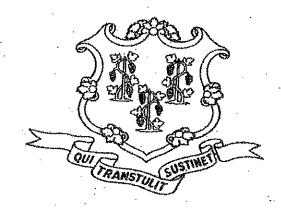
# **State of Connecticut**



# **Annual Report of Long-Term Care Facility**

Cost Year 2015

Name of Facility (as	licensed)		<u> </u>						
Spectrum Healthcare	e Derby, LLC d	/b/a Birmingha	am Health Cente	r					
Address (No. & Stre	et, City, State,	Zip Code)							
210 Chatifield Street	t, Derby, CT 06	418			•			•	
Type of Facility					,				
Chronic and (	Convalescent		Rest Home with	n Nursing	g				
☑ Nursing Hom	e only		Supervision onl	y		(Specify)			
(CCNH)			(RHNS)	•		`			
Report for Year Beg.	inning	*****	Report for Year	Ending					
10/1/2014			9/30/2015						
License Numbers:		CCNH	RHNS	(Specify)			Medicare Provider		
		2236-C					07-5059		
		I			,				
Medicaid Provider N	umbers:		CNH F		HNS		ICF-IID		
		10587						***************************************	
For Department Us	e Only						:		
Sequence Number	Signed and	Date	Sequence N	ımber	Cionada	and Mataulan	1	Data Danaissa d	
Assigned	Notarized	Received	Assigne	d	Signed	and Notarize	=CL	Date Received	
				.3					
	·	<u>.</u>			<u> </u>				

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#### General Information

	AVE HE TAKOT ARRESON			
Name of Facility (as licensed)	License No.	Report for Year Ended	Page	<b>O</b> :
Spectrum Healthcare Derby, LLC d/b/a Birmingham I	2236-C	9/30/2015	1	3′

#### Administrator's/Owner's Certification

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

I HERBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Spectrum Healthcare Derby, LLC d/b/a Birmingham Health Center [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)	2/	Date 2/11/16	Signed (Owner)	Date 2/4/16
Printed Name (Administrator) Robert Guastella			Printed Name (Owner) Sean Murphy	1 112
Subscribed and Sworn to before me:	State of Connecticet	Date 2/11/16	Signed (Notary Public)	Comm. Expires
Address of Notary Public  141 Vernan St W	lest M	Janch as	les, CF 06012	, -5 157 160.

(Notary Seal)

# State of Connecticut **Department of Social Services**

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	tm	ent		Page 1A	of 37
Name of Facility		Period Cov	ered:	From	То
Spectrum Healthcare Derby, LLC d/b/a Birmingham Health Cente	er			10/1/2014	9/30/2015
Address of Facility 210 Chatifield Street, Derby, CT 06418					
Report Prepared By		Phone Nun		Date	
Gennaro Evangelista		860-871-54	154	2/1/2016	
Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$				
2. Laundry wages paid	\$				
3. Housekeeping wages paid	\$				
4. Nursing wages paid	\$				
5. All other wages paid	\$				
6. Total Wages Paid	\$	,			
7. Total salaries paid	\$				
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$				

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.** 

State of Connecticut Annual Report of Long-Term Care Facility CSP-2 Rev. 10/2005

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

	Pho	ne No. of Fac	cility	Report for Yea	ar Ended	Page		of
		-735 <b>-</b> 7401		9/30/2015		2		37
Name of Facility (as shown on license)		Address (No	o. & i	Street, City, Sta	te, Zip)			
Spectrum Healthcare Derby, LLC d/b/a Birmingham Hea	alth C	210 Chatific	eld St	treet, Derby, CT	Ր 06418			
CCNH		RHNS		(Specify)		Medicare P	rovid	er No.
License Numbers: 2236-C	<u></u>		<u> </u>			07-5059		
Type of Facility (Check appropriate box(es))								
Chronic and Convalescent Nursing Home only (CCNH)		t Home with ervision only			(Specify)	)		
Type of Ownership (Check appropriate box)								
O Proprietorship O LLC O Partnership	0	Profit Corp.	0	Non-Profit Corp		Government	0	Trust
Ted :- Caliference of on along distingtion of year provide			Date	e Opened	Date Clo	sed		
If this facility opened or closed during report year provid	ic.							
Has there been any change in ownership					~~!!~~	1 . 6 11		
or operation during this report year?	_ 0	Yes	<u> </u>	No	If "Yes,"	explain fully	у	
Administrator				Nursing Ho	ma		·	
Name of Administrator				Administrate	1	0936		
Robert Guastella				License N		0300		
Other Operators/Owners who are assistant administrators	s (ful)	or part time	of the		<u> </u>			<del></del>
Name			·	License N	lo.:			
					l			
				<del></del>				
	· · ·		· .					
·								

# General Information and Questionnaire Partners/Members

Name of Facility		License No.	Report for Y	Page of	
Spectrum Healthcare Derby, I	I C d/h/a Rirmingham l	4	9/30/2015		3 37
Spectrum Heatincare Derby, I	AC (1/0/a Diriiningilaliki	12230	7730,2010	State(s) and	or Town(s) in
	1 1 T T W	Business	ممسادة		Registered
Legal Name of Part	inership/LLC				Cognitioned
Spectrum Healthcare Derby, I	LC d/b/a Birmingham	27 Nack Road,	vernon, C1	Derby, CT	
Health Center		06066			
· · · · · · · · · · · · · · · · · · ·					
31 CD of one / A form house	Business A	ddress		Title	% Owned
Name of Partners/Members	DGSHIOSS 71	aquoos			
			7 11 10	OFO.	65
Howard Dickstein	27 Naek Road, Vernor	ı, CT 06066	President &	CEO	0.5
•					
		GT 06066	VD. On supti	000	17.5
Brian Dickstein	27 Naek Road, Vernor	n, CI 06066	VP, Operati	0118	1,,,,,
	AM37 1 D 1 37	CT 0/0//	CFO		17.5
Sean Murphy	27 Naek Road, Vernor	n, C1 00000	Cro		1,.5
					1
				, <u>, , , , , , , , , , , , , , , , , , </u>	
				<del></del>	
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·					
·					
I	1		1		

State of Connecticut Annual Report of Long-Term Care Facility CSP-3A Rev. 10/2005

# **General Information and Questionnaire Corporate Owners**

Name of Facility	License No.	Report for Year En	ded	Page of
Spectrum Healthcare Derby, LLC d/b/a Birm	2236-C	9/30/2015		3A 37
If this facility is owned or operated as a corpo	oration, provide th	e following informa	tion:	
Legal Name of Corporation		s Address	State(s) in Whi	ch Incorporated
				No. Shares
Name of Directors, Officers	Busines	s Address	Title	Held by Each
·				•
	•			
			<b> </b>	
· · · · · · · · · · · · · · · · · · ·				
Names of Stockholders Owning at Least	Į			
10% of Shares				
			:	
	and the second second			
·				
·				<u> </u>
	[			

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-3B Rev. 10/2005

# General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Spectrum Healthcare Derby, LLC d/b/a Birmingha	2236-C	9/30/2015	3B	37
If this facility is owned or operated as an individua	l proprietorship, p	rovide the following informat	ion:	
Owi	ner(s) of Facility			
	<del></del>			
-				
			<del></del>	
		<b></b>		
	44			
			-	·

State of Connecticut
Annual Report of Long-Term Care Facility
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# General Information and Questionnaire Related Parties\*

Name of Facility Spectrum Healthcare De	Name of Facility Spectrum Healthcare Derby, LLC d/b/a Birmingham H	License No. 2236	e No. 2236-C	Re 9/:	Report for Year Ended 9/30/2015		Page 4	of 37
Are any individuals rece marriage, ability to conti	Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?	icility rel	mg	O Yes	es © No	If "Yes," provide the Name/Address and complete the information on Page 11 of the report.	e Name/Add	ress and ge 11 of the report.
Are any individuals or c including the rental of p related through family a association to any of the	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?	or service to this facontrol, of this fa	cility, or busines, cility?	Ø	⊙ Yes O No	If "Yes," provide the following information:	e following	information:
								<del></del>
		Alsc	Also Provides		AND THE RESERVE OF THE PROPERTY OF THE PROPERT	Indicate Where		
Name of Related	Business	Non-Re	Goods/Services to Non-Related Parties	 မ	Description of Goods/Services	in Annual Report	Cost	Actual Cost to the
Individual or Company	Address	Yes	No %**	*	Provided	Page #/Line#	Reported	Related Party
Spectrum Healthcare, LLC	27 Naek Rd., Vernon, CT 06066	0	•	Ho	Home office costs consisting admin., clerical Page 16 Line m. 12	Page 16 Line m. 12	360,000	360,000
Spectrum Derby Realty, LLC	27 Naek Rd., Vernon, CT 06066	0	•	Re	Rental of real estate	Page 22, line 9	720,000	720,000
Spectrum Healthcare Torrington	225 Wyoming Ave Torrington, CT	0	•	Š	Social Services	Page 33 Line A12	3,770	3,770
Spectrum Healthcare Torrington	225 Wyoming Ave Torrington, CT	0	•		MDS	Page 10 Line al 2b2	539	539
Spectrum Healthcare Torrington	225 Wyoming Ave Torrington, CT	0	•	Ď	Dietician	Page 10 Line a5a	799	99T
		0	0					
		0	0					
		0	0					
		0	0		9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9			
				$\left  \right $				

<sup>\*</sup> Use additional sheets if necessary.

<sup>\*\*</sup> Provide the percentage amount of revenue received from non-related parties.

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

Name of Facility	License No	).	Report for Year Ended	Page	of
Spectrum Healthcare Derby, LLC d/b/a Birmin			9/30/2015	5	37
If the facility is licensed as CDH and/or RCH o	r provides A	AIDS or TB	I services with special Medical	d rates,	costs
must be allocated to CCNH and RHNS as follow	ws:				
Item			Method of Allocation		
Dietary	,	Number of	meals served to residents		
Laundry			pounds processed		
Housekeeping			square feet serviced		
		Number of	hours of routine care provided	by EAC	CH
Nursing		employee o	classification, i.e., Director (or	Charge [	Nurse),
		Registered	Nurses, Licensed Practical Nu	rses, Ai	des and
		Attendants			
Direct Resident Care Consultants			hours of resident care provide	d by EA	.CH
		specialist (	(See listing page 13)		
Maintenance and operation of plant		Square feet	Ė		
Property costs (depreciation)		Square fee	t		
Employee health and welfare		Gross salaı	ries		
Management services			e cost center involved		
All other General Administrative expenses			rect and Allocated Costs		
The preparer of this report must answer the foll	owing ques	tions applic	able to the cost information pr	ovided.	
1. In the preparation of this Report, were all			If "No," explain fully why suc	h alloca	ition was
costs allocated as required?	• Yes	O No	not made.		
2. Explain the allocation of related company ex	menses and	attach conv	of appropriate supporting dat	a.	
Z. Explain the anocation of related company of	iponous arre	····			
_					
<b>:</b>					
3. Did the Facility appropriately allocate and so	elf-disallow	direct and	indirect costs to non-nursing h	ome cos	t centers?
(e.g., Assisted Living, Home Health, Output	ient Service	s. Adult Da	v Care Services, etc.)		
(c.g., Assisted Diving, Home Health, Output			If "No," explain fully why su	ch alloc:	ation was
	• Yes	O No	not made.		2011 Was

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# General Information and Questionnaire Leases (Excluding Real Property)

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

	ear Ended Page of	9			Annual		Lease of Lease Claimed		77.00								<del></del>
	Report for Year Ended	9/30/2015				Date of	Lease**										_
	License No,	2236-C	The second secon				Description of Items Leased										
		m Health	Related * to	Owners,	Operators,	Officers	No	0	0	0	0	0	0	0	0	0	
		rmingha	Rela	Ó	Ope	Ŏ Ö	Yes	0	0	0	0	0	0	0	0	0	
should not be included in these amounts.	Name of Facility	Spectrum Healthcare Derby, LLC d/b/a Birmingham Health					Name and Address of Lessor										

Is a Mileage Log Book Maintained for All Leased Vehicles?

O Yes

Total \*\*\*

% 0

\* 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	License No.	Report for Year Ended		Page	of
Spectrum Healthcare Derby, LLC d	4	9/30/2015		7	37
The records of this facility for the p	eriod covered by this report	were maintained on the following basis:			
	Modified Cash			<u>, , , , , , , , , , , , , , , , , , , </u>	
Is the accounting basis for this			,		
	Yes	If "No," explain.			
F	No				<u>,,,,,,,,,,,,,,,,</u>
Independent Accounting Firm		and the second s		.,	
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)			
1 Blum, Shapiro & Company		29 So. Main St., W Hartford, CT 06127			
2 MidCap Funding		,			
3					
4					
Services Provided by This Firm (de.	scribe fully)			17.000	
<ol> <li>Reviewed Financial Statements, Tax 1</li> </ol>	return preparation		\$	17,000	
2 Due Diligence Exam				19,048	
3			\$		
4	<u></u>		\$		
			Charge fo	r Services F	rovided
			\$	36,048	
Are These Charges Reflected in the Expens	diture Portion of This Report? If	es, Specify Expense Classification and Line No.			
	Page 15, Line 1 d.				
Legal Services Information	<u> </u>				
Name of Legal Firm or Independent	t Attorney		Telephon	e Number	
1 Robinson & Cole LLC					
2 American Arbitration Associate	es/Treasurer State of CT/Dea	by Probate Court			
3 Michalik, Bauer, Silvia/Carmo					
4 MidCap Funding	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	•	İ		
5 Krasnoger & Krasnogor					
Address (No. & Street, City, State,	Zip Code)				
1 280 Trumbell St. Hartford, CT					
2					
3 4					
5 706 Bedford St. Stamford, CT	06901				
Services Provided by This Firm (de	escribe fully)				
1 General Labor			\$	293	
2 Arbitration/Conservator Fees			\$	1,045	
3 Collection Matters			\$	7,138	
4 Loan Amendments			\$	5,010	
5 Immigration Matter			\$	1,030	
			Charge fo	or Services I	Provided
			\$	14,515	-41
Are These Charges Reflected in the Expen  O Yes O No	diture Portion of This Report? If Page 15, Line 1 e.	Yes, Specify Expense Classification and Line No.	,		
O TES O NO					

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 9/2002

# Schedule of Resident Statistics

Spectrum Healthcare Derby, LLC d/b/a Birmingham Health Center	Health Ce	nter	License No 2236	e No. 2236-C			Report for 9/30/2015	Report for Year Ended 9/30/2015	궁		Page 8	of 37
					1	Period 10/1 Thru 6/30	1 Thru 6/	30		Period 7/1	Thru 9/30	0
	Total All	Total CCNH	Total RHNS	Total								
	Levels	Level	Level	(Specify)	Total	CCNH	RHNS	(Specify)	Total	CCNH	RHINS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	120	120			120	120			120	120		
B. On last day of THIS report period	120	120			120	120			120	120		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	110	110			110	110			118	118		
B. As of midnight of THIS report period	601	109			811	118			109	109		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,362	2,362			1,733	1,733	·		629	629		
B. Medicaid (Conn.)	32,429	32,429			24,038	24,038			8,391	. 8,391		
C. Medicaid (other states)												
D. Private Pay	1,612	1,612			1,232	1,232			380	380		
E. State SSI for RCH												
F. Other (Specify)	3,744	3,744			2,794	2,794			950	950		
G. Total Care Days During Period (3A thru F)	40,147	40,147			161,62	29,797			10,350	10,350		
Total Number of Days Not Included in Figures in 3G 4. for Which Revenue Was Received for Reserved												
Beds												
A. Medicaid Bed Reserve Days	2	2			2	2						
B. Other Bed Reserve Days	25	25			17	17			8	00		
5. Total Resident Days (3G+4A+4B)	40,174	40,174			29,816	29,816			10,358	10,358		

# Annual Report of Long-Term Care Facility

CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Faci	ility			Lice	nse No.				Repor	t for Year	Ended		Page	of
Spectrum He	althcare	Derby,	LLC d/b/a Birm	2	236-C					9/30/201	5		9	37
		-	in the certified		apacity d	uring 1	the rep	ort yea	ar?	0	Yes	0	No	
			f Change	I		nange	in Bed	e	•	Ca	nacity Afi	ter Change	1	
Date of		RHNS	(Specify)	<b>-</b>	Lost	idiigo	1	Gaine	<u></u>	- VA	Datoley 1 km	lor Change	1	
	CCIVII	KIIVS	(Бреспу)	<u> </u>	TYOSE		ļ	Janic	<u> </u>	1				
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	Reason f	or Change
	`			<u> </u>				<u> </u>				1 3/		
	ļ													
	<u> </u>	<b></b>	,,,,			لــــا							İ	
5. If there v	was any	change	in certified bed	capac	ity during	g the r	eport y	ear (a	s repor	ted in iter	n 4 above	) provide the nu	ımber of	
	_		90 days followir	_				`	•			•		
				<u> </u>								T		
			Change in Re	esider	t Days					cc	NH	RHNS	(Spe	cify)
1st chang	ge				,									
2nd chan														
3rd chan														
4th chan		1	I.D. C. C.	1	20 - 60	-4.57							J	
6. Number	or Resid	ients and	d Rates on Septe Medicare	ember	Medi		ar	F		S <sub>0</sub>	lf-Pay		Other Sta	te Assisted
		ŀ	Wedicare		IVICUI	Lasu				1 30	ii-i ay	T	Other Sta	to 7 tablatou
	Item	- 1	CCNH	C	CNH	RF	INS	רכ	NH	RH	INS	(Specify)	R.C.H.	ICF-MR
No. of Re			11		86		шю		12	ICC	1140	(Specify)	I.C.III	104 21120
Per Dien														
a. One b			various		241.97	•	435.00							
b. Two b	oed rms.	,	various		241.97		410.00							
c. Three		,												
bed r	ms.													
													-	
7 Total Nu	mhan af	Dhygios	I Therapy Treat	manta			•			TO:	rat	CCNH	RHNS	(Specify)
	Medica			itteitte	•					10.	4,069	4,069	KILIAS	(apecity)
			usive of Part B)											
			Treatments							What had the second	662	662		
		orative '	Treatments	,										
	Other										588	588		
			Therapy Treatm		-		·				5,319	S,319		
	mber of Medica		Therapy Treatm	ents							219	219		
			usive of Part B)											
			Treatments								44	44	NAMES OF TAXABLE PROPERTY.	TOTAL COMPANY OF THE STREET, S
			Freatments											
	Other										19	19		
			herapy Treatme								282	282		
			tional Therapy	Creatn	nents									
	Medica										3,792	3,792		rankés diament
			usive of Part B) Treatments								Minimus Image	450		
			reatments				· · · · · · · · · · · · · · · · · · ·				458	458		
	Other		L = ~4452A1V48\$17					·····			634	634		
		ccupatio	onal Therapy T	reatm	ents						4,884	4,884		
******	~~~~	_	^~	· · · · · · · · · · · · · · · · · · ·					·					

#### **Annual Report of Long-Term Care Facility**

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

	xpenditures	- Salali	cs ox wagi	es		*******
Name of Facility	License No.		Report for Yea	r Ended	Page	of
Spectrum Healthcare Derby, LLC d/b/a Birmingham Heal	th 2236-C		9/30/2015		10	37
Are time records maintained by all individuals receiving c	ompensation?	•	Yes	0	No	***************************************
	_		Total Cost a			
	1036	ł	I otai Cost a	na Hours	1	
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*		266	TO THE STATE OF	2041-4	P S SUBS	110013
<ol> <li>Operators/Owners (Complete also Sec. I</li> </ol>						
of Schedule A1)						
Administrator(s) (Complete also Sec. III						
of Schedule A1)	124,640	2,079				
3. Assistant Administrator (Complete also Sec. IV						
of Schedule A1)	Sananovo verse					
4. Other Administrative Salaries (telephone	175.00					
operator, clerks, receptionists, etc.)  5. Dietary Service	175,927					
a. Head Dietitian	33,800					
b. Food Service Supervisor	53,925					
c. Dietary Workers	357,580	25,203				
Housekeeping Service						
a. Head Housekeeper					AT A PARTICULAR OF THE PARTICU	221112222222
b. Other Housekeeping Workers	200200000000000000000000000000000000000	100000000000000000000000000000000000000				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance b. Other Maintenance Workers	71,296	2,126				
8. Laundry Service	56,992	3,245				CS CHOOSE VALUE
a. Supervisor						PERSONAL PROPERTY OF THE PERSON PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY P
b. Other Laundry Workers						
Barber and Beautician Services				·		
10. Protective Services			-			*******
11. Accounting Services						
a. Head Accountant						
b. Other Accountants 12. Professional Care of Residents			DAOLVONUS SINCE O SOCIETO			
· · · · · · · · · · · · · · · · · · ·						
Directors and Assistant Director of Nurses     B. RN	222,879	4,984		service continues	in a second second second second second second second second second second second second second second second	\$550 555 \$155 \$155 \$155 \$200
1. Direct Care	456.262	11 244				
2. Administrative**	456,262 228,786	11,346 6,326				
c. LPN						
1. Direct Care	1,135,372	36,492				
2. Administrative**						
d. Aides and Attendants	1,538,016	95,120				
e. Physical Therapists						- Live
f. Speech Therapists						21/24-
g. Occupational Therapists h. Recreation Workers	100 100					-
i. Physicians	106,198	5,319				
1. Medical Director	THE REAL PROPERTY.					
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists	<del>  </del>					
k. Pharmacists I. Podiatrists	<del>                                     </del>					
m. Social Workers/Case Management	121,202	A (71				
n. Marketing	121,202	4,671				
o. Other (Specify)						i i salah sa
See Attached Schedule	60,947	4,115	nerowanie wie der Gereichte gegen ge	areministrati		
A-13. Total Salary Expenditures	4,743,822	210,221				

<sup>\*</sup> 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.

<sup>\*\*</sup> 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.

<sup>\*\*\*</sup> 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)

	CCI	NH	RI	ANS	(Spec	ify)
Position	\$	Hours	\$	Hours	\$	Hours
Scheduler	\$ 31,071	2,089				
Medical Records	\$ 29,876	2,026				
					32 01265	
Cotol	\$ 60,947		<b>S</b>			

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

	CC	NН	RH	INS	(Spec	ify)
Service	\$	Hours	\$	Hours	\$	Hours
Total	15		8		\$	
			bi serimum 0 - promin	161610100000000000000000000000000000000	Hercens are supply to a series	can a company a construction

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

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

		J	rosroran	omerimment i	rossistant rannusuators and Omes Negator Falties.	Nelate	ע ד מונוכט			
Name of Facility				License No.		Report for	Report for Year Ended		Page	of
Spectrum Healthcare Derby, LLC d/b/a Birmingham Health Center	d/b/a Birmi	ngham Hea	Ith Center	2236-C		9/30/2015			11	37
			-							
		Salary Faid		Fringe Benefits						•
				and/or Other	Enll Desoriation of	Total	Line Where	Nome and Addustry of All	Total	
Name	CCNH	RHINS	(Specify)	(describe fully)	Services Rendered	Worked	Page 10	Other Employment**	Worked	Received
Section I - Operators/Owners						·				
					-		****			
Annually (***)										
							:			
	-									
Section II - Other related										
parties of Operators/Owners										
employed in and paid by										1.0
facility (EXCEPT those who			•				-			
Assistant Administrators who										
are identified on Page 12),				·•···						
The state of the s										
						· · · · · · · · · · · · · · · · · · ·				
				,						
						· · · · · · · ·				
A STATE OF THE PERSON NAMED OF THE PERSON NAME		-								

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

<sup>\*\*</sup> Include all employment worked during the cost year.

State of Connecticut

Annual Report of Long-Term Care Facility CSP-12 Rev. 10/2005 Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties\*

		1	ALC LA LA VINEAL	TATTITION TO	A ABBIDITATION AND COMPANION OF ALLICS	ろさら	י מוונט			,
Name of Facility (as licensed)				License No.		Report for Year Ended	ear Ended		Page	Ju
Spectrum Healthcare Derby, LLC d/b/a Birmingham Health Center	d/b/a Birmi	ngham Hea	Ith Center	2236-C		9/30/2015			12	7.
		Colomy Doid	-							
		Salaly rai								
				Fringe Benefits and/or Other		Total	Line Where		Total	•
,	{	;	,	Payments	Full Description of	Hours	~	Name and Address of All	Hours	Compensation
Name	CCNH	KHINS	(Specify)	(describe fully)	Services Rendered	Worked	Page 10	Other Employment**	Worked	Received
Section III - Administrators***										
Robert Guastella 10/01/14- 09/30/15	124,640					2 079 42	٨2			
						4,017	72			
Section IV - Assistant Administrators										
								The state of the s		
		_								
*No allowance for salaries will be considered unless full information is	be conside	red unless f	1,11 informatio	sal 1 les	provided Hise additional sheets if required	mired				

'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.

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

ame of Facility	License No.		Report for Y	ear Ended	Page	of   37
pectrum Healthcare Derby, LLC d/b/a Birmingham	2236	5-C	9/30/2015		13	31
			Total Cost	and Hours	Т	Γ
	COMIT	TTana	RHNS	Hours	(Specify)	Hours
<u>Item</u>	CCNH	Hours	KTHAD	110416		
B. Direct care consultants paid on a fee						
for service basis in lieu of salary						
(For all such services complete Schedule B1)  1. Dietitian						
Dietitian     Dentist						
3. Pharmacist	9,376	125				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	246,547	4,110	<u> </u>	<u></u>		<del> </del>
b. Other						ļ
6. Social Worker				<u> </u>		<del> </del>
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	64,209	856				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting	89,454	1,192			<del> </del>	
c. Resident Care**		D. ALGERTANIA				
d. Administrative Services facility						ii orang manahatan
Infection Control Committee     (Quarterly meetings)						
2. Pharmaceutical Committee						1
(Quarterly meetings)				<u> </u>		<del> </del> -
3. Staff Development Committee			1		Į	
(Once annually)						
e. Other (Specify)			A PARTICIPATION OF THE PROPERTY OF THE PARTICIPATION OF THE PARTICIPATIO	2 22 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
9. Speech Therapist						
	31,843	424	R WANTE STATEMENT OF THE PARTY	H- XXXXXXX		
a. Resident Care  b. Other						er sveissninnssol
10. Occupational Therapist						
a. Resident Care	257,715	4,296				<u> </u>
b. Other				***		
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	122,315	2,224	<u> </u>			
2. Administrative***						
b. LPN						AND DESCRIPTION OF THE PARTY OF
1. Direct Care	33,398	742				
2. Administrative***	<u> </u>	<u> </u>				+
c. Aides	100	4				<del> </del>
d. Other						
0.1 /0 10 \						renderaturatura grant
12. Other (Specify) See Attached Schedule	20213040370000	Discrete Company	ATT THE PARTY OF T		1	Į.

<sup>\*</sup> 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.

<sup>\*\*</sup> 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	License No.		Report for Y 9/30/2015	ear Ended	Page 14		of 37
Spectrum Healthcare Derby, LLC d/b/a Birr Name & Address of Individual	Full Explanation of Service		* to Owners, rs, Officers	Expla	nation of	Relatio	
		Yes	No				
Carlos Schweitzer, MD-300 Seymour Ave., Derby, CT 06418	Medical Staff	0	•				
The Nurse Network-5 Central Ave., E Hartford, CT 06150	Pool Nursing	0	•				
Pharamerica, PO Box 409251, Atlanta, GA 30384	Pharmacy Consultant	0	•				
Dr. Lionel Lim-Griffin Hospital-130 Division St., Derby, CT 06418	Medical Director	0	0		·····		
Select Rehabilitation, Inc., 550 Frontage Rd., Suite 2415 Northfield, IL 60093	Contract Therapy	0	0				
Dr. Joseph Brenes-The Hospitalist Company-PO Box 844929, Los Angles, CA 90084-4929	Medical Director	0	•				.,
		0	0				
		0	0				
		0	0				
		0	0				
		0	0				
		0	0				
***	•	0	0				
		0	0				,
		0	0				
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		10	0				
		0	0				<u> </u>
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		0	0				AL.::
		0	0				
		0	0				

<sup>\*</sup> Use additional sheets if necessary.

<sup>\*\*</sup> Refer to Page 4 for definition of related.

# **Annual Report of Long-Term Care Facility**

CSP-15 Rev. 10/2005

# C. Expenditures Other Than Salaries - Administrative and General

Name of Facility License No.	Ŀ	Report for Ye	ear Ended	Page 15	of   37
Spectrum Healthcare Derby, LLC d/b/a Birmingt 2236-C	<u>-   </u>	/30/2015		13	<u> </u>
		maka1	CCNH	RHNS	(Specify)
Item		Total	CCMI	KIND	
1. Administrative and General					
a. Employee Health & Welfare Benefits		200 724	300,734		
1. Workmen's Compensation	\$	300,734	300,734		
2. Disability Insurance	\$				
3. Unemployment Insurance	\$	510 201	510 201		<del>                                     </del>
4. Social Security (F.I.C.A.)	\$	519,391	519,391		
5. Health Insurance	\$	771,611	771,611		
6. Life Insurance (employees only)	and the same of th				
(not-owners and not-operators)	\$		051.051		<del> </del>
7. Pensions (Non-Discriminatory)	\$	261,061	261,061		
(not-owners and not-operators)			0.500		
8. Uniform Allowance	\$	8,730	8,730		
9. Other (Specify)	\$	34,137	34,137		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and	\$[				
Profit Sharing Plans for Owners and	2000				
Operators (Discriminatory)*	To the state of th				
	1				
c. Bad Debts*	\$	60,000	60,000		
d. Accounting and Auditing	\$	36,048	36,048		
e. Legal (Services should be fully described on Page 7)	\$	14,515	14,515		
f. Insurance on Lives of Owners and	\$[		TOTAL CHARGE STREET, STREET, STREET, STREET, STREET, STREET, STREET, STREET, STREET, STREET, STREET, STREET, S		
Operators (Specify)*					
g. Office Supplies	\$	17,006	17,006		
h. Telephone and Cellular Phones					
Telephone & Pagers	\$	26,666	26,666		
2. Cellular Phones	\$	1,183	1,183		
i. Appraisal (Specify purpose and	\$			MARKS HER STATE OF THE PROPERTY OF THE PARTY	
attach copy)*					
attuch copy )					
j. Corporation Business Taxes (franchise tax)	\$				
k. Other Taxes (Not related to property - See Page 22)					
1. Income*	\$	NA SERVICE CONTRACTOR STREET, COLUMNIC OF STRE			
2. Other (Specify)	\$				
See Attached Schedule	- 1				
	\$	762,185	762,185		
3. Resident Day User Fee  Subtotal	\$	2,813,266			

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

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

Spectrum Healthcare Derby, LLC d/b/a Birmingham Health Center 9/30/2015

Attachment Page 15

# Schedule of Other Employee Benefits

Description	CCNH		RHNS	(Specify)
Umon Training Fund	\$ 30.6			
Bmployee Background Checks	\$ 3,4	81		
Total	8 34	37 8		

# Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
<b>Potal</b>			

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

Name of Facility License No.		Report for	Year Ended	Page	of ·
Spectrum Healthcare Derby, LLC d/b/a Birmingham 2236-C		9/30/2015		16	37
Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forwa	rd:	2,813,266	2,813,266		
Travel and Entertainment					
1. Resident Travel and Entertainment	\$	6,560	6,560		
2. Holiday Parties for Staff	\$	1,080	1,080		
3. Gifts to Staff and Residents	\$	1,057	1,057		
4. Employee Travel	\$	617	617		
5. Education Expenses Related to Seminars and Conventions	\$	2,794	2,794		
6. Automobile Expense (not purchase or depreciation)	\$				
7. Other (Specify)	\$	356	356		
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (all such expenses )	\$	CONTRACTOR CONTRACTOR (AND			
2. Advertising Telephone Directory (all such expenses )***	\$				
3. Advertising Other (Specify)***	\$	2,486	2,486		and the second s
See Attached Schedule					
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied	\$				AND THE RESIDENCE IN THE MEMORY OF MANAGEMENT OF
directly and not by contract or fee for service)***					
7. Postage	\$	6,008	6,008		
* 8. Dues and Membership Fees to Professional	\$	23,737	23,737		
Associations (Specify)					
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions***	\$			A DESCRIPTION OF THE PARTY OF T	
See Attached Schedule					
11. Services Provided by Contract (Specify and Complete	\$				
Schedule C-2, Page 21 for each firm or individual)					
12. Administrative Management Services**	\$	360,000	360,000		
13. Other (Specify)	\$	122,803	122,803		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	\$	3,340,766	3,340,766		

<sup>\*</sup> Do not include Subscriptions, which should go in item 9.

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

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

#### Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
	\$ 356		
	\$ 356.	\$	\$

#### Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Advertising Promotional	\$ 100		
Marketing Expenses	\$ 2,386		
Total Other Advertising to the control of the contr	\$ 2,486		15

#### Schedule of Dues

Description	CCNH	RHNS	(Specify)
Diverse Subscriptions in the language of the l	\$ 23,737		Manage en ez en ez en ez
			23172531111000111111111111111111111111111111
Minera nua kun maka dia kuman 122 kata dia kampina ya minera minera kun 122 ka 122 k Minera kun minera kun			
	MINIMUMER KICH		
	HORRENMENDHER.		ieksenasimi
Total Dies name de la company de la company de la company de la company de la company de la company de la comp	\$ 23,737	\$	Summanuscu.

#### Schedule of Contributions

Description	CCNH	RHNS	(Specify)
	Manager 200		
Continue to the continue of th	S	SHERWARE	S

## Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Dalu Processing Fees Payrolling II and an including the processing Fees Payrolling II and the processing Fees Payrolling II and the processing Fees Payrolling II and the processing Fees Payrolling II and the processing Fees Payrolling II and the processing Fees Payrolling II and the processing Fees Payrolling II and the processing Fees Payrolling II and the processing Fees Payrolling II and the processing II and II a	<b>S</b> 32,634		
Data Processing Pees-MDI	S 11,805		
	1 232		
Software Teles IVANS   District	1,131		
Software Maintenance   Fall   1994   1995   1995   1995   1995   1995   1995   1995   1995   1995   1995   199	\$ 14,565		
Computer Maintenance	\$ 25,150		
Cable Television	\$ 13,657		
Ambiyes in the first of the control	\$ 13,112		
Ficenses	<b>s</b> 2,399		
	\$ 2,802		
Miscellaneous-Hall Rental Union Meetings	\$ 570		
Copier Equipment	3,374		
Dues & Subscriptions	\$ 60		
Small Equipment Porchases	312		
Total Other Administrative and General	<b>5</b> 122,803	\$	<b>3</b>

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

Name of Facility Spectrum Healthcare Derby, LLC d/b/a B	License No. 2236-C	Report for Year Ended 9/30/2015	Page of 17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Spectrum Healthcare, LLC	360,000	Home office services, Accounting, Personnel & Benefits admin., Treasury, Operations, QA	Page 16, line m. 12

<sup>\*</sup> 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

Name of Facility   Spectrum Healthcare Derby, LLC d/b/a Birmingham H   2236-C   Spectrum Healthcare	of 37
Item	31
2. Dietary a. In-House Preparation & Service 1. Raw Food 3. 277,830 2. Non-Food Supplies 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) Small Equipment Purchased Equipment Repair & Maintenance  2E. Total Dietary Expenditures (2a + b + c + d) 3 13,717  313,717  2F. Dietary Questionnaire G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes  O No  If yes, specify amt.  J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?  O Yes  O No  If yes, specify cost.	====
2. Dietary a. In-House Preparation & Service 1. Raw Food 3. 277,830 2. Non-Food Supplies 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)  Small Equipment Purchased Equipment Repair & Maintenance  2E. Total Dietary Expenditures (2a + b + c + d)  Small Equipment Repair & Maintenance  2F. Dietary Questionnaire  G. Resident Meals: Total no. of meals served per day:*  H. Is cost of employee meals included in 2E?  O Yes  No  If yes, specify amt.  J. Where is the revenue received reported in the Cost Report? (Page/Line Item)  Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?  O Yes  O No  If yes, specify cost.	6a
a. In-House Preparation & Service  1. Raw Food  2. Non-Food Supplies  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)  Small Equipment Purchased Equipment Repair & Maintenance  2E. Total Dietary Expenditures (2a + b + c + d)  313,717  313,717  313,717  Total CCNH RHNS (Specify Is cost of employee meals included in 2E? O Yes  No  If yes, specify amt.  J. Where is the revenue received reported in the Cost Report? (Page/Line Item)  Is cost of meals provided to persons other  K. than employees or residents (i.e., Board O Yes Members, Guests) included in 2E?  J. Ves. (Page, Specify Cost.)  If yes, specify cost.	
1. Raw Food 2. Non-Food Supplies 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)  Small Equipment Purchased Equipment Repair & Maintenance  2E. Total Dietary Expenditures (2a + b + c + d)  Small Equipment Purchased Equipment Purchased Equipment Repair & Maintenance  2F. Dietary Questionnaire  G. Resident Meals: Total no. of meals served per day:*  H. Is cost of employee meals included in 2E? O Yes  O No  If yes, specify amt.  J. Where is the revenue received reported in the Cost Report? (Page/Line Item)  Is cost of meals provided to persons other  K. than employees or residents (i.e., Board O Yes O No If yes, specify cost.  Members, Guests) included in 2E?  If yes, specify  If yes, specify  L. Type Specify and D Yes  Members, Guests) included in 2E?  O Yes  O No  If yes, specify  Cost.	
2. Non-Food Supplies \$ 26,439   26,439    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)   \$ 8,671   8,671    Small Equipment Purchased Equipment Repair & Maintenance    2E. Total Dietary Expenditures (2a + b + c + d) \$ 313,717    2F. Dietary Questionnaire   Total   CCNH   RHNS   (Specify Resident Meals: Total no. of meals served per day:*  H. Is cost of employee meals included in 2E? O Yes O No If yes, specify amt.  J. Where is the revenue received reported in the Cost Report? (Page/Line Item)  Is cost of meals provided to persons other K. than employees or residents (i.e., Board O Yes O No If yes, specify cost.  Members, Guests) included in 2E? If yes, specify cost.	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)  c. Management Services*  d. Other (Specify)  Small Equipment Purchased Equipment Repair & Maintenance  2E. Total Dietary Expenditures (2a + b + c + d) \$ 313,717 313,717   2F. Dietary Questionnaire  G. Resident Meals: Total no. of meals served per day:*  H. Is cost of employee meals included in 2E? O Yes O No  If yes, specify amt.  J. Where is the revenue received reported in the Cost Report? (Page/Line Item)  Is cost of meals provided to persons other  K. than employees or residents (i.e., Board O Yes O No If yes, specify cost.  Members, Guests) included in 2E?  J. Yes O No If yes, specify cost.  If yes, specify cost.	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) c. Management Services** \$ \$ 8,671 8.671  Small Equipment Purchased Equipment Repair & Maintenance  2E. Total Dietary Expenditures (2a + b + c + d) \$ 313,717 313,717  2F. Dietary Questionnaire  G. Resident Meals: Total no. of meals served per day:*  H. Is cost of employee meals included in 2E? O Yes O No  If yes, specify amt.  J. Where is the revenue received reported in the Cost Report? (Page/Line Item)  Is cost of meals provided to persons other K. than employees or residents (i.e., Board O Yes O No If yes, specify cost.  Members, Guests) included in 2E?  If yes, specify  If yes, specify  If yes, specify  Cost.	
than through Management Services) (Complete Schedule C-2 att. Page 21)  c. Management Services**  d. Other (Specify) Small Equipment Purchased Equipment Repair & Maintenance  2E. Total Dietary Expenditures (2a + b + c + d)  Signal Equipment Repair & Maintenance  2F. Dietary Questionnaire  G. Resident Meals: Total no. of meals served per day:*  H. Is cost of employee meals included in 2E? O Yes  O Yes  O No  If yes, specify amt.  J. Where is the revenue received reported in the Cost Report? (Page/Line Item)  Is cost of meals provided to persons other  K. than employees or residents (i.e., Board O Yes O No If yes, specify cost.  Members, Guests) included in 2E?  O Yes  O No  If yes, specify cost.	
than through Management Services) (Complete Schedule C-2 att. Page 21)  c. Management Services**  d. Other (Specify) Small Equipment Purchased Equipment Repair & Maintenance  2E. Total Dietary Expenditures (2a + b + c + d)  Signall Equipment Repair & Maintenance  2F. Dietary Questionnaire  G. Resident Meals: Total no. of meals served per day:*  H. Is cost of employee meals included in 2E? O Yes  O Yes  O No  If yes, specify amt.  J. Where is the revenue received reported in the Cost Report? (Page/Line Item)  Is cost of meals provided to persons other K. than employees or residents (i.e., Board O Yes O No Members, Guests) included in 2E?  If yes, specify Cost.	
than through Management Services) (Complete Schedule C-2 att. Page 21)  c. Management Services**  d. Other (Specify) Small Equipment Purchased Equipment Repair & Maintenance  2E. Total Dietary Expenditures (2a + b + c + d)  Signall Equipment Repair & Maintenance  2F. Dietary Questionnaire  G. Resident Meals: Total no. of meals served per day:*  H. Is cost of employee meals included in 2E? O Yes  O Yes  O No  If yes, specify amt.  J. Where is the revenue received reported in the Cost Report? (Page/Line Item)  Is cost of meals provided to persons other K. than employees or residents (i.e., Board O Yes O No If yes, specify cost.  Members, Guests) included in 2E?  O Yes  O No  If yes, specify cost.  If yes, specify cost.	
c. Management Services**  d. Other (Specify) Small Equipment Purchased Equipment Repair & Maintenance  2E. Total Dietary Expenditures (2a + b + c + d) \$ 313,717 313,717  2F. Dietary Questionnaire Total CCNH RHNS (Specify) H. Is cost of employee meals included in 2E? O Yes  O No  I. Did you receive revenue from employees? O Yes  O No  Is cost of meals provided to persons other K. than employees or residents (i.e., Board O Yes Members, Guests) included in 2E?  Tender of the service o	
c. Management Services**  d. Other (Specify) Small Equipment Purchased Equipment Repair & Maintenance  2E. Total Dietary Expenditures (2a + b + c + d)  313,717  2F. Dietary Questionnaire Total CCNH RHNS (Specify) I. Is cost of employee meals included in 2E? O Yes  O No  I. Did you receive revenue from employees? O Yes  O No  If yes, specify amt.  J. Where is the revenue received reported in the Cost Report? (Page/Line Item)  Is cost of meals provided to persons other K. than employees or residents (i.e., Board O Yes Members, Guests) included in 2E?  If yes, specify Cost.  If yes, specify Cost.	
d. Other (Specify) Small Equipment Purchased Equipment Repair & Maintenance  2E. Total Dietary Expenditures (2a + b + c + d) \$ 313,717 \$ 313,717 \$  2F. Dietary Questionnaire  G. Resident Meals: Total no. of meals served per day:*  H. Is cost of employee meals included in 2E? O Yes O No  I. Did you receive revenue from employees? O Yes O No  I. Where is the revenue received reported in the Cost Report? (Page/Line Item)  Is cost of meals provided to persons other  K. than employees or residents (i.e., Board O Yes Members, Guests) included in 2E?  If yes, specify cost.  If yes, specify Life yes, specify cost.	
Small Equipment Purchased Equipment Repair & Maintenance  2E. Total Dietary Expenditures (2a + b + c + d) \$ 313,717 313,717  2F. Dietary Questionnaire  Total CCNH RHNS (Specific Resident Meals: Total no. of meals served per day:*  H. Is cost of employee meals included in 2E? O Yes O No  I. Did you receive revenue from employees? O Yes O No  If yes, specify amt.  J. Where is the revenue received reported in the Cost Report? (Page/Line Item)  Is cost of meals provided to persons other  K. than employees or residents (i.e., Board O Yes O No Members, Guests) included in 2E?  If yes, specify cost.  If yes, specify If yes, specify If yes, specify	www.cmanfyr
Equipment Repair & Maintenance  2E. Total Dietary Expenditures (2a+b+c+d) \$ 313,717 313,717  2F. Dietary Questionnaire  G. Resident Meals: Total no. of meals served per day:*  H. Is cost of employee meals included in 2E? O Yes O No  I. Did you receive revenue from employees? O Yes O No  J. Where is the revenue received reported in the Cost Report? (Page/Line Item)  Is cost of meals provided to persons other  K. than employees or residents (i.e., Board O Yes O No If yes, specify cost.  Members, Guests) included in 2E?  If yes, specify  Cost.  If yes, specify  Cost.  If yes, specify  Cost.	
2E. Total Dietary Expenditures (2a + b + c + d) \$ 313,717 313,717    2F. Dietary Questionnaire	
2F. Dietary Questionnaire  G. Resident Meals: Total no. of meals served per day:*  H. Is cost of employee meals included in 2E? O Yes O No  If yes, specify amt.  J. Where is the revenue received reported in the Cost Report? (Page/Line Item)  Is cost of meals provided to persons other  K. than employees or residents (i.e., Board O Yes O No If yes, specify cost.  Members, Guests) included in 2E?  If yes, specify cost.	
G. Resident Meals: Total no. of meals served per day:*  H. Is cost of employee meals included in 2E? O Yes O No  If yes, specify amt.  J. Where is the revenue received reported in the Cost Report? (Page/Line Item)  Is cost of meals provided to persons other  K. than employees or residents (i.e., Board O Yes O No Members, Guests) included in 2E?  The second of the cost Report? (Page/Line Item)  If yes, specify cost.  If yes, specify cost.	
G. Resident Meals: Total no. of meals served per day:*  H. Is cost of employee meals included in 2E? O Yes O No  If yes, specify amt.  J. Where is the revenue received reported in the Cost Report? (Page/Line Item)  Is cost of meals provided to persons other  K. than employees or residents (i.e., Board O Yes O No Members, Guests) included in 2E?  If yes, specify cost.	ify)
H. Is cost of employee meals included in 2E? O Yes ⊙ No  If yes, specify amt.  J. Where is the revenue received reported in the Cost Report? (Page/Line Item)  Is cost of meals provided to persons other  K. than employees or residents (i.e., Board O Yes ⊙ No Members, Guests) included in 2E?  If yes, specify cost.  If yes, specify cost.	
I. Did you receive revenue from employees? O Yes   No If yes, specify amt.  J. Where is the revenue received reported in the Cost Report? (Page/Line Item)  Is cost of meals provided to persons other  K. than employees or residents (i.e., Board O Yes O No Members, Guests) included in 2E?  If yes, specify cost.  If yes, specify cost.	
I. Did you receive revenue from employees? O Yes amt.  J. Where is the revenue received reported in the Cost Report? (Page/Line Item)  Is cost of meals provided to persons other  K. than employees or residents (i.e., Board O Yes O No Cost.  Members, Guests) included in 2E?  If yes, specify  If yes, specify	
Is cost of meals provided to persons other  K. than employees or residents (i.e., Board O Yes O No Cost.  Members, Guests) included in 2E?  If yes, specify  If yes, specify  O Yes O No	
Is cost of meals provided to persons other  K. than employees or residents (i.e., Board O Yes O No Cost.  Members, Guests) included in 2E?  If yes, specify  If yes, specify	
K. than employees or residents (i.e., Board O Yes O No cost.  Members, Guests) included in 2E?  If yes, specify	
Members, Guests) included in 2E?  If yes, specify	
If yes, specify	
L. Is any revenue collected from these people? O ies amt.	
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)	
Is cost of food (other than meals, e.g.,	
snacks at monthly staff meetings, board O Yes O No	
N. meetings) provided to employees included cost.	
in 2E?	
O Is any revenue collected from employees? O Yes O No	
O. Is any revenue collected from employees? O Yes O No amt.	
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)	

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

<sup>\*\*</sup> 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	License		Report for Y		Page 19	of
Spectrum Healthcare Derby, LLC d/b/a Birmingham He	<u> </u>	236-C	9/30/2015	9/30/2015		37
Item		Total	CCNH	RHNS	(S	pecify)
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies,	Lbs.					
gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	19,232	19,232			
Employee items including uniforms, gowns, etc. washed, ironed and/or	Lbs.					
processed.***	Amt. \$					
3. Personal clothing of residents	Lbs.					
washed, ironed, and/or processed.***	Amt. \$					
4. Repair and/or purchase of linens.***	Lbs.					
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	Amt. \$	3,097 304,879	3,097 304,879			
c. Management Services**	\$					
d. Other ( <i>Specify</i> ) Supplies	\$	460	460			
3E. Total Laundry Expenditures (3a+b+c+d)	\$	327,668	327,668			
3F. Laundry Questionnaire  G. Is cost of employee laundry included in 3E? O	Yes	•	No	If yes, specify cost.	·	
H. Did you receive revenue from employees?	Yes	•	No	If yes, specify amt.		
I. Where is the revenue received reported in the Cost	Report?		(Page/Line	Item)		
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?	Yes	•	No	If yes, specify cost.		
K. Did you receive revenue from these people? O	Yes	•	No	If yes, specify amt.		
L. Where is the revenue received reported in the Cost	Report?		(Page/Line	Item)		

<sup>\*</sup> 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.

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

<sup>\*\*\*</sup> 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.	Rep	ort for Year E	nded	Page	of
Spectrum Healthcare Derby, LLC d/b/a Birmin	2236-C		9/30/2015		20	37
Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced					
a. In-House Care	by Personnel					
1. Supplies - Cleaning (Mops,	Amt.	\$	1,948	1,948		
pails, brooms, etc.)						
b. Purchased Services (by contract other	Sq. Ft. Serviced					
than through Management Services)	by Personnel					
(Complete Schedule C-2 att.	Amt.	\$	- 310,869	310,869		
Page 21)						
c. Management Services*		\$				
d. Other (Specify)		\$	313	313		
Equipment Repair & Maintenance						
4E. Total Housekeeping Expenditures (4a +	b+c+d)	\$	313,130	313,130		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		\$	•	t.	<i>,</i>	
2. Purchased from		\$	220,072	220,072	24/27	
	-					
b. Medicine Cabinet Drugs		\$	26,009	26,009		
c. Medical and Therapeutic Supplies		\$	172,437	172,437		
d. Ambulance/Limousine***		\$	158	158	7.9/28	
e. Oxygen						
For Emergency Use		\$				
2. Other***		\$	42,015	42,015	29/32	
f. X-rays and Related Radiological		\$	19,171	19,171	29/24	
Procedures***						
g. Dental (Not dentists who should be inc	luded under	\$				
salaries or fees)		k				
h. Laboratory***		\$	16,225	16,225	24/30	
i. Recreation		\$	4,210	4,210		
j. Other (Specify)****		\$	49,822	49,822		
See Attached Schedule						
5K. Total Resident Care Expenditures (5a - 5	j)	\$	550,119	550,119		

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

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

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

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

## Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Supplies (Non Medical)			
Nursing Office Supplies	\$ . 691 \$ 200		
Small Equipment Purchased	920		
Complex Medical Equipment Complex Medical Equipment			
Complex Equip Wheelchairs; Bedside Chairs, Bite			
Ontende Medical Services			
Audiology-Services			
inalione Resident Gate	3377 298924		

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

Name of Facility	T C d/h/a Rirminoham	Health Center		License No. 2236-C	Report for Year Ended 9/30/2015		-		Page of 21   37
Specium realificate Delby,									
		Related ** to Owners,	o Owners,				Fotal Cost/	Total Cost/Page Ref.***	
		Operators, Omcess	Omicers						
Name of Individual or Company	Address	Yes	No	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	(Specify)	Pg Line
Automotic Data Processing	Waitham, MA 02454	0	0		Payroll Processing	32,634			16 M13
Authur Dam 1999	St. Louis. MO 63146	0	•		GL/AR/AP/Clinical Program	11,805			16 M13
Healthcare Services (from	Bensalem, PA 19020	0	0		Laundry Services	304,879			19 35
Healthcare Services Group	Bensalem, PA 19020	0	<b>©</b> .		Housekeeping Services	310,869			20 4b
		0	0				į		
		0	0						
		0	0						
		0	0						
		0	0						
		0	0						
		0	0						
		0	0						
		0	0						
		С	0						

<sup>\*</sup> List all contracted services over \$10,000. Use additional sheets if necessary.

<sup>\*\*</sup> Refer to Page 4 for definition of related. \*\*\* Please cross-reference amount to the annountate name in the Annual Benort Monee 16 10 10 10 on and 10

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

Name of Facility License No.	Report for Ye	ear Ended		Page	of 37
Spectrum Healthcare Derby, LLC d/b/a Birmit 2236-C	 9/30/2015			22	31
Item	Total	CCNH	RHNS	(Spe	cify)
6. Maintenance & Operation of Plant	}				
a. Repairs & Maintenance	\$ 46,516	46,516			
b. Heat	\$ 51,626	51,626		<u> </u>	
c. Light & Power	\$ 90,687	90,687		<u> </u>	
d. Water	\$ 26,550	26,550			
e. Equipment Lease (Provide detail on page 6)	\$				
f. Other (itemize)	\$ 79,927	79,927		ar incorporation	
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 295,305	295,305			
7. Depreciation (complete schedule page 23*)					
a. Land Improvements	\$ 583	583			
b. Building & Building Improvements	\$ 305,704	305,704			
c. Non-Movable Equipment	\$ 15,634	15,634			
d. Movable Equipment	\$ 11,809	11,809			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 333,730	333,730			
8. Amortization (Complete att. Schedule Page 24*)					
a. Organization Expense	\$ 	!			
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$ ·				
d. Other (Specify)	\$				
*8e. Total Amortization Costs (8a + b + c + d)	\$	·			
9. Rental payments on leased real property less				ļ	
real estate taxes included in item 10b	\$ 720,000	720,000			
10. Property Taxes					
a. Real estate taxes paid by owner	\$ 120,136	120,136			
b. Real estate taxes paid by lessor	\$				
c. Personal property taxes	\$ 4,349	4,349			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,178,215	1,178,215		<u> </u>	

<sup>\*</sup> 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)
Irash Removal	\$ 14,264 3 7,756		
Hazardous Wasie Removal	<u>3</u> 12,385		
Service Contracts	\$15 233		
Supplies  Grounds Maintenance			
Grounds Landscaping	8 7,521		
Small-Equipment-Rurchases	\$		
	3 79.927		8
Total Other Repairs and Maintenance			i e Michelle Schliger de Siu

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Depreciation Schedule

Section of Facility   Section   Property Item   Leadth Center   Liconars No.   Standard   Page   Sta				Taldar	Dept ectation Schedule	nenne					
Historical Cost   Less   Cost to Be   Beginning of   Computing	Name of Facility Spectrum Healthcare Derby, LLC d/b/a Birmi	ingham Healt	h Center	License No. 2236	Ų		Report for Year E 9/30/2015	nded		Page 23	of 37
Property Item   Property Item   Exclusive of Salvage   Cost to Be   Beginning of Computing Useful Depreciated   Variat Operation   Life for This Yapher of Item   Property Item   Land   Value   Depreciated   Variat Operation   Life for This Yapher of Item   Land   Cost to Be   Beginning of Cost to Be   Beginning of Computing Useful Depreciation   Life for This Yapher   Land				Historical Cost	Less		Accumulated Depreciation to	Method of			
iried piore in this report period (attach schedule)  and Building Improvements  and Building Improveme	Pronerty Item			Exclusive of Land	Salvage Value	Cost to Be Depreciated	Beginning of Year's Operations	Computing Depreciation	Useful Life	Depreciation for This Year	Totals
11,650   10,292   10,292   10,292   10,292   10,292   204,   20	Land Improvements							4			
State   Stat	<del>,</del> i			11,650		11,650	10,292			583	
		•									
Sand Building Improvements   Sand Building Improvements   Sand Building Improvements   Sand Building Improvements   Sand Building Improvements   Sand Building Improvements   Sand Building Improvements   Sand Building Improvements   Sand Building Improvement   Sand Building Improv		h schedule)	,								
1. Acquired furting this report period (attach schedule)	A-4. Subtotal										583
1. Acquired prior to this report period   0,103,921   0,103,921   3,134,190   510, 510, 510, 510, 510, 510, 510, 510,						4				1	
2. Disposate during this report period (attach schedule)   3. Acquired during this report period (attach schedule)   12.410   12.410   12.410   13.77,716   15.5	I. Acquired prior to this report period			6,103,921		6,103,921	3,134,190			305,704	
Subtoral Non-Movable Equipment  Norable Equipment  Novable Equipment  Accumed during this report period  and year of each vehicle)  b. Disposals (attach schedule)  c. Acquired during this report period  a. Acquired during this report period  b. Disposals (attach schedule)  c. Acquired during this report period  b. Disposals (attach schedule)  c. Acquired during this report period  c. Acquired during this report period  c. Acquired during this report period  c. Acquired prior to this report period  d. Acquired prior to this report period  c. Acquired prior to this report period  d. Acquired prio	Z. Disposais (anachi scricturie)	1. a.1. d.d.)									
1. Acquired prior to this report period   469,234   377,716   15.     2. Disposals (attach schedule)	~[7	n schedule)									305,704
1. Acquired prior or this report period (stach schedule)   3. Acquired during this report period (stach schedule)   3. Acquired during this report period (stach schedule)   3. Acquired during this report period (stach schedule)   3. Acquired during this report period (stach schedule)   3. Acquired during this report period (stach schedule)   469,234   469,234   377,716   154,102   154,10   154,	4										
2. Disposals (attach schedule)  3. Acquired during this report period (attach schedule)  Subtotal  Movable Equipment  1. Motor Vehicles (Specify name, model)  2. Movable Equipment  3. Acquired prior to this report period (attach schedule)  3. Acquired during this report period (attach schedule)  3. Acquired during this report period  3. Acquired during this report period  4. Acquired prior to this report period  5. Subtotal  4. Acquired form of this report period  6. Acquired during this report period  6. Acquired during this report period  7. Subtotal  8. Ois Novable Equipment  8. Ois Novable Equipment  9. Disposals (attach schedule)  9. Disposals (attach schedule)  11.927  11.927  11.927	-			469,234	•	469,234	377,716			15,220	
3. Acquired during this report period (attach schedule)   12.410   12.410   12.410	2. Disposals (attach schedule)										
Subrotal  Lightoolk Institutional Cost to Be and year of each vehicle)  a. Acquired buting this report period  b. Disposals (attach schedule)  c. Acquired during this report period  c. Subrotal  Total Depreciation  Is a mileage    Isa mileage   Depreciation   Depreciation   Depreciation   Depreciation   Life for This and year of each vehicle)  a. Acquired buting this report period  c. Acquired during this report period  c. Subrotal  Total Depreciation    Is a mileage   Dependent   Depreciation   Depreciation   Life for This and year of each vehicle)  a. Acquired during this report period  c. Acquired during this report period  c. Subrotal  Total Depreciation    Is a mileage   Dependent   Depreciation   Life for This and year of each vehicle)   Dependent   Depreciation   Life for This and year of each vehicle)   Dependent   Depreciation   Life for This and year of each vehicle)   Dependent   Depreciation   Life for This and year of each vehicle)   Dependent   Depreciation   Life for This and year of each vehicle)   Dependent   Depreciation   Life for This and year of each vehicle)   Dependent   Depreciation   Life for This and year of each vehicle)   Depreciation   Life for This and year of each vehicle   Depreciation   Life for This and year of each vehicle   Depreciation   Life for This and year of each vehicle   Depreciation   Life for This and year of each vehicle   Depreciation   Life for This and year of each vehicle   Depreciation   Life for This and year of each vehicle   Life for		h schedule)		12,410		12,410				414	
Is a mileage   Date of maintained?   Date of maintained?   Apquisition   Fiscinity   Date of maintained?   Apquisition   Fiscinity   Date of maintained?   Apquisition   Fiscinity   Date of maintained?   Apquisition   Date of Salvage   Cost to Be Beginning of Computing   Useful   Depreciation   Depreciation   Depreciation   Life for This and year of each vehicle)   Applies (Specify name, model and year of each vehicle)   Applies (Specify name, model and year of each vehicle)   Applies (Specify name, model and year of each vehicle)   Applies (Specify name, model and year of each vehicle)   Applies (Specify name, model and year of each vehicle)   Applies (Specify name, model and year of each vehicle)   Applies (Specify name, model and year of each vehicle)   Applies (Specify name, model and year of each vehicle)   Applies (Specify name, model and year of each vehicle)   Applies (Specify name, model and year of each vehicle)   Applies (Specify name, model and year of each vehicle)   Applies (Specify name, model and year of each vehicle)   Applies (Specify name, model and year of each vehicle)   Applies (Specify name, model and year of each vehicle)   Applies (Specify name, model and year of each vehicle)   Applies (Specify name, model and year of each vehicle)   Applies (Specify name, model and year of each vehicle)   Applies (Specify name, model and year of each vehicle)   Applies (Specify name, model name, model name, model name, name	Sai										15,634
Movable Equipment  1. Motor Vehicles (Specify name, model and year of each vehicle)  2. Movable Equipment  3. Subtotal  7 res No Mouth Year Eand Vehicles (Specify name, model and year of each vehicles)  6. Acquired during this report period  6. Acquired during this report period  7 res No Mouth Year Eand Vehicle (Specify name, model and year of each vehicle)  8 07,415  8 07,415  11,927  11,927  11,927  11,927  11,927  12 read to Sperioristic of Computing Useful Depreciation  1 read for This fo		Is a mileage logbook	Date of	Historical Oct			Accumulated Denreciation to	Method of			
Movable Equipment  1. Motor Vehicles (Specify name, model and year of each vehicle)  2. Movable Equipment  3. Subtoral  3. Subtoral  Movable Equipment  c. Acquired during this report period  (attach schedule)  3. Subtoral  Total Depreciation  Movable Handing this report period  (attach schedule)  (attach schedule)  3. Subtoral  Total Depreciation  Movable Equipment  a. Acquired period  (attach schedule)				Exclusive of		Cost to Be	Beginning of		Useful	Depreciation	,
Movable Equipment  1. Motor Vehicles (Specify name, model and year of each vehicle)  2. Movable Equipment  3. Subtoral  7. Acquired during this report period  6. C. Acquired during this report period  7. Acquired during this report period  6. C. Acquired during this report period  7. Acquired during this report period  8.07,415  8.07,415  8.07,415  11,927  7. Acquired during this report period  6. Acquired during this report period  7. Subtornal  7. Acquired during this report period  8.07,415  8.07,415  8.07,415  8.07,415  11,927  7. Acquired during this report period  8.07,415  7. Acquired during this report period  7. Acquired during this report period  8.07,415  7. Acquired during this report period  7. Acquired during this report period  8.07,415  7. Acquired during this report period  8.07,415  7. Acquired during this report period  8.07,415  7. Acquired during this report period  9. Acquired dur		No		Land	Value	Depreciated	Year's Operations	—- <del> </del>	Life	for This Year	Totals
b. c. d. 2. Movable Equipment a. Acquired prior to this report period b. Disposals (attach schedule) c. Acquired during this report period (attach schedule) Subtoral  Subtoral  Total Depreciation	MC :										
c. Acquired during this report period  b. Disposals (attach schedule)  c. Acquired during this report period  attach schedule)  c. Acquired during this report period  attach schedule)  Subtoral  Subtoral	, a.										
a. Acquired prior to this report period  b. Disposals (attach schedule)  c. Acquired during this report period  (attach schedule)  Subtoral  Subtoral	Ö										
a. Acquired prior to this report period  b. Disposals (attach schedule)  c. Acquired during this report period  (attach schedule)  Subtotal  Total Depreciation	d.										
b. Disposals (attach schedule)  c. Acquired during this report period  (attach schedule)  Subtotal  Total Depreciation	Ž,					807.415					
c. Acquired during this report period.  (attach schedule)  Subtoral  Total Depreciation											
Subtotal Total Depreciation				<b>加加斯斯斯斯斯</b> 11,927						1,036	
	Subtot										11,809
											333,730

Useful

Useful

Spectrum Healthcare Derby, LLC d/b/a Birmingham Health Center

Schedule of Land Improvements Acquired during this report period

is Acquited during this report period		Useful	
Description of Item	Cost	Life	Deprectation
		- Company - Children - Company - Child	-S marrosmenoscotomores
			Lie Alles Denkinstern Seminari.
			\$ 2 2 10 2 2
inang kandi salah darah salah darah salah sa Salah salah sa	ADDITIONAL OF THE OWNER OWNER OF THE OWNER OWN		
		namatan kanta	
		unacunalabilihan Tanggalakung	the state of the s
Venena and the same of the sam			3
	ovements:	Description of Item  Cost  Overments:  Significant statements of the statement of the state	Description of Item Cost Life  Cost Life  Property of Item Cost Cost Cost Cost Cost Cost Cost Cost

<sup>\*</sup>Ties to Page 23, Line A3

Schedule of Building Improvements Acquired during this report period

equisition Date	Description of Item	Cost	Life	Depreciation
			anginirahan marahilika	
	ge Insprovements			
				<b>3</b>
orar admining to brown				
eletions:				of additional contract of the property of the contract of the
	g Improvements			
PROPERTY OF STREET				<b>3</b> 48 E

<sup>\*</sup>Ties to Page 23, Line B3

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:	A STATE OF THE STA	Distributed with the Color of the Color	nvielininosepennii\(\frac{1}{2}\)	ACREDIBLE CONTROL
05/14/15		\$ 12,410		3 414
Total additions for	Non-Movable Equipment	\$ 12,410		8 44
Deletions:		//Suppose and Suppose and Supp		
Total deletions for	Non-Novable Equipment 1995	\$ 1.55		

<sup>\*</sup>Ties to Page 23, Line C3

<sup>\*\*</sup>Ties to Page 23, Line A2

<sup>\*\*</sup>Ties to Page 23, Line B2

<sup>\*\*</sup>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:		A STATE OF THE STA	omnorson sustantina	
10/01/14	Air Pressure Matrices System 2; Bioosto (Heade)		10.00	\$ 167
12/05/14	Boosto Heatest in the property of the property	# H = # 50 P = 50 020		196
20206 55				\$11.270
00)24715	Managara Asar Salas Sala	tana makaman ing Kabupatèn Angkatan ing Kabupatèn Angkatan ing Kabupatèn Angkatan ing Kabupatèn Angkatan ing K	12	Single in 50
9/24/16				30
0/20/15		\$ 7.244		6 216
Lotal additions for	Hill Dody Slings Mayable Populynich	\$ E E 927		\$             11038
D-1-45	l .		anna an an an an an an an an an an an an	Name and the second
				time the sale of t
Local-deletions for	Moyable Equipments			

<sup>\*</sup>Ties to Page 23, Line D2c

## Schedule of Leasehold Improvements Acquired during this report period

sentante of Seasonain mile	Toyements Acquired during this report period		Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
dditions:		150-1-1	in manusan da da da da da da da da da da da da da	rada propropriada de la
of a south from the self-	ld Improvement			<b>8</b> -111111111111111
3				l .
eletions:				
				en and and a
				Accidental Control
	al mprovenent			
				ng a sa
otal deletions for Leascho	ld Improvement			ASSESSED FOR

<sup>\*</sup>Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

<sup>\*\*</sup>Ties to Page 23, Line D2b

Annual Report of Long-Term Care Facility CSP-24 Rev. 10/2006 State of Connecticut

# Amortization Schedule\*

Nam	Name of Facility		License No.		Renort for Year Ended	r Ended		Расе	of
Spec	Spectrum Healthcare Derby, LLC d/b/a Birmingham Health	gham Health (	2236-C		9/30/2015			24	37
					Accumulated				
,		Date of			Amort. to				
		Acquisition			Beginning of	Basis for			
			Length of	Cost to Be	Year's	Computing	Rate	Amortization	•
	Item	Month Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
Ą.	Organization Expense								
	1.							30 P408	
<u> </u>	2.								
	3.							<i>6</i> ,7,636	
A-4.	Subtotal								:
B.	Mortgage Expense								
	1,								
	2.								
	3.								
B-4.	Subtotal								
ن	Leasehold Improvements and Other								
	1. Acquired prior to this report period								
	2. Disposals (attach schedule)			٠					
<u></u>	3. Acquired during this report period								
	(attach schedule)						·		
0. 4.	. Subtotal								
D.	Total Amortization								
	T T T T T T T T T T T T T T T T T T T								

\* 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 Spectrum Healthcare Derby, LLC d/b/	License No. 2236-C	Report for Year En 9/30/2015	ded		Pa 2		of 37
11. Property Questionnaire			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		_,		
Part A					,	_	
Is the property either owned by the	e Facility	Yes	0	No	If "Yes," co		
or leased from a Related Party?*					If "No," co	mpiete i	Part C.
*If any owner or operator of this fac	ility is related by family,	marriage, ownership, abil	lity to control or				
business association to any person of	r organization from whor	n buildings are leased, th	en it is considered				
a related party transaction.  Description		Total					
1. Date Land Purchased							
2. Date Structure Completed							
3. If <b>NOT</b> Original Owner, Date	of Purchase	03/31/03					
4. Date of Initial Licensure		11/01/99					
<ol><li>Total Licensed Bed Capacity</li></ol>		120					
6. Square Footage		31,000 incr to 42,000					
7. Acquisition Cost							
a. Land							
b. Building  Part B - Owner and Related Part	utios	1st Mortgage	2nd Mortgage	3rd Mortgage	4th	Mortgag	ge
1. Financing	ties	13t Workingung					
a. Type of Financing (e.g., fi	xed. variable)	HUD Mortgage	SEATS DIVINISHES LIBOUR LIBOUR				
b. Date Mortgage Obtained	,	06/13/13					
c. Interest Rate for the Cost	Year	3.22%					
d. Term of Mortgage (number		35			<u> </u>		
e. Amount of Principal Borre	owed				<u> </u>		
f. Principal balance outstand		8,643,440					
Complete if Mortgage was I							
During Current Cost Ye							
g. Type of Financing (e.g., fi	xed, variable)				<del> </del>		
h. Date of Refinancing					<u> </u>		<del></del>
i. New Interest Rate j. Term of Mortgage (number	er of vears)						
k. Amount of Principal Borre							
l. Principal Outstanding on l							
Part C - Arms-Length Lease		Improvements Onl	у				
Name and Address of Lesso		operty Leased	Date of Lease	Term of Lease	Annual A	mount (	of Lease
			<u> </u>			<del></del>	
			<u> </u>			·····	
	l						
			<del> </del>				
							<del></del>
Market Address of the Control of the							

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 Ye	ar Ended		Page of
Spectrum Healthcare Derby, LLC d/b 2236-C		9/30/2015			26   37
Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable	е				
Equipment					
1. First Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
2. Second Mortgage	\$	простинения приментов			
Name of Lender	Rate				
Address of Lender					
3. Third Mortgage	\$	THE SECTION OF THE SE		\$1105/MMM/M/MM/M/M/	A STATE OF THE PARTY OF THE PAR
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage	\$	NAMES OF THE PROPERTY OF THE P	Wilder California Transfer Tra		
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)	\$				
		(Carr	Subtotals f	orward to n	ext page)

(Carry Subtotals forward to next page)

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

Name of Facility	License No.		Report for Y	ear Ended		Page	of
Spectrum Healthcare Derby, LLC	1		9/30/2015			27	37
Ite	<u>m</u>		Total	CCNH	RHNS	(Spec	cify)
	Subtotals Bro	ught Forward:					
12. C. Movable Equipment		_					
1. Automotive Equipme		\$					
A. Item	Rate	Amount					
Lender	,						
Address of Lender							
2. Other (Specify)	. ,,	\$					
A. Item	Rate	Amount					
	, , , , , ,						
Lender							
Address of Lender							
	<u>,</u>	<b>4</b>					
B. Item	Rate	Amount					
Toudou		<u> </u>					
Lender							
Address of Lender							
1xdd ob of Domes							
12. C. 3. Total Movable Equips	nent Interest	-	SIND OF THE PROPERTY OF THE PR	(A. 110 A. 1			
Expense (C1 + 2)		\$					
12. D. Other Interest Expense (S	Specify)	\$	95,139	95,139			
Working Capital and Ver	ndor Interest						
13. Total All Interest Expense (1	2B7 + 12C3 + 12D	) \$	95,139	95,139			
14. Insurance	.:: : : : : : : : : : : : : : : : : : :	Δ.					
<ul><li>a. Insurance on Property (b)</li><li>b. Insurance on Automobile</li></ul>		\$					
		hove)					
c. Insurance other than Prop 1. Umbrella ( <i>Blanket Co</i>	• • •	.bove)	70,182	70,182			
2. Fire and Extended Co		\$	10,102	10,102			
3. Other (Specify)	1 V.48V	\$					•
in the copy of		Ψ					
•							
14d. Total Insurance Expenditure	cs(14a+b+c)	\$	70,182	70,182			
15. Total All Expenditures (A-13	thru C-14)	\$	12,083,022	12,083,022			

### D. Adjustments to Statement of Expenditures

	e of Fa	•	care Derby, LLC d/b/a Birmingham Health Ce	ł	cense No. 2236-C	Report for Ye 9/30/2015	ar Ended	Page 28	of 37
Speci	irum 1	leann	Tale Delby, LAX Word Diffiningham Health Ce	1	Total	7/30/2013		<u> </u>	
Ttam	Page	I ina			Amount of				
	No.		Item Description		Decrease	CCNH	RHNS	(Spec	ifv)
			es and Wages		Decrease				
rage	10-3	uiuri	Outpatient Service Costs	\$					
2.			Salaries not related to Resident Care	<del>- Ф</del>					
3.			Occupational Therapy	\$			<del> </del>		
3. 4.	-		Other - See attached Schedule	<del>-</del> \$			,,,,,,,		
	12 Y	) wafas	sional Fees	Φ					
1 uge 5.		10jes	Resident Care Physicians **	\$				200021-002-200002	
6.			Occupational Therapy	\$			***************************************	-	
7.			Other - See attached Schedule	<u>*</u>	·				
	c 15 &	16	Administrative and General	Ψ					
8.	150	10 -	Discriminatory Benefits	\$			Anna sa	12.00 (10.00 PM 10.00	CONTRACTOR DESCRIPTION OF THE PERSON OF THE
9.	15	1c	Bad Debts	\$	60,000	60,000			
10.	13	10	Accounting & Legal	\$		00,000		ļ	
11.			Telephone	\$					
12.			Cellular Telephone	\$					-
13.			Life insurance premiums on the life	Ψ					
1.7.			of Owners, Partners, Operators	\$				Eller Kreeksser	ACESSESSESSESSESSESSESSESSESSESSESSESSESS
14.	~~~		Gifts, flowers and coffee shops	\$					
15.			Education expenditures to colleges or	Ψ					
15.			universities for tuition and related costs						
			for owners and employees	\$				2442248333344	\$\$1200000000000000000000000000000000000
16.	-		Travel for purposes of attending	Ψ					
10.			conferences or seminars outside the						
			continental U.S. Other out-of-state		Halis Barrier				
	ļ		travel in excess of one representative	\$				20100012135353535	THE PERSONS
17.			Automobile Expense (e.g. personal use)	\$					
18.	16	m2	Unallowable Advertising *	\$	2,486	2,486			
19.	10	1113	Income Tax / Corporate Business Tax	\$		2,100			
20.			Fund Raising / Contributions	\$					
21.			Unallowable Management Fees	\$				<u> </u>	
22.			Barber and Beauty	<u>\$</u>				<u> </u>	
23.			Other - See attached Schedule	\$			4.00		
	10 D	i atau	Expenditures	<del>.</del>					
	10 - D		Meals to employees, guests and others	····					
24.			who are not residents	\$					
Dana	10 Y			Φ					
25.	19 - L		ry Expenditures  Laundry services to employees, guests						
23.			and others who are not residents	\$					
na	20 1			Ф					
	20 - H		keeping Expenditures						
26.			Housekeeping services to employees, guests	Φ					
			and others who are not residents  Subtotal (Items 1 - 26)	<u>\$</u>		62,486		<del> </del>	
			Subtotal (Items 1 - 20)	φ		arry Suhtotal f		<u> </u>	

<sup>\*</sup> All except "Help Wanted".

<sup>(</sup>Carry Subtotal forward to next page)

<sup>\*\*</sup> 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)
		Description			
	Salaries	Adjustmenti ale se e e e e e e e e e e e e e e e e e		\$ 2	\$
intii Nelethiininintii	NAME OF THE PERSON NAME OF THE PERSON NAME OF THE PERSON NAME OF THE PERSON NAME OF THE PERSON NAME OF THE PER	АДДУ, ЗАКУАТА БАЛЛИНЕЖЖЕНИЕ ГЕНЕВИР ПЕТОСЕ БИВИНИНИНИ В ВЕМИНЕЖИНИ В ВИТИТЕТИТЕТИТЕТИТЕТИТЕТИТЕТИТЕТИТЕТИТЕТИ			****

#### Schedule of Fees Adjustments

		Description	CCNH	RHNS	(Specify)
					aletratement manufacture (CO)
		usinents		8	8
total Wine	LECGS ACU			<u> Манада факсивация.</u>	

#### Schedule of Other A&G Adjustments

Page Ref Line Ref Description CCNH RHN	
Patal Other A&G Adjustments 5	

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

			D. Adjustments to Stateme	nt	of Expend	litures (co	ont'd)		
Nam	e of Fa	acility		Lic	ense No.	Report for Y	ear Ended	Page	of
Spec	trum F	lealth	care Derby, LLC d/b/a Birmingham Health		2236-C	9/30/2015		29	37
					Total				
Item	Page	Line			Amount of				
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	(Sr	ecify)
			Subtotals Brought Forward	\$	62,486	62,486			
Page	20 - I	Reside	ent Care Supplies***						
27.			Prescription Drugs	\$					
28.			Ambulance/Limousine	\$					
29.			X-rays, etc	\$					
30.			Laboratory	\$					
31.			Medical Supplies	\$					
32,			Oxygen (non emergency)	\$					
33.			Occupational Therapy	\$	· · · · · · · · · · · · · · · · · · ·				
34.			Other - See Attached Schedule	\$					
Page	22 - A	Laint	enance 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	\$			ļ		
39.			Other - See Attached Schedule	\$					
Page	27 - I	nsura	nce						
40.			Mortgage Insurance	\$				ļ <u></u>	,
41.			Property Insurance	\$					on and the second
Othe	r - Mis	scella	neous						5.00
42.			Research or Experimental Activities	\$					
43.			Radio and Television Revenue	\$		<u></u>			
44.			Vending Machine Revenue	\$					
45.			Purchase Discounts and Allowances	\$					
46.			Duplications of functions or services	\$	**************************************	v valvisoveoperateresti van i			SOME SECTION
47.			Expenditures made for the protection,		tale and the second				
			enhancement or promotion of the						
			providers interest	\$		<u></u>			
48.			Interest Income on Accounts Rec	\$		or Assertion and process to the process process and the			
49.			Other (include personnel and other						
			costs unrelated to resident care) - See						
			Attached Schedule	\$	26,620	26,620		mark version at	
Not I	For Pr	ofit P	roviders Only						
50.			Building/Non Movable Eq. Depreciation						
			Unallowable Building Interest -						
			See Attached Schedule	\$					
51.	Total	Amo	unt of Decrease (Items 1 - 50)	\$	89,106	89,106			

<sup>\*\*\*</sup> 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.

Spectrum Healthcare Derby, LLC d/b/a Birmingham Health Center 9/30/2015

#### Schedule of Other Ancillary Costs

		Description	CCNH	RHNS	(Specify)
MINISTER STREET	BONESCHERTING				
				Control of the second s	
Total Other	Ancillary	Costs		\$	

#### Schedule of Excess Movable Equipment Depreciation

Page Ref	Linc Ref	Description	CCNH	RHNS	(Specify)
hyddynan nagadd Tagarian nagadd Tagarian nagadd					
- September 1					
Total Exces	s Movable	Equipment Depreciation			

#### Schedule of Other Property Adjustments

		Description	CCNH	RHNS	(Specify)
				amadak taman di dibe	
	THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER.				
and an analysis	<b>D</b>	Adjustments 3			3
	rrotteray			s Pharman and Legitle in Sec	

Page Rof	Line Ref	Description	CCNH	RHNS	(Specify)
		Yendor intorests and the property of the control of	\$ 26,620		
	ないのはつロスコロリー				
			7		
			\$ 26,620	S F III	

### Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
		Description  A series of the s			
		To the same of the			
Lotal Unal	lowable B				

### F. Statement of Revenue

Name of Facility License No.		Report for Y	Page	of		
Spectrum Healthcare Derby, LLC d/b/a B 2236-C		9/30/2015	30	37		
Item		Total	CCNH	RHNS	(Spec	ify)
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (CT only)	\$	13,311,360		Juno de La Caracteria d	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2KM2041027—1
b. Medicaid Room and Board Contractual Allowance **	\$	(5,467,374)				
2. a. Medicaid (All other states)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (all inclusive)	\$		975,165			
b. Medicare Room and Board Contractual Allowance **	\$		194,050			
4. a. Private-Pay Residents and Other	\$	2,040,845	2,040,845	***		
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$	83,635	83,635	Wedern Charles	1002312002000000	NU SEE
b. Prescription Drugs - Medicare Contractual Allowance **	\$	(83,635)	(83,635)			
c. Prescription Drugs - Non-Medicare	\$	116,825	116,825			•
d. Prescription Drugs - Non-Medicare Contractual Allowance **	<u>\$</u>	(116,825)	(116,825)			
	<u></u> \$	(110,022)	(110,023)		<u> </u>	
a. Medical Supplies - Medicare     b. Medical Supplies - Medicare Contractual Allowance **	<u>_</u> \$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$	100.000	400.000			
3. a. Physical Therapy - Medicare	\$	427,970	427,970			
b. Physical Therapy - Medicare Contractual Allowance **	\$	(323,675)	(323,675)			
c. Physical Therapy - Non-Medicare	\$		.,,			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$		1-00			
4. a. Speech Therapy - Medicare	\$	45,862	45,862	··· <del>····</del>	ļ	
b. Speech Therapy - Medicare Contractual Allowance **	\$	(36,700)	(36,700)		<u> </u>	
c. Speech Therapy - Non-Medicare	\$				<u> </u>	
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$	439,558	439,558			
b. Occupational Therapy - Medicare Contractual Allowance **	. \$	(341,565)	(341,565)			
c. Occupational Therapy - Non-Medicare	\$					
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (Specify) - Medicare	\$					
b. Other (Specify) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)	\$	11,265,496	11,265,496	Same a proper programme of the		
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (Specify)	\$	26	26			
6. Private Duty Nurses' Fees	\$	· · · · · · · · · · · · · · · · · · ·				
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (Specify)	\$	1,168	1,168			
V. Total Other Revenue (1 thru 8)	\$	1,194	1,194			
				- 4.414-		
VI. Total All Revenue (III+V)	\$	11,266,690	11,266,690		<b>!</b>	

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

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

#### Schedule of Other Resident Revenue - Medicare

#### Related Exp

Page Ref Description	CCNH	RHNS	(Specify)
	ASTROPHICAL PROPERTY.		
Total Other Resident Revenue, Medicare 1888		<b>.5</b> .	8

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

#### Related Exp

Page Ref Description	CCNH	RHNS	(Specify)
Total Other Resident Revenue	Station and the state of		ls:

#### **Interest Income**

#### Account

Page Ref Account	Balance	CCNH	RHNS	(Specify)
ACCOUNTRECTIVATE NAME OF THE PROPERTY OF THE P		\$ 26		
Total Interest liconic		26		

#### Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Medical Récords: Disployee Questi Méals:	3 1172		
	Employee:Guest Meats	8 26		
Total Othe	i Revenue	\$ 1,168 \$		

### G. Balance Sheet

Name	e o	f Facility	License No.	Report for Year Ended		Page	of
Spect	trui	m Healthcare Derby, LLC d/b/a	2236-C	9/30/2015		31	37
			Account			An	nount
Asset	ts						
A.	Cu	nrent Assets					
	1.	Cash (on hand and in banks)			\$		83,865
	2.	Resident Accounts Receivable			\$		1,037,814
	3.	Other Accounts Receivable (I	Excluding Owners or	Related Parties)	\$		
-+	4	Inventories		·········	\$		5,013
	5.	Prepaid Expenses	•	g.m.*	\$		424,786
		a. Prepaid-Expenses	· · · · · · · · · · · · · · · · · · ·	53,544			
		b. Prepaid-Insurance		371,242	_#		
		c					
		d.					
	6.	Interest Receivable	···		\$		
	7.	Medicare Final Settlement Re			\$_		
	8.	Other Current Assets (itemize	)	4-4-0-0	\$		154,928
		Resident Refunds		154,928	-		
					$\dashv$		
<b>4-</b> 9.	To	tal Current Assets (Lines A1 t	thru 8)		\$		1,706,407
3.	Fix	xed Assets					
	1.	Land			\$		
	2.	Land Improvements	*Historical Cost		\$		
			Accum. Depreciation	n Net			
	3.	Buildings	*Historical Cost		\$		
			Accum. Depreciation	on Net			
	4.	Leasehold Improvements	*Historical Cost		\$		
			Accum. Depreciation	on Net			
	5.	Non-Movable Equipment	*Historical Cost	205,099	\$		88,294
			Accum. Depreciation	on 116,805 Net			
	6.	Movable Equipment	*Historical Cost	479,361	\$		32,912
			Accum. Depreciation	on 446,449 Net			
	7.	Motor Vehicles	*Historical Cost		\$		
			Accum. Depreciation	n Net			***
•	8.	Minor Equipment-Not Deprec	iable		\$		
	9.	Other Fixed Assets (itemize)			\$		
					$\dashv$		
3-10.		Total Fixed Assets (Lines B1	thru 9)		\$	<u> </u>	121,206

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

## G. Balance Sheet (cont'd)

		f Facility	License No.	Report for Year Ended		Page	of
Spec	ctrur	m Healthcare Derby, LLC d/b/a	2236-C	9/30/2015		32	37
			Account			Am	iount
				Total Brought Forward:	\$		1,827,613
C.	Le	asehold or like property records	ed for Equity Purposes				
	1.	Land			\$		
	2.	Land Improvements	*Historical Cost	11,650			
			Accum. Depreciation	10,875 Net	\$		775
	3.	Buildings	*Historical Cost	6,103,921			
			Accum. Depreciation		\$		2,664,027
	4.	Non-Movable Equipment	*Historical Cost	276,545			
			Accum. Depreciation	276,545 Net	\$	<u></u>	
	5.	Movable Equipment	*Historical Cost	339,981			
	_		Accum. Depreciation	339,981 Net	\$	-	-///-1
	6.	Motor Vehicles	*Historical Cost				
			Accum, Depreciation	Net	\$		·
	7.	Minor Equipment-Not Deprec	iable		\$		
C-8	To	tal Leasehold or Like Properti	es (C1 thru 7)		\$		2,664,802
D.	Inv	estment and Other Assets					
	1.	Deferred Deposits			\$		
	2.	Escrow Deposits	•		\$		
	3.	Organization Expense	*Historical Cost				
			Accum. Depreciation	Net .	\$		
	4.	Goodwill (Purchased Only)			\$		<u></u>
	5.	Investments Related to Reside	nt Care (itemize)		\$	nacement of the state of the st	Ca D YN ANGUSHIS YMWYD YN Y ERWYD AM Y SABSIAN Y
	6.	Loans to Owners or Related Pa	arties ( <i>itemize</i> )		\$		
		Name and Address	Amount	Loan Date			
					\$		
	7.	7. Other Assets (itemize)					30,758
		Lease Deposits/Utility Depo	osits	1,523			
		Utility Deposit		29,235			
		tal Investments and Other Asso			\$		30,758
D-9.	To	tal All Assets (Lines A9 + B10	+ C8 + D8)		\$		4,523,173

<sup>\*</sup> 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 Fac	-		License No.	Report for Year	Ended	Page	of
Spectrum H	ealthc	are Derby, LLC d/b/a Birn		9/30/2015		33	37
			Account			Aı	nount
Liabilities	~	, we distribute					
A.		rrent Liabilities			¢.		1,175,902
	1.	Trade Accounts Payable		<u>, , , , , , , , , , , , , , , , , , , </u>	\$  \$		1,173,902
	2.	Notes Payable (itemize)			9		
					***		
				· · · · · · · · · · · · · · · · · · ·			
	3.	Loans Payable for Equips	nent (Current portion	ı)(itemize)	\$		,
		Name of Lender	Purpose	Amount	Date Due		
.,							
•							
•							
-							
	4.	Accrued Payroll (Exclusive			\$		336,418
	5.	Accrued Payroll (Owners	and/or Stockholders	only)	\$		-
	6.	Accrued Payroll Taxes Pa	yable		\$		12,359
	7.	Medicare Final Settlemen	t Payable		\$		
	8.	Medicare Current Financi	ng Payable		\$		
	9.	Mortgage Payable (Curre	nt Portion)		\$		
	10.	Interest Payable (Exclusiv	e of Owner and/or R	elated Parties)	\$		
	11.	Accrued Income Taxes*			\$		
	12.	Other Current Liabilities	(itemize)		\$		764,260
		Accrued Provider Tax	487,	900	-		
		Accrued Expenses	505,	647			
		Due To Related	(1,079,	540)			
		Working Capital Line of Credit	850,	253			
A-13	To	tal Current Liabilities (Li	nes A1 thru 12)		\$		2,288,939

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

# G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year	Ended	Page	of
Spectrum Healthcare Derby, LLC d/b/a Bir	2236-C	9/30/2015		34	37
Account Total Brought Forward:					ount
		2,288,939			
Liabilities (cont'd)					
B. Long-Term Liabilities				_	
1. Loans Payable-Equipment			\$		
Name of Lender	Purpose	Amount	Date Due		
•					
	<u> </u>				
		l l			
2. Mortgages Payable			\$	}	
3. Loans from Owners or Rela	ated Parties (itemize	)	\$	` }	
Name and Address of Lender	Amount	Loan D	ate		
	1				
· i					
4. Other Long-Term Liabilitie	es (itemize)		9		
-					
B-5. Total Long-Term Liabilities (	Lines B1 thru 4)		9		2 200 020
C. Total All Liabilities (Lines A-	13 + B-5)		[5	Ď	2,288,939

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

	ne of Facility License No. Report for Year Ended 2236-C 9/30/2015		Page 35	of   37
Spe	ctrum Healthcare Derby, LLC d/b/ 2236-C 9/30/2015  Account		<u> </u>	ount
A,	Reserves			
	1. Reserve for value of leased land	\$		775
	Reserve for depreciation value of leased buildings and appurtenances to be amortized	\$		2,664,027
	3. Reserve for depreciation value of leased personal property (Equity)	\$		
	4. Reserve for leasehold real properties on which fair rental value is based	\$		120,136
	5. Reserve for funds set aside as donor restricted	\$		
	6. Total Reserves	\$		2,784,938
В.	Net Worth	6		
_	1. Owner's Capital	\$		<u>,</u>
	2. Capital Stock	\$		
	3. Paid-in Surplus	\$		
	4. Treasury Stock	\$		
	5. Cumulated Earnings	\$		265,628
	6. Gain or Loss for Period 10/1/2014 thru 9/30/20	15 \$		(816,332
	7. Total Net Worth	\$		(550,704
C.	Total Reserves and Net Worth	\$		2,234,234
D.	Total Liabilities, Reserves, and Net Worth	\$		4,523,173

# H. Changes in Total Net Worth

Nam	e of Facility License No.	Report for Year	Ended	Page	of
	trum Healthcare Derby, LLC d/b/a E 2236-C	9/30/2015		36	37
Брес	Account		An	ount	
A.	Balance at End of Prior Period as shown on Report of 09	/30/2014		\$	(1,822,739)
В.	Total Revenue (From Statement of Revenue Page 30)			\$	11,266,690
<u>C.</u>	Total Expenditures (From Statement of Expenditures Page	ge 27)		\$	12,083,022
D.	Net Income or Deficit	***		\$	(816,332)
E.	Balance			\$	(2,639,071)
F.	Additions				
	Additional Capital Contributed (itemize)				
	•				
İ	2. Other (itemize)				
				100	
	•				
	TO 4.1 A J.M.		, , , , , , , , , , , , , , , , , , , ,	\$	WHINESE CONTRACTOR CONT
F-3.	Total Additions  Deductions				
G.	1. Drawings of Owners/Operators/Partners (Specify)			\$	
<u> </u>	Name and Address (No., City, State, Zip)	Title	Amount		
	Name and Address (110., Ony, Bate, 24)				
İ	·				
	2. Other Withdrawings (Specify)	1	1	\$	
<u></u>	Purpose	Amo	aint		
	t urbosc	1 1111			
<u> </u>	3. Total Deductions			\$	
H.	Balance at End of Period 09/30/15	)		\$	(2,639,071)

# I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Spectrum Healthcare Derby, LLC d/b/a	2236-C	9/30/2015	37	37
	Check appropriate category		_,	
☐ Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)	□ (Specify)		
	Preparer/Reviewer Certificati	on		
I have read the most recent Federal as appropriate personnel as to the possil applicable regulations. All non-reimbautomatically removed in the State raperformed by me are properly reported.	report and am familiar with the applicable and State issued field audit reports for the Fole inclusion in this report of expenses which the expenses of which I am aware (extended as such in this report on Pages 28 and 29 ained in this report is in agreement with the	acility and have inquired of ch are not reimbursable under scept those expenses known to ng reports, inquiry or other ser d (adjustments to statement of	the be vices	
Signature of Preparer	Title	Date Signed		
Demis Europhich	Accounting Manage	2/1/16		
Printed Name of Preparer				
Gennaro Evangelista	·			
Addres Address		Phone Number		
27 Naek Rd., Vernon, CT 06066		860-871-5454		