Costs	9	2006	40	166,941		Straight Line	25	4,174	
2.									
3.									
B-4. Subtotal									4,174
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
<b>D. Total Amortization</b>									4,174

\* 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 Portland Care and Rehabilitation Cent	License No. 871-C	Report for Year Ended 9/30/2017	Page 25	of 37
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11. Property Questionnaire

**Part A**

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

Yes  No

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

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

Description	Total			
1. Date Land Purchased	01/01/69			
2. Date Structure Completed	09/30/71			
3. If <b>NOT</b> Original Owner, Date of Purchase				
4. Date of Initial Licensure	01/01/71			
5. Total Licensed Bed Capacity	65			
6. Square Footage	40,000			
7. Acquisition Cost				
a. Land	181,505			
b. Building	946,061			

**Part B - Owner and Related Parties**

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

1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	06/23/05			
c. Interest Rate for the Cost Year	575.00%			
d. Term of Mortgage (number of years)	40 Years			
e. Amount of Principal Borrowed	4,080,500			
f. Principal balance outstanding as of 02/10/2018	3,659,233			
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
g. Type of Financing (e.g., fixed, variable)	Fixed			
h. Date of Refinancing	04/25/17			
i. New Interest Rate	365.00%			
j. Term of Mortgage (number of years)	40			
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off	3,659,233			

**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
Portland Care and Rehabilitation Cen		871-C	9/30/2017			26	37
Item		Total	CCNH	RHNS	(Specify)		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$					
Name of Lender		Rate					
Berkaida Commercial Mortgage		3.65%					
Address of Lender							
118 Welsh RoadHorsham, PA 19044-2207							
2. Second Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
3. Third Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
4. Fourth Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount		\$					
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expense		186,292	186,292				
12 B7. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$ 186,292	186,292				

(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	
Portland Care and Rehabilitation C		871-C		9/30/2017			27	37
Item				Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:				186,292	186,292			
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. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)				\$ 186,292	186,292			
14. Insurance								
a. Insurance on Property (buildings only)				\$ 14,080	14,080			
b. Insurance on Automobiles				\$ 1,335	1,335			
c. Insurance other than Property (as specified above)								
1. Umbrella (Blanket Coverage)				\$				
2. Fire and Extended Coverage				\$				
3. Other (Specify)				\$ 112,352	112,352			
General Liability= 91,260.00 , HUD MIP= 21,092								
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$ 127,767	127,767			
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$ 6,349,648	6,349,648			

### D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Portland Care and Rehabilitation Centre, Inc.				871-C	9/30/2017	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	12G	Occupational Therapy	\$ 221,074	221,074		
4.			Other - See attached Schedule	\$ 260,405	260,405		
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.	15	1d	Accounting & Legal	\$ 104	104		
11.	22	6.f	Telephone	\$ 16,932	16,932		
12.	15	1h.2	Cellular Telephone	\$ 3,946	3,946		
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	\$ 22,385	22,385		
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m3	Unallowable Advertising *	\$ 738	738		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 19,172	19,172		
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 544,756	544,756		

\* All except "Help Wanted".

(Carry Subtotal forward to next page)

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



**Schedule of Other Salaries Adjustment**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	A2	]Administrator Salary (Related Party)	\$ 82,184		
10	A4	Gerald Yuska (Office Manager) Cap	\$ 115,382		
10	A12.h	Constance Yuska (Recreation/Social Services) Cap	\$ 62,839		
<b>Total Other Salaries Adjustment</b>			\$ 260,405	\$ -	\$ -

**Schedule of Fees Adjustments**

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

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
15	2	Delete	\$ 5,000		
16	AG	Penalties	\$ 8,307		
16	10	Contributions	\$ 222		
16	2	Staff Holiday Parties	5244		
16	Other	Advertising	399		
<b>Total Other A&amp;G Adjustments</b>			\$ 19,172	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
Portland Care and Rehabilitation Centre, Inc.				871-C	9/30/2017	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 544,756	544,756		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5.a.1	Prescription Drugs	\$ 86,411	86,411		
28.	20	5.d	Ambulance/Limousine	\$ 14,872	14,872		
29.	20	5.f	X-rays, etc	\$ 4,343	4,343		
30.	20	5.h	Laboratory	\$ 6,771	6,771		
31.	20	5.j	Medical Supplies	\$ 12,114	12,114		
32.	20	e.2	Oxygen (non emergency)	\$ 14,851	14,851		
33.	20	5.j	Occupational Therapy	\$ 6,840	6,840		
34.			Other - See Attached Schedule	\$ 8,433	8,433		
<b>Page 22 - Maintenance and Property</b>							
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	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$ 21,092	21,092		
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$			
<b>Not For Profit Providers Only</b>							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51.	<b>Total Amount of Decrease (Items 1 - 50)</b>			\$ 720,483	720,483		

\*\*\* 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.

Portland Care and Rehabilitation Centre, Inc.  
9/30/2017

**Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	J	Social Service Supplies	\$ 12		
20	I	Recreation Supplies	\$ 8,421		
<b>Total Other Ancillary Costs</b>			\$ 8,433	\$ -	\$ -

**Schedule of Excess Movable Equipment Depreciation**

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

**Schedule of Other Property Adjustments**

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

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

Schedule of Unallowable Building Interest

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

### F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Portland Care and Rehabilitation Centre, 871-C		9/30/2017		30	37
Item	Total	CCNH	RHNS	(Specify)	
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 2,835,699	2,835,699			
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> )	\$ 1,297,927	1,297,927			
b. Medicare Room and Board Contractual Allowance **	\$				
4. a. Private-Pay Residents and Other	\$ 2,210,964	2,210,964			
b. Private-Pay Room and Board Contractual Allowance **	\$				
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$				
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
2. a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$ 55,426	55,426			
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$				
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$				
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other ( <i>Specify</i> ) - Medicare	\$				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 6,400,016	6,400,016			
<b>IV. Other Revenue*</b>					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income ( <i>Specify</i> )	\$				
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 183	183			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 183	183			
<b>VI. Total All Revenue</b> (III +V)	\$ 6,400,199	6,400,199			

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

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

**Schedule of Other Resident Revenue - Medicare**

Related Exp

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

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

Related Exp

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

**Interest Income**

Account

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

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
	United Bank Accounts Interest	\$ 57		
	Dividend Income	\$ 85		
	Overpayment of Title Insurance	\$ 41		
<b>Total Other Revenue</b>		\$ 183	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Portland Care and Rehabilitation Centre	871-C	9/30/2017	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	285,139
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	142,319
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	132,608
a. Prepaid Property Taxes	20,349			
b. Prepaid Building Insurance	94,682			
c. Prepaid Mtg Insurance	17,577			
d.				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	21,216
Undeposited Funds	5,982			
State Owed Money	425			
Residents Funds	12,546			
Prepaid Elevator Services	2,263			
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	581,282
B. Fixed Assets				
1. Land			\$	181,505
2. Land Improvements	*Historical Cost	666,455	\$	222,614
	Accum. Depreciation	443,841	Net	
3. Buildings	*Historical Cost	3,577,501	\$	1,860,394
	Accum. Depreciation	1,717,107	Net	
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	166,844	\$	78,578
	Accum. Depreciation	88,266	Net	
6. Movable Equipment	*Historical Cost	407,019	\$	35,481
	Accum. Depreciation	371,538	Net	
7. Motor Vehicles	*Historical Cost	36,360	\$	(6,278)
	Accum. Depreciation	42,638	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	266,623
HUD replacement reserve	146,980			
Financing Costs	119,643			
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	2,638,917

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

(Carry Total forward to next page)

### G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Portland Care and Rehabilitation Centre	871-C	9/30/2017	32	37
Account			Amount	
Total Brought Forward:			\$	3,220,199
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
3. Buildings			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
4. Non-Movable Equipment			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
5. Movable Equipment			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
6. Motor Vehicles			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 <b>Total Leasehold or Like Properties</b> (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> )			\$	
_____				
_____				
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$	3,220,199

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



### G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Portland Care and Rehabilitation Centre, Inc.	871-C	9/30/2017	33	37
Account			Amount	
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable			\$	184,545
2. Notes Payable ( <i>itemize</i> )			\$	13,138
Capital One Card			212	
Home Depot Card			690	
Bank of America Card			12,236	
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> )			\$	65,163
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )			\$	
6. Accrued Payroll Taxes Payable			\$	5,484
7. Medicare Final Settlement Payable			\$	
8. Medicare Current Financing Payable			\$	
9. Mortgage Payable ( <i>Current Portion</i> )			\$	72,140
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )			\$	
11. Accrued Income Taxes*			\$	
12. Other Current Liabilities ( <i>itemize</i> )			\$	222,769
User Fee Payable			90,722	Accrued Paid Time Off 117,240
401K Payable			1,191	Resident Account 12,546
Unum Insurance payable			1,074	
Accrued Bonus Tax			(4)	
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>			<b>\$</b>	<b>563,239</b>

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

(Carry Total forward to next page)

**G. Balance Sheet (cont'd)**

Name of Facility Portland Care and Rehabilitation Centre, In		License No. 871-C	Report for Year Ended 9/30/2017	Page 34	of 37
Account				Amount	
Total Brought Forward:				563,239	
<b>Liabilities (cont'd)</b>					
B. Long-Term Liabilities					
1. Loans Payable-Equipment ( <i>itemize</i> )				\$	
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$ 3,610,853	
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$	
Name and Address of Lender	Amount	Loan Date			
Berkadia					
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$	
_____					
_____					
_____					
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 3,610,853	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 4,174,092	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Portland Care and Rehabilitation Cent	871-C	9/30/2017	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
<b>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	39,000
3. Paid-in Surplus			\$	631,000
4. Treasury Stock			\$	<i>(555,760)</i>
5. Cumulated Earnings			\$	<i>(1,118,683)</i>
6. Gain or Loss for Period			\$	50,550
	10/1/2016	thru	9/30/2017	
7. Total Net Worth			\$	<i>(953,893)</i>
<b>C. Total Reserves and Net Worth</b>			\$	<i>(953,893)</i>
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	3,220,199

### H. Changes in Total Net Worth

Name of Facility Portland Care and Rehabilitation Centre,	License No. 871-C	Report for Year Ended 9/30/2017	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2016			\$	(1,008,772)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	6,400,199
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	6,349,647
D. Net Income or Deficit			\$	50,552
E. Balance			\$	(958,220)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
JE#4 Correct Retained Earnings to PY			4,330	(3)
F-3. Total Additions			\$	4,327
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <b>Balance at End of Period</b>			\$	(953,893)
				09/30/17

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

Name of Facility Portland Care and Rehabilitation Centre,	License No. 871-C	Report for Year Ended 9/30/2017	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)		
<b>Preparer/Reviewer Certification</b>				
<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				
Ryan Turko				
Address			Phone Number	
333 Main Street, Portland CT 06480			60-342-0370	

Error Check

Level    Item

Reported as