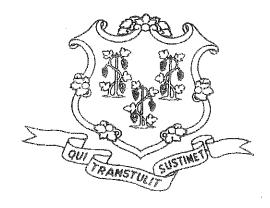
State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2015

Name of Facility (as I	licensed)						
Meriden Care Center,	, LLC						
Address (No. & Stree	-	ip Code)					
33 Roy St. Meriden, G	CT 06450						
Type of Facility							
Chronic and C	onvalescent		Rest Home with	1 Nursing			
✓ Nursing Home	e only		Supervision on	ly	□ (Specify)	
(CCNH)			(RHNS)				
Report for Year Begi	nning		Report for Yea	r Ending			
10/1/2014			9/30/2015				
License Numbers:		CCNH 2153-C	RHNS		(Specify)	Me	dicare Provider 07-5337
Medicaid Provider N	umhers'	CO	CNH	RI	HNS	IC	F-IID
ivicaled a 1 To vider 14	dillocis.	10660	į.		934		
For Department Use	e Only						
Sequence Number	Signed and	Date	Sequence N	umber	Signed on	d Notarized	Date Received
Assigned	Notarized	Received	Assign	ed	Signed an	u Notarizeu	Date Received
			<u> </u>				

Table of Contents

Gene	eral Information - Administrator's/Owner's Certification	1
Gene	eral Information and Questionnaire - Data Required for Real Wage Adjustment	1A
Gene	eral Information and Questionnaire - Type of Facility - Organization Structure	<u>2</u> 3
Gene	eral Information and Questionnaire - Partners/Members	3
Gene	eral Information and Questionnaire - Corporate Owners	3A
Gene	eral Information and Questionnaire - Individual Proprietorship	3B
Gene	eral Information and Questionnaire - Related Parties	4
Gene	eral Information and Questionnaire - Basis for Allocation of Costs	5
Gene	eral Information and Questionnaire - Leases	6
Gene	eral Information and Questionnaire - Accounting Basis	7
Sche	edule of Resident Statistics	8
Sche	edule of Resident Statistics (Cont'd)	9
A.	Report of Expenditures - Salaries & Wages	10
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant	
	Administrators and Other Relatives	. 11
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant	
	Administrators and Other Relatives (Cont'd)	12
B.	Report of Expenditures - Professional Fees	13
	Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee	
	for Service Basis	14
C.	Expenditures Other than Salaries - Administrative and General	15
C.	Expenditures Other than Salaries (Cont'd) - Administrative and General	16
	Schedule C-1 - Management Services	17
C. C.	Expenditures Other than Salaries (Cont'd) - Dietary	18
C.	Expenditures Other than Salaries (Cont'd) - Laundry	19
C.	Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
	Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C.	Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
	Depreciation Schedule	23
	Amortization Schedule	24
C.	Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C.	Expenditures Other than Salaries (Cont'd) - Interest	26
C. D.	Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D.	Adjustments to Statement of Expenditures	28
D.	Adjustments to Statement of Expenditures (Cont'd)	29
F.	Statement of Revenue	30
G.	Balance Sheet	31
G.	Balance Sheet (Cont'd)	32
G.	Balance Sheet (Cont'd)	33
G.	Balance Sheet (Cont'd)	34
G.	Balance Sheet (Cont'd) - Reserves and Net Worth	35
H.	Changes in Total Net Worth	36
Ī.	Preparer's/Reviewer's Certification	37

Annual Report of Long-Term Care Facility

CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2153-C	9/30/2015	1	37

Administrator's/Owner's Certification

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

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

		0.0.20	
Signed (Administrator)	Date	Signed (Owner)	Date
elle,	2/10/16	Must War	off 2/10/16
Printed Name (Administrator)		Printed Name (Owner)	
Raymond Hackling		Chris Wright	
		and the second	BRENDA WALSH
Subscribed and Sworn State of	Date	Signed (Notary Public)	Noto Commission Expires My Commission Expires
to before me:	1.1.1	b . (`)	february 29, 2020
Raumand Hackling CT	2/10/16	Drinda Wal	the first of the second
Address of Notary Public	•		
341 Bidwell Street, Ma	enchest	er, CT 06041	2

(Notary Seal)

State of Connecticut Annual Report of Long-Term Care Facility CSP-1A Rev. 6/95

State of Connecticut **Department of Social Services**

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	tm	ent		Page	of
				1A	37
Name of Facility		Period Cov	ered:	From	То
Meriden Care Center, LLC				10/1/2014	9/30/2015
Address of Facility					
33 Roy St. Meriden, CT 06450				1	
Report Prepared By		Phone Nun		Date	
Denise MacKinnon		860-570-21	40 ext 15		
ltem		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$				
2. Laundry wages paid	\$				
3. Housekeeping wages paid	\$				
4. Nursing wages paid	\$	·			
5. All other wages paid	\$				
6. Total Wages Paid	\$				
7. Total salaries paid	\$				
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire Type of Facility - Organization Structure

		ne No. of Fac -237-5457	ility	Report for Ye 9/30/2015	ar Ended	Page 2	of 37
Name of Facility (as shown on license)	203-		, e c	Street, City, Sta	ita Zin)	<u> </u>	<i>31</i>
Meriden Care Center, LLC				street, City, Sid len, CT 06450	не, ДП)		
CCNH		RHNS	, , 0, 10	(Specify)		Medicare F	Provider No.
License Numbers: 2153-C				(Sp. 11.)		07-5337	
Type of Facility (Check appropriate box(es))							
Chronic and Convalescent Nursing Home only (CCNH)		t Home with l ervision only			(Specify))	
Type of Ownership (Check appropriate box)		•					
O Proprietorship O LLC O Partnership	0	Profit Corp.	0	Non-Profit Co	rp. O	Government	O Trust
If this facility opened or closed during report year pro-	vide:		Date	e Opened	Date Clo	sed	
Has there been any change in ownership			t		L		
or operation during this report year?	0	Yes	•	No	If "Yes,"	explain full	у.
Administrator							
Name of Administrator				Nursing H			
Raymond Hackling				Administra		853	
	taua (6.1	Law rank Alman	£ 41	License	No.:		
Other Operators/Owners who are assistant administration Name	tors (Iui	or part time) OI II	License	No ·		
Name				Dicense	140		

General Information and Questionnaire Partners/Members

Name of Facility		License No.	1 *	Year Ended	Page	of
Meriden Care Center, LLC		2153-C	9/30/2015		3	37
Legal Name of Part	tnership/LLC	Business	Address	State(s) and Which	d/or Town(Registered	
Meriden Care Center, LLC		33 Roy St. Mer 06450	iden, CT	СТ		
Name of Partners/Members	Business A	Address		Title	% Ov	vned
Executive Advisors, LLC	341 Bidwell St. Man	chester, CT 06040	Member		47	.5
Apex Advisors LLC	341 Bidwell St. Man	chester, CT 06040	Member		47	.5
Christopher Wright	341 Bidwell St. Man	chester, CT 06040	Member		5	
-						

General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year	' Ended	Page	of
Meriden Care Center, LLC	2153-C	9/30/2015		3A	37
If this facility is owned or operated as a cor	poration, provide	the following info	rmation:		
Legal Name of Corporation	Busir	ness Address	State(s) in Wh	ich Incorp	orated
				\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
Name of Directors, Officers	Busir	ness Address	Title	No. Sh	
				Held by	Each
Names of Stockholders Owning at Least					
10% of Shares					
				*	
3					
			-		
·					

General Information and Questionnaire Individual Proprietorship

Name of Facility	License No. 2153-C	Report for Year Ended 9/30/2015	Page	of
Meriden Care Center, LLC If this facility is owned or operated as an individu			3B	37
On	wner(s) of Facility	novide the following informa	tion.	
	•			
	,			(3.101000-20002
	, , , , , , , , , , , , , , , , , , ,			
			•••	

State of Connecticut Annual Report of Long-Term Care Facility CSP-4 Rev. 10/2005

General Information and Questionnaire Related Parties*

Name of Facility Meriden Care Center, LLC		License No 215	e No. 2153-C	9	Report for Year Ended 9/30/2015		Page 4	of 37
Are any individuals receivi	Are any individuals receiving compensation from the facility related through	acility re	lated thro	1		If "Yes," provide the Name/Address and	e Name/Add	dress and
marriage, ability to control, ownership, family or business association?	ownership, family or busin	less assoc	siation?	0	Yes © No	complete the information on Page 11 of the report.	nation on Pa	ige 11 of the report.
Are any individuals or com	Are any individuals or companies which provide goods or services,	s or servi	ces,					
including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business	erty or the loaning of funds ciation, common ownership	to this fa	icility, , or busine	SS	• Yes O No			
association to any of the ov	association to any of the owners, operators, or officials of this facility?	of this f	acility?		1,1100044	If "Yes," provide the following information:	e following	information:
			i i			Ladionto Wilhows		
		Good	Also Provides	× +		Costs are Included		
Name of Related	Business	Non-R	Non-Related Parties	ties	Description of Goods/Services	in Annual Report	Cost	Actual Cost to the
Individual or Company	Address	Yes	No 9	**%	Provided	Page # / Line #	Reported	Related Party
See Attached		0	0					The state of the s
		0	0					
		0	0			,		
		0	0					
		0	0					
		0	0					
		0	0					
		0	0					
		0	0					
			1					

^{*} Use additional sheets if necessary.

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-4 Rev. 10/2005

Related Parties*

Meriden Care Center, LLC	de la companya de la			9/3/2015		4	37
		Also Provides	ovides		Indicate Where		6 de 60 0 100 0
Name of Related	Business	Goods/Services to Non- Related Parties	ces to nor Parties	Description of Goods/Services	Costs are included in Annual Report	Cost	Actual Cost to the
Individual or Company	Address	Yes No	**% 0		Page # / Line #	Reported	Party
Bidwell Care Center, LLC	333 Bidwell St. Manchester, CT 06040			Shared Employees		•	
Chelsea Place Care Center, LLC	25 Lorraine St. Hartford, CT 06105			Shared Employees		-	•
int Care	171 Main St. East Windsor, CT 06088			Laundry Services	19 3		•
int Care	171 Main St. East Windsor, CT 06088			Shared Employees		-	•
Care Center,	20 Scott Swamp Rd. Farmington, CT 06032			Bank Fees	16 M	790	(790)
Farmington Care Center,	20 Scott Swamp Rd. Farmington, CT 06032			Shared Employees		11,613	(11,613)
e Brook Care Center,	96 Prospect Hill Rd. East Windsor, CT 06088			Laundry Services	19 3		,
Kettle Brook Care Center,	96 Prospect Hill Rd. East Windsor, CT 06088			Shared Employees		•	ı
den Care Center, LLC er Springs)	33 Roy St. Meriden, CT 06450			Shared Employees			1
Center,	151 Hillside Ave. Hartford, CT 06106			Shared Employees		28,701	(28,701)
tside Care Center, LLC	349 Bidwell St. Manchester, CT 06040			Shared Employees		,	1
Wintonbury Care Center,	140 Park Ave. Bioomfield, CT			Shared Employees			1
ure Care Center LLC	60 West Street, Rocky Hill, CT 06067			Shared Employees		1.521	(1.521)
Tourshardings the entrany	171 Main St. East Windsor, CT			TVITALL	13 5810	35	(758.757)
	341 Bidwell St. Manchester, CT 06040			Building Lease & Rent	10,9,		(867,343)
TC	341 Bidwell St. Manchester, CT 06040			Postage & Legal	16, 15 M.E	44,963	(44,963)
J.	341 Bidwell St. Manchester, CT 06040			Shared EEs not part of memt agmt		125,224	(125,224)
				Management Services, Direct		150,413	(150,413)
				Management Services, Indirect	20 5j	53,438	(53,438)
				Management Services, Administrative	16 M12	310,833	(310,833)
							•
			 				
All O Care Centers mont on							
The Control of Ingine Co.							

^{*} Use additional sheets if necessary.

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

General Information and Questionnaire Basis for Allocation of Costs

Name of Facility	License No		Report for Year Ended	Page	ot
Meriden Care Center, LLC	2153-C	,	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 Medica	d rates,	costs
must be allocated to CCNH and RHNS as follo	ws:				
Item			Method of Allocation		
Dietary		Number of	meals served to residents		
Laundry		Number of	pounds processed		
Housekeeping		Number of	square feet serviced		
A		Number of	hours of routine care provided	by EAG	CH
Nursing		employee o	classification, i.e., Director (or	Charge	Nurse),
		Registered	Nurses, Licensed Practical Nu	ırses, Ai	ides and
		Attendants			
Direct Resident Care Consultants		Number of	hours of resident care provide	d by EA	CH
		specialist	(See listing page 13)		
Maintenance and operation of plant		Square fee	t		
Property costs (depreciation)		Square fee	t		
Employee health and welfare		Gross sala	ries		
Management services		Appropriat	te cost center involved		
All other General Administrative expenses		Total of D	irect and Allocated Costs		
The preparer of this report must answer the fol	lowing 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		ation was
costs allocated as required? O Yes O No not made.					
2. Explain the allocation of related company ex	xpenses and	attach copy	y of appropriate supporting dat	a.	1.112.00100
		F •	<u>, 11 1 11 φ</u>		
·					
3. Did the Facility appropriately allocate and s	elf-disallow	direct and	indirect costs to non-nursing h	ome cos	st centers?
(e.g., Assisted Living, Home Health, Output					
(0.5., 115515000 121115, 1150101, 0.5.)				ah allaa	atlan was
	⊙ Yes	O No	If "No," explain fully why sunot made.		ation was
					1.00

State of Connecticut Annual Report of Long-Term Care Facility CSP-6 Rev. 9/2002

General Information and Questionnaire Leases (Excluding Real Property)

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

should not be included in these amounts.							
Name of Facility			License No.	Report for Year Ended	ear Ended		Page of
Meriden Care Center, LLC			2153-C	9/30/2015			6 37
	Related * to	1 * to					
	Owners,	ers,					
	Operators,	tors,				Annual	
	Officers	ers		Date of	Term of	Amount	Amount
Name and Address of Lessor	Yes	No	Description of Items Leased	$Lease^{**}$	Lease	ofLease	Claimed
Accelerated Care Plus Corp. 4850 Joule Street, Suite A-1 Reno, NV	0	0	Omnistim Electrotherapy and Omnisound Therapeutic Ultrasound Equipment	02/18/10	automatic annual	16,602	16,602
ADP, Inc., One ADP Drive MS-100, Augusta, GA 30909	0	•	Time Clocks and Payroll Punch Equip	04/01/10	60 Months	8,451	8,451
Hasler Inc / Neopost	0	•	Postage Machine	04/30/08	automatic annual	596	596
CANON	0	0	Copier	80/90/80	automatic annual	908	908
Mail Finance/Neopost New England, 25881 Newtwork Place, Chicago, 1L 60673	0	•	Postage Meter Rental		Monthly	386	386
CIT Finance LLC	0	0	Copier		41949	15,543	15,543
	0	0					
	0	0					·
	0	0					
	0	0					

Is a Mileage Log Book Maintained for All Leased Vehicles?

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

Total ***

% O

O Yes

** 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
Meriden Care Center, LLC	2153-C	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			
Is the accounting basis for this		•		
F	Yes	If "No," explain.		
previous period? O	No			
Independent Accounting Firm				
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)		
1 O'Connor, Davies LLP		100 Great Meadow Road, Ste 401, Weth	ersfield, CT (06109
2				
3				
4	•			
Services Provided by This Firm (de	scribe fully)			
1 Taxes, financial statements, accounting	ng support		\$	3,780
2			\$	
3			\$	
4			\$	
			Charge for S	Services Provided
			\$	3,780
Ata Thosa Chargas Baffastad in the Evpan	ditura Portion of This Danort? If V	es, Specify Expense Classification and Line No.		3,700
• Yes O No	15D	es, operaty Expense Classification and time (10)		
Legal Services Information	1.02			
Name of Legal Firm or Independen	t Attorney		Telephone N	Jumber
I iCare Health Management, LL	•		860-570-214	
2 Starble and Harris	C		860-678-77	
3 Durant Nichols / Robinson & G	Cala LLD		860-275-820	
4 Various others (American Arb		Mustba Culling Dahingan	000-2/3-020	00
5 Starble and Harris, iCare Healt		, Murma Cumna, Roomson))		
Address (No. & Street, City, State,			.1	
1 341 Bidwell Street, Mancheste				
2 32 Main Street, Avon, CT				
3 280 Trumbull St, Hartford, CT				
4				
5 32 Main Street, Avon, CT & 3	341 Bidwell Street, Manchest	er CT		
Services Provided by This Firm (de				ι
1 Lease and contract issues, general leg	gal advice, Labor Law		. \$	43,169
2 Lease and contract issues, general leg	gal advice, union funds advice		\$	3,964
3 Employment law, arbitrations, contra	ct negotiations		\$	96,609
4 Employment Arbitrations, healthcare	law		\$	928
5 Collections			\$	651
			Charge for S	Services Provided
			\$	145,321
Are These Charges Reflected in the Expen	diture Portion of This Report? If Y	es, Specify Expense Classification and Line No.		. 10,021
	15D			
• Yes • No				

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

Schedule of Resident Statistics

Name of Facility			License No.	io.			Report for	Report for Year Ended	þ		Page	of
Meriden Care Center, LLC			21	2153-C			9/30/2015					37
					1	eriod 10/	Period 10/1 Thru 6/30	30	[Period 7/1	Period 7/1 Thru 9/30	0
	Total All	Total CCNH	Total RHNS	Total								
	Levels	Level	Level	(Specify)	Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
Certified Bed Capacity On last day of PREVIOUS report period	150	751	,		651	251	,		159	157	2	
B. On last day of THIS report period	159	157	2		159	157	2		159	157	2	
2. Number of Residents												
A. As of midnight of PREVIOUS report period	155	153	2		155	153	2		154	152	2	
B. As of midnight of THIS report period	151	150	-		154	152	2		151	150	-	
3. Total Number of Days Care Provided During Period												
A. Medicare	866	866			844	844			154	154		
B. Medicaid (Conn.)	49,570	48,857	713		36,772	36,226	546		12,798	12,631	167	
C. Medicaid (other states)												
D. Private Pay	. 602	602			487	487			115	115		
E. State SSI for RCH												
F. Other (Specify) INSURANCE/VA	4,415	4,415			3,502	3,502			913	913		
G. Total Care Days During Period (3A thru F)	585,585	54,872	713		41,605	41,059	546		13,980	13,813	167	
Total Number of Days Not Included in Figures in 3G 4. for Which Revenue Was Received for Reserved	rm											
Beds A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	55,585	54,872	713		41,605	41,059	546		13,980	13,813	191	

Schedule of Resident Statistics (Cont'd)

A. Were there may changes in the certified bed capacity during the report year? O Yes	Name of Faci	lity			Licer	ise No.				Report	for Year	Ended		Page	of
Temperature Place of Change Change Change Debt Change	Meriden Care	Center,	, LLC		2	153-C					9/30/201	5		9	37
Place of Change C		•	-			ipacity di	ıring 1	the repo	ort yea	ar?	0	Yes	•	No	
Date of CCNH RHNS (Specify Lost Gained Change Condition Change Condition Change Condition Change Condition Con	11 120	· · · · · · · · · · · · · · · · · · ·			lion.	Cl	nanoe	in Red	·		Car	nacity Afte	er Change		
Change (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) CCNH RHNS (Specify) Reason for Change 5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change. Change in Resident Days Second Change CCNH RHNS CCNH RHNS	Data of						iange			d	Ca	pacity 74th	or enange		
Social Content Soci	Date of	CCNH	KHNS	(Specify)		LOST	I		Jame	u	1				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change. Change in Resident Days Change in Resident Days Self-Pay CCNH RHNS CCNH RHNS (Specify) CCNH RHNS (Specify) CCNH RHNS CCNH RHNS Self-Pay Other State Assisted CONH No. of Residents and Rates on September 30 of Cost Year Medicare Medicare Medicare Medicare RHNS CCNH RHNS CCNH RHNS Self-Pay Other State Assisted To Date The Cond Self-Pay To Date The Cond Self-Pay To Total Number of Physical Therapy Treatments A. Medicare - Part B B. Medicard (Bixdustive of Part B) 1. Maintenance Treatments A. Medicare - Part B B. Medicare Therapy Treatments A. Medicare - Part B B. Medicare (Bixdustive of Part B) 1. Maintenance Treatments A. Medicare - Part B B. Medicare (Bixdustive of Part B) 1. Maintenance Treatments A. Medicare - Part B B. Medicare (Bixdustive of Part B) 1. Maintenance Treatments A. Medicare - Part B B. Medicare (Bixdustive of Part B) 1. Maintenance Treatments A. Medicare - Part B B. Medicare (Bixdustive of Part B) 1. Maintenance Treatments 2. Restorative Treatments 2. Restorative Treatments 3. Soli S. Soli S. Soli C. Other D. Total Specch Therapy Treatments 3. Medicare - Part B B. Medicare (Dixdustive of Part B) 1. Maintenance Treatments 2. Restorative Treatments 3. Medicare - Part B B. Medicare (Dixdustive of Part B) 1. Maintenance Treatments 2. Restorative Treatments 3. Medicare - Part B B. Medicare (Dixdustive of Part B) 1. Maintenance Treatments 2. Restorative Treatments 3. Medicare - Part B B. Medicare - Part B B. Medicare - Part B B. Medicare - Part B C. Other 3. Medicare - Part B A. Medicare - Part B A. Me	Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	Reason fo	or Change
RESIDENT DAYS for 90 days following the change. CCNH RHNS (Specify)		(./	(2)	(5)	(-)	(2)	(5)	(1)	(2)	(5)	COLUIT	THILL	(Specify)	recason re	7 Change
RESIDENT DAYS for 90 days following the change. CCNH RHNS (Specify)															
RESIDENT DAYS for 90 days following the change. CCNH RHNS (Specify)		4													
RESIDENT DAYS for 90 days following the change. CCNH RHNS (Specify)															
Step		•			-		g the 1	eport y	ear (a	s repor	ted in iter	n 4 above) provide the nu	mber of	
2nd change				Change in Ro	esider	nt Days					CC	NH	RHNS	(Spe	cify)
Attending															
All change			**												
Medicare															
Redicate Medicate Medicate Medicate Scif-Pay Other State Assisted			dents an	d Rates on Sente	ember	· 30 of Co	ost Ye	ear			L		L		
Remail	Or Hantoer	OI ICOBI									Sc	elf-Pay		Other Stat	te Assisted
No. of Residents			İ	•									1		
No. of Residents		Item		CCNH	C	CNH	RI	HNS	C	CNH	RI-	HNS	(Specify)	R.C.H.	ICF-MR
a. One bed rm. b. Two bed rms. 447.00 238.00 196.00 326.00 c. Three or more bed rms. 7. Total Number of Physical Therapy Treatments A. Medicare - Part B B. Medicaid (Exclusive of Part B) 1. Maintenance Treatments 2. Restorative Treatments A. Medicare - Part B B. Medicaid (Exclusive of Part B) 1. Maintenance Treatments 4. Medicare - Part B 1. Maintenance Treatments 4. Medicare - Part B 1. Maintenance Treatments 4. Medicare - Part B 1. Maintenance Treatments 5.501 5.501 8. Total Number of Speech Therapy Treatments A. Medicare - Part B 1. Maintenance Treatments 2. Restorative Treatments 4. Medicare - Part B 1. Maintenance Treatments 5. Joint Speech Therapy Treatments 6. Joint Speech Therapy Treatments 7. Total Number of Occupational Therapy Treatments 8. Joint Speech Therapy Treatments 9. Total Number of Toccupational Therapy Treatments 1. Maintenance Treatments 1.	No. of R	esidents	3	3				1							
Description	Per Dier	n Rate													
c. Three or more bed rms. TOTAL CCNH RHNS (Specify) 7. Total Number of Physical Therapy Treatments 2,649 2,649 B. Medicaid (Exclusive of Part B) 2,649 2,649 1. Maintenance Treatments 62 62 C. Other 2,790 2,790 D. Total Physical Therapy Treatments 5,501 5,501 8. Total Number of Speech Therapy Treatments 172 172 A. Medicare - Part B 172 172 B. Medicaid (Exclusive of Part B) 1 14 14 1. Maintenance Treatments 14 14 14 C. Other 202 202 202 D. Total Speech Therapy Treatments 388 388 9. Total Number of Occupational Therapy Treatments 2,916 2,916 A. Medicard - Part B 2,916 2,916 B. Medicaid (Exclusive of Part B) 2,916 2,916 B. Medicaid (Exclusive of Part B) 2,916 2,916 A. Medicard - Part B 2,916 2,916 B. Medicaid (Exclusive of Part B) 2,916 2,916 B. Medicaid (Exclusive of Part B)															
TOTAL CCNH RHNS (Specify)	b. Two	bed rms		447.00		238.00		196.00		326.00					
7. Total Number of Physical Therapy Treatments	c. Three	or mor	e												
A. Medicare - Part B B. Medicaid (Exclusive of Part B) 1. Maintenance Treatments 2. Restorative Treatments 62 62 C. Other 7,790 2,790 D. Total Physical Therapy Treatments 8. Total Number of Speech Therapy Treatments A. Medicare - Part B 9. Medicaid (Exclusive of Part B) 1. Maintenance Treatments 2. Restorative Treatments 14 14 C. Other 202 202 D. Total Speech Therapy Treatments 388 388 9. Total Number of Occupational Therapy Treatments A. Medicare - Part B 9. Total Speech Therapy Treatments 1. Maintenance Treatments 2. Restorative Treatments 3. Medicaid (Exclusive of Part B) 1. Maintenance Treatments 2. Restorative Treatments 388 388 9. Total Number of Occupational Therapy Treatments A. Medicare - Part B 2. Medicaid (Exclusive of Part B) 1. Maintenance Treatments 2. Restorative Treatments 3. Medicaid (Exclusive of Part B) 1. Maintenance Treatments 2. Restorative Treatments 3. Medicaid (Exclusive of Part B) 1. Maintenance Treatments 2. Restorative Treatments 3. Medicaid (Exclusive Treatments 3. Medicaid (Exclusive Treatments 4. Medicare - Part B 5. Medicaid (Exclusive of Part B) 1. Maintenance Treatments 2. Restorative Treatments 3. Medicaid (Exclusive Of Part B) 3. Medicaid (Exclusive Of Part B) 4. Medicare - Part B 5. Medicaid (Exclusive Of Part B) 5. Medicaid (Exclusive Of Part B) 6. Medicaid (Exclusive Of Part B) 7. Maintenance Treatments 7. Restorative Treatments 9. Medicaid (Exclusive Of Part B) 1. Maintenance Treatments 2. Restorative Treatments 3. Medicaid (Exclusive Of Part B) 4. Medicaid (Exclusive Of Part B) 5. Medicaid (Exclusive Of Part B) 6. Medicaid (Exclusive Of Part B) 7. Medicaid (Exclusive Of Part B) 8. Medicaid (Exclusive Of Part B) 9. Total Number Of Occupational Therapy Treatments 9. Medicaid (Exclusive Of Part B) 9. Medic	bed	rms.		***											
B. Medicaid (Exclusive of Part B) 1. Maintenance Treatments 62 62 62 62 62 62 62 6					tment	S					то			RHNS	(Specify)
1. Maintenance Treatments 62 62 2. Restorative Treatments 62 62 C. Other 2,790 2,790 D. Total Physical Therapy Treatments 5,501 5,501 8. Total Number of Speech Therapy Treatments 172 172 B. Medicaid (Exclusive of Part B) 172 172 1. Maintenance Treatments 14 14 2. Restorative Treatments 14 14 388 388 388 9. Total Speech Therapy Treatments 388 388 9. Total Number of Occupational Therapy Treatments 2,916 2,916 B. Medicaid (Exclusive of Part B) 2,916 2,916 B. Medicaid (Exclusive of Part B) 1,623 1,623 1. Maintenance Treatments 1,623 1,623 2. Restorative Treatments 1,623 3,406)										
C. Other 2,790 2,790 D. Total Physical Therapy Treatments 5,501 5,501 8. Total Number of Speech Therapy Treatments 172 172 A. Medicare - Part B 172 172 B. Medicaid (Exclusive of Part B) 1 14 14 C. Other 202 202 D. Total Speech Therapy Treatments 388 388 9. Total Number of Occupational Therapy Treatments 2,916 2,916 B. Medicaid (Exclusive of Part B) 2,916 2,916 1. Maintenance Treatments 1,623 1,623 2. Restorative Treatments 1,623 3,406 C. Other 3,406 3,406												- and Color II describe profession (a relative a cons	man a familiar for the control of the state	Andrews Andrews Control Consult (Special Spec	AND DESCRIPTION OF THE PROPERTY OF THE PROPERT
D. Total Physical Therapy Treatments			torative	Treatments									62		
8. Total Number of Speech Therapy Treatments 172 172 A. Medicare - Part B 172 172 B. Medicaid (Exclusive of Part B) 1. Maintenance Treatments 14 14 2. Restorative Treatments 14 14 14 C. Other 202 202 D. Total Speech Therapy Treatments 388 388 9. Total Number of Occupational Therapy Treatments 2,916 2,916 A. Medicare - Part B 2,916 2,916 B. Medicaid (Exclusive of Part B) 2,916 2,916 1. Maintenance Treatments 1,623 1,623 2. Restorative Treatments 1,623 1,623 C. Other 3,406 3,406				an an											
A. Medicare - Part B B. Medicaid (Exclusive of Part B) 1. Maintenance Treatments 2. Restorative Treatments 14 14 C. Other 202 202 D. Total Speech Therapy Treatments 388 388 9. Total Number of Occupational Therapy Treatments A. Medicare - Part B B. Medicaid (Exclusive of Part B) 1. Maintenance Treatments 2. Restorative Treatments 1. C. Other 3.406												5,501	5,501		
B. Medicaid (Exclusive of Part B) 1. Maintenance Treatments 1. Maintenance Treatments 14 2. Restorative Treatments 14 C. Other 202 D. Total Speech Therapy Treatments 388 9. Total Number of Occupational Therapy Treatments 2,916 A. Medicare - Part B 2,916 B. Medicaid (Exclusive of Part B) 2,916 1. Maintenance Treatments 1,623 2. Restorative Treatments 1,623 C. Other 3,406					nents							172	172		
1. Maintenance Treatments 14 14 14 2. Restorative Treatments 202 202 202 D. Total Speech Therapy Treatments 388 388 9. Total Number of Occupational Therapy Treatments 2,916 2,916 A. Medicare - Part B 2,916 2,916 B. Medicaid (Exclusive of Part B) 2,916 2,916 1. Maintenance Treatments 1,623 1,623 2. Restorative Treatments 1,623 3,406 C. Other 3,406 3,406					· · · ·							1/2	172		
2. Restorative Treatments 14 14 14 C. Other 202 202 D. Total Speech Therapy Treatments 388 388 9. Total Number of Occupational Therapy Treatments 2,916 2,916 A. Medicare - Part B 2,916 2,916 B. Medicaid (Exclusive of Part B) 2,916 3,406 1. Maintenance Treatments 1,623 1,623 C. Other 3,406 3,406]				,										
C. Other 202 202 D. Total Speech Therapy Treatments 388 388 9. Total Number of Occupational Therapy Treatments 2,916 2,916 A. Medicare - Part B 2,916 2,916 B. Medicaid (Exclusive of Part B) 3,916 3,916 1. Maintenance Treatments 1,623 1,623 2. Restorative Treatments 3,406 3,406						-						14	14		
9. Total Number of Occupational Therapy Treatments A. Medicare - Part B 2,916 B. Medicaid (Exclusive of Part B) 1. Maintenance Treatments 2. Restorative Treatments 1,623 1,623 C. Other 3,406	C.											202	202		
A. Medicare - Part B 2,916 2,916 B. Medicaid (Exclusive of Part B) 1. Maintenance Treatments 1,623 1,623 C. Other 3,406 3,406												388	388		
B. Medicaid (Exclusive of Part B) 4 1. Maintenance Treatments 1,623 2. Restorative Treatments 1,623 C. Other 3,406					Treat	ments									
1. Maintenance Treatments 1,623 1,623 2. Restorative Treatments 1,623 1,623 C. Other 3,406 3,406											mid by this Continue or the SA	2,916	2,916	A bola and his home and the Man Strick owner.	hereard a shall be a state of the state of t
2. Restorative Treatments 1,623 1,623 C. Other 3,406 3,406] B.)										
C. Other 3,406 3,406												1		-	
			torative	rreauments							-		 		
			Occupat	ional Therapy T	reatr	nents							1		

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.		Report for Year		Page	of
Meriden Care Center, LLC	2153-C		9/30/2015		10	37
Are time records maintained by all individuals receiving co	mpensation?	•	Yes	0	No	
			Total Cost a	nd Hours	***************************************	
			10111 0057 11			
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I						
of Schedule A1) 2. Administrator(s) (Complete also Sec. III						
of Schedule A1)	143,245	2,249	1,861	29		
3. Assistant Administrator (Complete also Sec. IV	113,213	2,219	1,001	2)		
of Schedule A1)						
4. Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)	179,664	8,538	2,335	111	70.00	
5. Dietary Service						
a. Head Dietitian	61.207	2.050	669	27		
b. Food Service Supervisor c. Dietary Workers	51,397 484,604	2,059 27,935		27 363		
6. Housekeeping Service	484,004	21,933	0,277	303		
a Head Housekeeper		689		9		
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
Engineer or Chief of Maintenance	50,681	1,996		26		
b. Other Maintenance Workers	48,587	2,212	631	29		
B. Laundry Service a. Supervisor						
b. Other Laundry Workers			1		1	
Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants 12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	202,938	4,192	1,318	27		
b. RN	202,950	7,172	1,510	24 /		
1. Direct Care	565,795	12,932	3,676	84		
2. Administrative**	234,975	5,758	1,527	37		
c, LPN						
1. Direct Care	1,485,462	50,232	9,651	326	1	
2. Administrative** d. Aides and Attendants	2,023,631	122,097	13,144	793		
e. Physical Therapists	2,023,031	122,077	15,111	175		
f. Speech Therapists						
g. Occupational Therapists	V-10					
h. Recreation Workers	159,938	7,953	2,078	103		
i. Physicians						
Medical Director Utilization Review						
3. Resident Care***						
4. Other (Specify)						
. Doubleton						
j. Dentists		 	_		 	
k. Pharmacists l. Podiatrists	+					
m. Social Workers/Case Management	143,767	5,699	1,868	74		
n, Marketing						
o. Other (Specify)						
See Attached Schedule	27,347					
A-13. Total Salary Expenditures	5,802,029	256,053	46,068	2,059	<u> </u>	<u> </u>

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

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

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

Schedule of Other Salaries and Wages (Page 10)

		CC	NH		RH	NS	(Spec	cify)
Position		\$	Hours		\$	Hours	\$	Hours
UNIT SECRETARIES SALARIES	\$	12,122	495	\$	158	6		
MEDICAL RECORDS SALARIES	\$	-	-	\$	_			
CENTRAL SUPPLY SALARIES	\$	15,225	1,018	\$	198	13		
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	 -			 				
	ļ			 				-
Total	\$	27,347	1,513	\$	355	19	\$ -	

Schedule of Other Fees (Page 13)

		CC	NH		RH	INS	(Spe	cify)
Service		\$	Hours		\$	Hours	\$	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$	3,742	55	\$	49	1		
ADMISSIONS C/S LABOR	\$	31,608	682	\$		9		
CENTRAL SUPPLY CONTRACT SERVICE	\$	10,025	262	\$	130	3		
ADMINISTRATIVE CONTRACT SERVICE LABOR	\$	93,516	2,807	\$	1,215	36		
RESPIRATORY THERAPY CONTRACT SERVICES	\$	1,339	30	\$.	17	0.38		
			•					
444								
		·					1	
			:					
	1			 				
Total	\$	140,229	3,836	\$	1,411	50	\$ -	-

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

Schedule A1 - Salary Information for Operators/Owners; Administrators,

istant Administrators and Other Related Parties*

		,	Assistan	t Administra	Assistant Administrators and Other Related Parties*	r Kelate	d Parties	¥		
Name of Facility				License No.		Report for	Report for Year Ended		Page	Jo
Meriden Care Center, LLC				2153-C		9/30/2015			11	37
		Salary Paid	p.							
				Fringe Benefits and/or Other		Total	Line Where		Total	
Name	CCNH	RHINS	(Specify)	Payments (describe fully)	Full Description of Services Rendered	Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours Worked	Compensation Received
Section I - Operators/Owners										
				1				`		
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
									·	
			(
		``								
* No allowance for calaries will be considered unless full information is movided. He additional sheets if required	he consider	f salan ba	all informatio	a is propided. He	additional sheets if red	nired				

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

^{**} Include all employment worked during the cost year.

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*

(L 11 /				T. Contract NI.		Donout for Voor Endod	Con Endad		Dage	٥٠
Name of Facility (as licensed)				Ficense Ino.		Report for 1	ar Ellaca		ਾ ਕੁਲੂਹ -	 5
Meriden Care Center, LLC				2153-C		9/30/2015			12	37
And the state of t		Salary Paid	-							
				Fringe Benefits and/or Other		Total	Line Where		Total	
Name	CCNH	RHINS	(Specify)	Payments (describe fully)	Full Description of Services Rendered	Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours Worked	Compensation Received
Section III - Administrators***										
		dende versifueren beleefe fift enkert beleefe be		same as employees less						
Raymond Hackling	35,695	398		union funds	Administrator	567 A2	42			
Patrick McDonnell (10/01/2014 -				same as						
06/15/15)	107,550	1,463		union funds	Administrator	1,711 A2	42			
Section IV - Assistant Administrators		*				,				
								,		
]:			;].				

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

^{**} Include all other employment worked during the cost year.

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

Annual Report of Long-Term Care Facility

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.		Report for Y	ear Ended	Page	of
Meriden Care Center, LLC	215	3-C	9/30/2015		13	37
		T	Total Cost a	and Hours		
	,		1,			
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee			200000			
for service basis in lieu of salary						
(For all such services complete Schedule B1)					-	
1. Dietitian	32,145	689	418	9		
2. Dentist						
3. Pharmacist	10,587	182	138	2		
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	116,538	1,411				
b. Other						
6. Social Worker	2,613	training	34	training		
7. Recreation Worker	13,637	12+Cable	177	1 + cable	١	
8. Physicians						
a. Medical Director (entire facility)	38,500	243	500	3		
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility			15.00			
1 Infection Control Committee	\$ 1 m					
(Quarterly meetings) 2. Pharmaceutical Committee	-		<u> </u>			-
(Quarterly meetings)						
3. Staff Development Committee						
(Once annually)						
e. Other (Specify)						
Physician Care Contract Services	25,342	252		3		
9. Speech Therapist						
a. Resident Care	15,288	227				
b. Other						
10. Occupational Therapist			0.000			
a. Resident Care	124,980	1,663				
b. Other						
11. Nurses and aides and attendants						
a. RN	1 1					
1. Direct Care	84,455	1,233	549			
2. Administrative***	33,311	666	216	4		
b. LPN						
1. Direct Care	21,759	487		3		
2. Administrative***		ļ				
c. Aides	2,413	108	16	1		
d. Other						
12. Other (Specify)						
See Attached Schedule	140,229	3,836	1,411	50		
B-13 Total Fees Paid in Lieu of Salaries	661,798	10,997	3,459	76		

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

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

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

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

Name of Facility	License No.		Report for	Year Ended	Page of	
Meriden Care Center, LLC	2153-C		9/30/2015		14 37	
			to Owners,			
Name & Address of Individual	Full Explanation of Service		rs, Officers	Expla	nation of Relationship	
		Yes	No		····	
Omnicare	Pharmacy Consulting	0	•			
Tocuhpoints Therapy	Therapy	0	0	Common Own	ership	
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Shared Employees	•	0	Common Own	ership	
Healthcare Dental	Audiology, Dental and Podiatry	0	•			
Ready Nurse, Nurse Network	Nursing pool (RN, LPN,CNA)	0	•		· · · · · · · · · · · · · · · · · · ·	
Masonicare	Medical Director	0	•			
IPC Hospitalists	Medical Director	0	0			
		0	0			
		0	0		,	
		0	0			
		0	0			
		0	0			
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^{*} Use additional sheets if necessary.

^{**} Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility License No.	Report for Y	ear Ended	Page	of ·
Meriden Care Center, LLC 2153-C	9/30/2015		15	37
Item	 Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits			100000000000000000000000000000000000000	
Workmen's Compensation	\$ 492,301	485,987	6,315	
2. Disability Insurance	\$			
3. Unemployment Insurance	\$			
4. Social Security (F.I.C.A.)	\$ 543,136	536,169	6,967	
5. Health Insurance	\$ 1,038,151	1,024,834	13,317	
6. Life Insurance (employees only)				
(not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory)	\$ 331,213	326,965	4,249	
(not-owners and not-operators)			211	
8. Uniform Allowance	\$			
9. Other (Specify)	\$ 43,427	42,869	557	
See Attached Schedule				
b. Personal Retirement Plans, Pensions, and	\$			And the second s
Profit Sharing Plans for Owners and				
Operators (Discriminatory)*				
			100	
c. Bad Debts*	\$ 144,149	144,149		
d. Accounting and Auditing	\$ 3,780	3,732	48	
e. Legal (Services should be fully described on Page 7)	\$ 145,321	143,457	1,864	
f. Insurance on Lives of Owners and	\$			
Operators (Specify)*				
g. Office Supplies	\$ 12,490	12,330	160	
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 35,811	35,351	459	
2. Cellular Phones	\$ 1,308	1,291	17	
i. Appraisal (Specify purpose and	\$ 			
attach copy)*				
2.,				
j. Corporation Business Taxes (franchise tax)	\$ 252	249	3	
k. Other Taxes (Not related to property - See Page 22)				
1. Income*	\$			
2. Other (Specify)	\$ 			
See Attached Schedule		ining a second desired		
3. Resident Day User Fee	\$ 1,168,397	1,153,409	14,987	
Subtotal	\$ 3,959,736	3,910,792	48,943	

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

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

Meriden Care Center, LLC 9/30/2015

Attachment Page 15

Schedule of Other Employee Benefits

Description		CCNH	RHNS	(Specify)	
UNION TRAINING	\$	42,869	\$ 557		
	:				
		i janaki			
			*50.45		
·					
Total	\$	42,869	\$ 557	\$ -	

Schedule of Other Taxes

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

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

Name of Facility	License No.		Report for Y	Year Ended	Page	of
Meriden Care Center, LLC	2153-C		9/30/2015	:	16	37
T4			T-4-1	COMIL	DING	(Cif-)
Item	Aula Danualit Cama		Total	CCNH	RHNS	(Specify)
	otals Brought Forwa	ra:	3,959,736	3,910,792	48,943	
1. Travel and Entertainment		Φ.		*		
1. Resident Travel and Entertainment		\$				
2. Holiday Parties for Staff		\$				
3. Gifts to Staff and Residents		\$	4.5.45	4.400		
4. Employee Travel	1 24	\$	4,243	4,188	54	
5. Education Expenses Related to Seminars		\$	8,035	7,932	103	
6. Automobile Expense (not purchase or de	epreciation)	\$				
7. Other (<i>Specify</i>)		\$	962	950	12_	
See Attached Schedule						
m. Other Administrative and General Expenses						
 Advertising Help Wanted (all such exper 		\$	7,287	7,194	93	
2. Advertising Telephone Directory (all suc	ch expenses)***	\$				
3. Advertising Other (Specify)***		\$	9,778	9,653	125	
See Attached Schedule						
4. Fund-Raising***		\$				
5. Medical Records		\$				
6. Barber and Beauty Supplies (if this servi-	ce is supplied	\$				
directly and not by contract or fee for ser	vice)***					
7. Postage		\$	4,973	4,909	64	
* 8. Dues and Membership Fees to Profession	nal	\$	10,787	10,649	138	
Associations (Specify)						
See Attached Schedule					\$16 G (F)	
8a. Dues to Chamber of Commerce & Other Nor	n-Allowable Org.***	\$				233
9. Subscriptions		\$	373	368	5	
10. Contributions***		\$	568	561	7	•
See Attached Schedule		•				
11. Services Provided by Contract (Specify a	md Complete	\$	113,583	112,126	1,457	
Schedule C-2, Page 21 for each firm or i	-	-	,	,	,	
12. Administrative Management Services**		\$	310,833	306,846	3,987	
13. Other (Specify)		\$	31,190	30,790	400	
See Attached Schedule		7	,,,,,	- 7 3		
C-14 Total Administrative & General Expenditur	es	\$	4,462,347	4,406,957	55,390	

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

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

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

Schedule of Other Travel and Entertainment

Description			CCNH	RHNS	(Specify)
MEALS			\$ 950	\$ 12	
		* a			
				5.50	
		raginal for the end a few	1.10		244 2.27
Total Other Travel and	Entertainment		\$ 950	\$ 12	\$ -

Schedule of Other Advertising

Description	CNH	R	HNS	(Specify)
COMMUNICATIONS SPECIAL EVENTS	\$ 9,653	\$	125	
Total Other Advertising	\$ 9,653	\$	125	\$ -

Schedule of Dues

Description		CCNH	RHNS	(S	pecify)
Dues					
CAHCF Dues	\$	10,649.03	\$ 138.37		
OTHER DUES					
	T				
	1		 		
Total Dues	\$	10,649	\$ 138	\$	-

Schedule of Contributions

Description	C	CNH	J	RHNS	(Spec	ify)
CHARITABLE CONTRIBUTIONS	s	561	\$	7		
·						
Total Contributions	\$	561	\$	7	\$	

Schedule of Other Administrative and General

Description	_	CCNH	Γ	RHNS	(Specify)
SOCIAL SERVICE SUPPLIES	\$	-	\$	-	
SOC SVC MINOR EQUIPMENT	\$	738	\$	10	
ADMINISTRATIVE MINOR EQUIPMENT	\$	2,721	\$	35	
EMPLOYEE RELATIONS	\$	7,932	\$	103	
EMPLOYEE RELATIONS-OTHER	\$	893	\$	12	
PERMITS & LICENSES	\$	3,534	\$	46	
VOLUNTEER EXPENSE	\$	-	.\$	-	
BANK FEES	\$	10,261	\$	133	
CMS REVISIT USER FEES	\$	-	\$		
PENALTIES	\$	1,145	\$	15	
LATE FEES	\$	3,566	\$	46	
Rounding					
Total Other Administrative and General	\$	30,790	\$	400	S ~

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Meriden Care Center, LLC	2153-C	9/30/2015	17 37
Name & Address of Individual or Company Supplying Service iCare Management, LLC/iCare Health Management, LLC	Cost of Management Service 310,833	Full Description of Mgmt. Service Provided Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Indicate Where Costs are Included in Annual Report Page #/Line # Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	148,483	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	52,753	MANAGEMENT FEES- INDIRECT CARE	Pg 20 j
,			
,			

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

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

		Ţ		n Page 5)					
Nan	ne of Facility		Licens	e No.	1 ^		ear Ended	Page	of
Mer	iden Care Center, LLC			2153-C	g	9/30/2015		18	37
	Item			Total		CCNH	RHNS	(S	pecify)
2.	Dietary			3 3000			A CONTRACTOR		
	a. In-House Preparation & Service								
	1. Raw Food		\$	334,856		330,560	4,295		
- "	2. Non-Food Supplies		\$	46,964		46,362	602		
	3. Other (Specify)		. \$	28,824		28,454	370		
	DIETARY SUPPLEMENTS					100			
	b. Purchased Services (by contract other	-	\$	(1,153))	(1,139)	(15)		
	than through Management Services)								
	(Complete Schedule C-2 att. Page 21)						Banks School		
	c. Management Services**		\$						
	d. Other (Specify)		\$	10,557		10,421	135		
	DIETARY MINOR EQUIPMENT		-"						
	•						35 2 35 Ca		
2E.	Total Dietary Expenditures $(2a + b + c + d)$		\$	420,047		414,659	5,388		
2F.	Dietary Questionnaire			Total		CCNH	RHNS	(S	pecify)
G.	Resident Meals: Total no. of meals served pe	r day	U•*	463	+	457	6		F <i>J</i>
			Yes		No			1	
Н.	Is cost of employee meals included in 2E?		1 68		INO				
I.	Did you receive revenue from employees?	0	Yes	•	No		If yes, specify		
							amt.		
J.	Where is the revenue received reported in the	Co	st Repo	rt? (Page/Line	Item	1)			
	Is cost of meals provided to persons other						If yes, specify		
K.	than employees or residents (i.e., Board	0	Yes	•	No				
	Members, Guests) included in 2E?						cost.		
	10 . 10	\sim	V	0	NI-		If yes, specify		
L.	Is any revenue collected from these people?	U	Yes	•	No		amt.		
M.	Where is the revenue received reported in the	Co	st Repo	rt? (Page/Line	Iten	1)			
	Is cost of food (other than meals, e.g.,		1			r			
	snacks at monthly staff meetings, board	_		_			If yes, specify		
N.	meetings) provided to employees included	O	Yes	•	No		cost.		
	in 2E?								
							If yes, specify		
O.	Is any revenue collected from employees?	0	Yes	•	No		amt.		
<u></u>			4 D		T.	`	41111.		
Р,	Where is the revenue received reported in the	Co	st Kepo	rt (Page/Line	iten	1)			

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

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

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

Name of Facility			e No.	Report for Y	ear Ended	Page	of
Mer	den Care Center, LLC	2	153-C	9/30/2015		19	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. \$	1,300	1,283	17	- Section - Sect	
	2. Employee items including uniforms, gowns, etc. washed, ironed and/or	Lbs.					
	processed.***	Amt. \$					
	 Personal clothing of residents washed, ironed, and/or processed.*** 	Lbs.					
	washed, froned, and/or processed.	Amt, \$					
	4. Repair and/or purchase of linens.***	Lbs.					<u> </u>
		Amt. \$					
	b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$	416,129	410,791	5,338		
	c. Management Services**	\$					
	d. Other (Specify) LAUNDRY SUPPLIES	\$	0.00				
3E.	Total Laundry Expenditures (3a + b + c + d)	\$	418,211	412,847	5,364		
3F. G.	Laundry Questionnaire Is cost of employee laundry included in 3E? O	Yes	•	No	If yes, specify cost.		
Н.	Did you receive revenue from employees?	Yes	•	No	If yes, specify amt.		
1.	Where is the revenue received reported in the Cos	t Report?	?	(Page/Line	e 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 Cos	t Report?	?	(Page/Line	e Item)		

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

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

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

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

į.	ne of Facility	License No.	Repo	ort for Year E	nded	Page	of
Mer	iden Care Center, LLC	2153-C		9/30/2015		20	37
	Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced	ı				
	a. In-House Care	by Personnel					
	1. Supplies - Cleaning (Mops,	Amt.	\$	28,308	27,945	363	
	pails, brooms, etc.)						
	b. Purchased Services (by contract other	Sq. Ft. Serviced		1	,		
	than through Management Services)	by Personnel					
	(Complete Schedule C-2 att.	Amt.	\$	468,401	462,392	6,008	
	Page 21)						
	c. Management Services*		\$				
	d. Other (Specify)		\$				
	HOUSEKEEPING MINIR EQUIP	MENT					
4E.	Total Housekeeping Expenditures (4a +	b+c+d)	\$	496,709	490,338	6,371	
5.	Resident Care (Supplies)**						
	a. Prescription Drugs***				100000000000000000000000000000000000000		
	1. Own Pharmacy	\$		a an a three and the state of t			
	2. Purchased from		\$	260,399	257,059	3,340	
	OMNICARE PHARMACY						
	b. Medicine Cabinet Drugs		\$	19,354	19,105	248	
	c. Medical and Therapeutic Supplies		\$	76,479	75,498	981	
	d. Ambulance/Limousine***		\$	3,479	3,479		
	e. Oxygen		~~~~				
	1. For Emergency Use		\$	3,420	3,420		
	2. Other***		\$				
	f. X-rays and Related Radiological		\$	3,666	3,666		
	Procedures***						
	g. Dental (Not dentists who should be inc	luded under	\$				Common Co
	salaries or fees)						
	h. Laboratory***		\$	10,316	10,316		
	i. Recreation		\$,· · ·		
	j. Other (Specify)****		\$	316,767	313,405	3,362	
	See Attached Schedule		-			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
5K.		<u></u>	\$	693,880	685,949	7,931	

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

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

^{***} Facility should self-disallow the expense on Page 29 of the Cost Report.

^{****} ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	(CCNH]	RHNS	(Specify)
NURSING ADMIN SUPPLIES	\$	1,031	\$	13	
NURSING MINOR EQUIP	\$	5,808	\$	75	
MEDICAL RECORDS SUPPLIES	\$		-\$	-	·
MEDICAL RECORDS MINOR EQUIPMENT	\$	-	\$	-	
MANAGEMENT ALLOCATIONS - DIRECT	\$	148,483	\$	1,929	· .
NON-COVERED PPS DR. VISITS	\$	650	\$		
RESIDENT CARE SUPPLIES	\$	149	\$	2	
CENTRAL SUPPLY MINOR EQUIPMENT	\$	7,916	\$	103	
PERSONAL CARE SUPPLIES	\$	11,618	\$	151	
INCONTINENCY SUPPLIES	\$	26,846	\$	349	
VACCINE RESIDENTS	\$	1,447	\$	19	
PATIENT SPECIAL NEEDS	\$	417	\$	5	
PHYSICAL THERAPY SUPPLIES	\$	- N	\$		
PHYSICAL THERAPY EQUIPMENT RENT	\$		\$	_	
PHYSICAL THERAPY MINOR EQUIPMENT	\$	_	\$	-	
OCCUPATIONAL THERAPY SUPPLIES	\$. 17	\$	0	
OCCUPATIONAL THERAPY EQUIP RENTAL	\$		\$		
OCCUPATIONAL THERAPY MINOR EQUIP	\$		\$		
SPEECH THERAPY SUPPLIES	\$		\$		
SPEECH THERAPY EQUIPMENT RENT	\$		\$	- 1	
SPEECH THERAPY MINOR EQUIPMENT	\$	- 1	\$	-	
RENTALS FOR NURSING EQUIPMENT NON BILLABLE	\$	39,757	\$	<u>-</u>	
EQUIPMENT RENTAL: AIDS UNIT	\$	-	\$	-	
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$	4,180	\$	-	
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$	30	\$	_	
HI LOW BED RENTAL & MATTRESSES	\$	2,388	\$	-	
IV THERAPY SUPPLIES	\$	7,700	\$	-	
IV THERAPY CONTRACT SERVICE	\$	<u> </u>	\$	· _	:
MEDICAL WASTE CONTRACT SERVICE	\$	945	\$	12	
ACTIVITIES SUPPLIES	\$	1,268	\$	16	
ACTIVITIES MINOR EQUIPMENT	\$		\$	-	
MANAGEMENT ALLOCATION - INDIRECT	\$	52,753	\$	685	
ADMISSIONS SUPPLIES	\$		\$		
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$		\$		
	1,100		14 (14)		in the second
Total Other Resident Care	\$	313,405	\$	3,362	\$ -
Total Other Resident Care	3	313,403	2	3,302	5 -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 10/2001

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

Name of Facility Meriden Care Center, LLC				License No. 2153-C	Report for Year Ended 9/30/2015				Page 21	of 37
				Address Transfer						
		Related ** to Owners, Operators, Officers	o Owners, Officers				Total Cost/	Total Cost/Page Ref.***	. بد	
Name of Individual or	,	,	,	Explanation of	Full Explanation of	111 600	or drawn.	(g b)		,
Company	Address	Yes	No	Kelationship	Service Provided"	CCNH	KHINS	(Specify)	20 20	Line
Health Services Group	3220 Hillman Drive, Bensalem, PA 19020	0	0	VENDOR	Housekeeping Services	466,500			20	4b
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020 -	0	0	VENDOR	Laundry Services	414,440			19	36
Eagle Elevator		0	0	VENDOR	Elevator Contract	9,189			22	6F
Bioserve, Inc.		0	0	VENDOR	Medical Waste	766			22	6F
The Brickman Group/ Twin Landscaping		0	0	VENDOR	Snow Removal/Landscaping	16,671			22	6F
USA - Recycling		0	0	VENDOR	Trash removal	42,255			22	6F
American HealthTech		0	0	VENDOR	Software Maintenance Contract	10,713			91	M
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	0	0	VENDOR	Payroll Services	48,883			16	MII
National Datacare Corp		0	0	VENDOR	Resident Trust Software	3,418			16	M11
Prime Care Technologuy services		0	0	VENDOR	Computer Consulting Services	20,337			16	MII
Priotity Express		0	0	VENDOR	Courier Services	5,949	1		16	M11
Point Right Inc		0	0	VENDOR	Nursing Software	4,680			19	MII
10000 0 000		0	0	VENDOR						
		0	0	VENDOR						
and the state of t										

^{*} List all contracted services over \$10,000. Use additional sheets if necessary.

^{**} Refer to Page 4 for definition of related.

^{***} Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Ye	ear Ended		Page	of
Meriden Care Center, LLC	2153-C	9/30/2015			22	37
Item		Total	CCNH	RHNS	(Specif	y)
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	32,326	31,912	415		
b. Heat	\$	45,205	44,625	580		
c. Light & Power	\$	135,264	133,529	1,735		
d. Water	\$	87,096	85,979	1,117		
e. Equipment Lease (Provide detail on p	age 6) \$	42,384	41,840	544		
f. Other (itemize)	\$	107,382	106,004	1,377		
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a -	-6f) \$	449,657	443,889	5,768		
7. Depreciation (complete schedule page 23	*)					
a. Land Improvements	\$!				
b. Building & Building Improvements	\$	16,071	15,865	206		
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$	43,900	43,339	560		
*7e. Total Depreciation Costs $(7a + b + c + d)$) \$	59,971	59,204	767		
8. Amortization (Complete att. Schedule Page	ge 24*)					
a. Organization Expense	\$					
b. Mortgage Expense	\$:
c. Leasehold Improvements	\$	45,277	44,696	581		
d. Other (Specify)	\$					
*8e. Total Amortization Costs (8a + b + c + d	l) \$	45,277	44,696	581		
9. Rental payments on leased real property !	ess					
real estate taxes included in item 10b	\$	662,412	653,915	8,497		
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	135,948	134,204	1,744		
c. Personal property taxes	\$	7,068	6,978	91		
11. Total Property Expenses (7e + 8e + 9 +	10) \$	910,676	898,997	11,679		

^{*} 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)
PLANT SUPPLIES	\$ 13,775	\$ 179	
PLANT CONTRACT SERVICE LABOR	\$ 496	\$ 6	
ELEVATOR CONTRACT SERVICE	\$ 12,011	\$ 156	
FIRE/SPRINKLER CONTRACT SERVICE	\$ 5,170	\$ 67	
LANDSCAPING CONTRACT SERVICE	\$ 8,269	\$ 107	A
SNOW REMOVAL CONTRACT SERVICE	\$ 8,189	\$ 106	
TRASH REMOVAL CONTRACT SERVICE	\$ 41,713	\$ 542	
HVAC CONTRACT SERVICE	\$ -	\$ -	
SECURITY CONTRACT SERVICE	\$ -	\$ -	
PLANT CONTRACT SERVICE OTHER	\$ 9,501	\$ 123	
PLANT MINOR EQUIPMENT	\$ 6,881	\$ 89	
RENT AUTO	\$ -	\$ -	
RENT EQUIPMENT	\$ -	\$ -	
RENT OTHER	\$ -	\$ -	
		-	
Total Other Repairs and Maintenance	\$ 106,004	\$ 1,377	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility CSP-23 Rev. 10/2006

				Ω	epreci	Depreciation Schedule	hedule					
Name of Facility Meriden Care Center, LLC				Licens	License No. 2153-C	c		Report for Year Ended 9/30/2015	guded		Page 23	and a state of the
				Hist	Historical Cost	Less		Accumulated Depreciation to	Method of			
Property Item				Exclu	Exclusive of Land	Salvage Value	Cost to Be Depreciated	Beginning of Year's Operations	Computing Depreciation	Useful Life	Depreciation for This Year	
A. Land Improvements									-			
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)	th schedu	le)										
A-4. Subtotal												
B. Building and Building Improvements												
1. Acquired prior to this report period				.,,	321,424		321,424	0			16,071	
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)	th schedu	le)										
B-4. Subtotal												
C. Non-Movable Equipment												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)	h schedu	le)						A CASA CAN AND AND AND AND AND AND AND AND AND A		440000000000000000000000000000000000000	TO A SECURITY OF S	
C-4. Subtotal												
	Is a mîleage	age										
	logbook		Date of	Hist	Historical			Accumulated	1			
	maintained?	당	Acquisition		Cost	Less		Depreciation to	Method of			
					Exclusive of	Salvage	Cost to Be			Useful	Depreciation	
- 1	Yes	No N	Month Year	CONTRACTOR CO.	Land	value	Deprecialed	rears Operations	Depreciation	Constitution	JOI THIS TOWN	Transfers h
D. Movable Equipment 1. Motor Vehicles (Specify name, model and year of each vehicle) a.				2 m								
b.												
C.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period				· ·	591,229		591,229	449,101			42,503	
b. Disposals (attach schedule)				and the second s								
c. Acquired during this report period												
(attach schedule)					33,576	ever and country as section from South Section	271 (0400 / Keng)), Outp. (077 / King)	A TANAHA MARANA MANANA	The second section of the second seco	Call Carrey Species Common Hamping	1,396	
D-3. Subtotal												
E. Total Depreciation												

16,071

Totals

Totals

of 37

43,900 59,971

Schedule of Land Improvements Acquired during this report period

•	overheins seed in earlying this report period		Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
			The second secon	
		1 1 1 1 1 1 1		
		114, 1444		CLEAN CAPE
Total additions for Lan	d Improvements	\$ -		\$
Deletions:				
		1.		
	And the father of the light of the		1 2 4 4 1 4 1 4 1 4 1 4 1 4 1 4 1 4 1 4	1000
			in the second second	1 1 1 1 1 1
l'otal deletions for Land	d Improvements	\$ -		\$

^{*}Ties to Page 23, Line A3

Schedule of Building Improvements Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
dditions:				
Cotal additions for Building Im	provements	- \$ -		\$
Deletions:				
				<u> </u>
				1.10
Fotal deletions for Building Im	provements	\$	1	\$

^{*}Ties to Page 23, Line B3

Schedule of Non-Movable Equipment Acquired during this report period

, .	mont required during this report period		Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
	-			
				<u> </u>
		· ·		
	27	\$ -	+	
Fotal additions for Non-Movabl	e Equipment	3 -		\$ -
Deletions:				
	the state of the state of	1.		
				14 1 1 1 1 1
		TO THE REAL PROPERTY OF THE PARTY OF THE PAR		

^{*}Ties to Page 23, Line C3

^{**}Ties to Page 23, Line A2

^{**&#}x27;Ties to Page 23, Line B2

^{**}Ties to Page 23, Line C2

Acquisition Date	Description of Item		Cost	Useful Life	De	preciation
Additions:						•
2/5/2015	Window Blinds: Direct supply	\$	1,591	60	\$	186
1/7/2015	Dishwasher Motor: Proline	\$	2,355	60	\$	314
12/31/2014	Plumbing Washer & Dryer; James T Kay & Daniels equipmen t	\$	4,760	120	\$. 357
3/18/2015	Steam Table: Direct Supply	8	2,240	120	\$	112
3/17/2015	Electric Bed- Medline	\$	3,573	60	\$	357
8/4/2015	Electrick Beds: Direct Supply & Medline	\$	4,225	60	\$	70
9/1/2015	Fant Cornic Board, Sjhas, Panacea Bed: Direct Supply	\$	6,751	60	\$	
9/4/2015	Bed & Mattress: Medline	\$	8,080	60	\$	-
			11.		1.5	1.7
Total additions for	r Movable Equipment	\$	33,576		\$	1,396
Deletions:						
					Ϊ	
		1				
		T			1	
Total deletions for	Movable Equipment	\$			\$	т. н

^{*}Ties to Page 23, Line D2c **Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

	•		Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
1/23/2015	Shower tub & wall - Sahar Shalom	\$ 6,248	60	\$ 833
1/6/2015	Upgrade walk in Freezer: Climatech Mechanical	\$ 1,780	120	\$ 119
2/23/2015	1st Floor Shower Renovation: Sahar Shalom	\$ 6,248	60	\$,833
5/28/2015	Locks, Alarms, Keypads, Ect.: S&S Wired Systems	\$ 8,285	.120	\$.276
6/2/2015	Replace Compressor Walk in Cooler, Climatech Mechanical	\$ 3,297	180	\$ 55
9/14/2015	Replace Motor on Flud Inducer; Climatech	\$ 2,606	120	\$ -
9/18/2015	Locks, Alarms, Keypads, Ect.: S&S Wired Systems	\$ 8,279	120	\$ -
9/20/2015	Fence & Sidewalk: Sahar Shalom	\$ 6,806	240	\$ -
Total additions for	r Leasehold Improvement	\$ 43,549		\$ 2,110
Deletions:				
				Marin 1
Total deletions for	Leasehold Improvement	\$ -		\$ -

^{*}Ties to Page 24, Line C3

^{**}Ties to Page 24, Line C2

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

Amortization Schedule*

Nan	Name of Facility		License No.		Report for Year Ended	r Ended		Page	of
Mer	Meriden Care Center, LLC		2153-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	Rate Amortization	
	Item	Month Year	- Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
Α.	Organization Expense								
	1. Organization Expense		5	3,614	3,614				
ļ 	2.								
<u>.</u>	3.								
A-4.	. Subtotal								
B.	Mortgage Expense								
								·	
	2.								00
	3.								
B-4.	. Subtotal								
Ċ.	Leasehold Improvements and Other	-							
	1. Acquired prior to this report period			422,335	189,467			43,161	
	2. Disposals (attach schedule)								
	3. Acquired during this report period								
	(attach schedule)			43,549				2,116	
C-4.	C-4. Subtotal								45,277
Ω	Total Amortization								45,277

* 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; ORC. Remaining Life of Lease; ORD. Actual Life if owned by Related Party.

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

Name of Facility	License No.	Report for Year En	ded		Page of
Meriden Care Center, LLC	2153-C	9/30/2015			25 37
11. Property Questionnaire					
Part A				· · · · · · · · · · · · · · · · · · ·	
Is the property either owned by tl	he Facility	V	0	NI.	If "Yes," complete Part B.
or leased from a Related Party?*	· ·	Yes	O	No	If "No," complete Part C.
*If any owner or operator of this fa					-
business association to any person a related party transaction.	or organization from whom	buildings are leased, the	en it is considered		
Description		Total			
Date Land Purchased	**************************************	12/01/03			
2. Date Structure Completed					
If NOT Original Owner, Dat	e of Purchase	12/01/03			
4. Date of Initial Licensure		12/01/03			
5. Total Licensed Bed Capacity		159	7.00		
6. Square Footage				1	
7. Acquisition Cost			That Section		
a. Land b. Building	,,				
Part B - Owner and Related Pa	rties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing	11 0103	73t tviortgage	Ziid Wortgage	Std Mortgage	4th Mortgage
a. Type of Financing (e.g., f	fixed, variable)	FIXED HUD			
b. Date Mortgage Obtained		05/30/13			
c. Interest Rate for the Cost		335,00%			
d. Term of Mortgage (numb		26	44.0		
e. Amount of Principal Born		2,990,000	***************************************		
f. Principal balance outstan	-	2,830,704			
Complete if Mortgage was					
g. Type of Financing (e.g., f					
h. Date of Refinancing	ixed, variable)				
i. New Interest Rate					
j. Term of Mortgage (numb	er of years)		-		***************************************
k. Amount of Principal Born					
Principal Outstanding on					
Part C - Arms-Length Leas				mman.	· · · · · · · · · · · · · · · · · · ·
Name and Address of Lesso	or Pro	perty Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility	License No.		Report for Y	ear Ended		Page of
Meriden Care Center, LLC	2153-C		9/30/2015			26 37
Ite	m		Total	CCNH	RHNS	(Specify)
12. Interest						(aparta)
A. Building, Land Impro	vement & Non-Movab	le				
Equipment	•					
1. First Mortgage		\$				
Name of Lender		Rate				
Address of Lender		•				
2. Second Mortgage		\$				
Name of Lender		Rate				
Address of Lender		•				
3. Third Mortgage		\$				
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage	<u> </u>	4	3			
Name of Lender		Rate			3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	
Address of Lender					All Indiana de la Carte de la	
B. CHEFA Loan Inform	ation			200		
1. Original Loan Am	ount	\$	3			
2. Loan Origination l	Date					
3. Interest Rate %						
4. Term						
5. CHEFA Interest E	xpense				The same second	
12 B7. Total Building Interest E	-N	5) \$	3			
	_ `			ry Subtotals	Course and to a	

(Carry Subtotals forward to next page)

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

Name of Facility Meriden Care Center, LLC	License No. 2153-0	7		Report for Y 9/30/2015	ear Ended		Page o 27 37	
Tricinati dare comer, EBC	2100			7/30/2013			4 3	
Ite	m			Total	CCNH	RHNS	(Specify)	
	Subtota	ls Brou	ıght Forward:					
12. C. Movable Equipment								
1. Automotive Equipme			\$					
A. Item	I	Rate	Amount					
Lender								
Address of Lender								
2. Other (Specify)			\$					
A. Item	ī	Rate	Amount					
Lender								
Address of Lender								
B. Item]	Rate	Amount					
Lender								
Address of Lender								
Address of Lender								
12. C. 3. Total Movable Equip Expense (C1 + 2)	ment Interest		\$					
12. D. Other Interest Expense (Specify)		\$		10,287	134		
INTEREST								
13. Total All Interest Expense (12B7 + 12C3	+ 12D) \$	10,420	10,287	134		
14. Insurance								
a. Insurance on Property (t)	\$		8,663	113		
b. Insurance on Automobil		4.00	\$					
c. Insurance other than Pro		cified a						
1. Umbrella (Blanket C			\$		59,435	772		
2. Fire and Extended Co 3. Other (<i>Specify</i>)	overage		\$ \$	_	4 160	F A		
5. Other (Specify)			D.	4,214	4,160	54		
14d. Total Insurance Expenditur	res (14a + b +	c)	\$	73,197	72,258	939		28/256
15. Total All Expenditures (A-1	3 thru C-14)		\$		14,300,006	148,491		

D. Adjustments to Statement of Expenditures

Name		-	nter, LLC	Lie	cense No. 2153-C	Report for Ye 9/30/2015	ar Ended	Page 28	of
Meric	ien Ca	re Ce	nter, LLC		Total	9/30/2013		20	37
ļ, l	ъ.								
Item					Amount of	CC3.11.1	DID 16		10.
	No.		Item Description		Decrease	CCNH	RHNS	(Sp	pecify)
Page	10 - S	alarie	es and Wages						
1.			Outpatient Service Costs	\$					
2.			Salaries not related to Resident Care	\$					
3.			Occupational Therapy	\$					
4.			Other - See attached Schedule	\$					
Page	13 - P	rofes:	sional Fees						
5.			Resident Care Physicians **	\$					
6.			Occupational Therapy	\$]			
7.			Other - See attached Schedule	\$					
Pages	s 15 &	16 -	Administrative and General						
8.			Discriminatory Benefits	\$					
9.			Bad Debts	\$		144,149			
10.			Accounting & Legal	\$					
11.			Telephone	\$					
12.			Cellular Telephone	\$					
13.			Life insurance premiums on the life	Ψ					
12,			of Owners, Partners, Operators	\$					
14.			Gifts, flowers and coffee shops	\$					
$\overline{}$				Φ					
15.			Education expenditures to colleges or						
			universities for tuition and related costs	d)					
			for owners and employees	\$					
16.			Travel for purposes of attending		NEWS OF S	1000			
			conferences or seminars outside the						
			continental U.S. Other out-of-state						
			travel in excess of one representative	\$					
17.			Automobile Expense (e.g. personal use)	\$					
18.			Unallowable Advertising *	\$	9,778	9,653	125		
19.			Income Tax / Corporate Business Tax	\$					
20.			Fund Raising / Contributions	\$	6				
21.			Unallowable Management Fees	\$					
22.			Barber and Beauty	\$	3				
23.			Other - See attached Schedule	\$	25,750	25,689	61		
	18 - L)ietar	y Expenditures						
24.		Ī	Meals to employees, guests and others						
			who are not residents	\$					
Dago	10 1	ания	ry Expenditures						
25.	1/72		Laundry services to employees, guests						
45.			and others who are not residents	\$					
D	20 '				2				
	20 - I	10USE	keeping Expenditures						
26.			Housekeeping services to employees, guests	đ	,			Ten (1997)	
		L .	and others who are not residents	\$				ļ	
			Subtotal (Items 1 - 26)	\$	179,677	179,490	187		

^{*} All except "Help Wanted".

⁽Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	 		CCN	NH	RHN	NS	(Speci	ify)
			 •	 						
otal Othe	r Salaries .	Adjustment			\$	-	\$	-	\$	

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16		Management fee over cost	\$ -	\$ -	
	6			1	

					-
otal Othe	r Fees Adj	ustments	\$	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref Description		CCNH]	RHNS	(Specify)
16a	PENALTIES	\$	1,145	\$	15	
16a	LATE FEES	\$	3,566	\$	46.	
16a	PRIOR PERIOD EXPENSES	-				
	rounding		0			
	Provider user fee for Medicare days		20,977.96			÷
Total Othe	r A&G Adjustments	\$	25,689	\$	61	\$ -

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

Name	e of Fa	ecility	D. Adjustments to Statemen		ense No.	Report for Y	 / 	Page	of
			nter, LLC	1./10	2153-C	9/30/2015	car Ended	29	37
IVICIN	uch Ca		nter, ble		Total	7/30/2013		27	
Item	Page	Line			Amount of				
	No.		Item Description		Decrease	CCNH	RHNS	(Sn	ecify)
110,	110.	110.	Subtotals Brought Forward	\$	179,677	179,490	187	(Sp.	Jenry)
Page	20 ~ 1	Reside	nt Care Supplies***	Ψ.	175,677	177,470	107		
27.	<u> </u>	Legitie	Prescription Drugs	\$					
28.			Ambulance/Limousine	\$	3,479	3,479			
29.			X-rays, etc	\$	3,666	3,666			
30.			Laboratory	\$	10,316	10,316			
31.			Medical Supplies	\$					
32.			Oxygen (non emergency)	\$			1		
33.			Occupational Therapy	\$,		
34.			Other - See Attached Schedule	\$	650	650			
Page	22 - 1	Mainte	enance and Property						
35.			Excess Movable Equipment Depreciation			-			
		1	See Attached Schedule	\$					
36.			Depreciation on Unallowable						
			Motor Vehicles	\$	PHASE 110		and the second second second second second		moment of the state of the stat
37.			Unallowable Property and Real						
			Estate Taxes	\$			7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7		
38.			Rental of Building Space or Rooms	\$					
39,			Other - See Attached Schedule	\$					
Page	27 - J	nsura	nce						
40.			Mortgage Insurance	\$					
41.			Property Insurance	\$					
Othe	r - Mi	scella	neous						
42.		L	Research or Experimental Activities	\$;				
43.	<u> </u>		Radio and Television Revenue	\$					
44.			Vending Machine Revenue	\$					
45.			Purchase Discounts and Allowances	\$					
46.			Duplications of functions or services	\$					
47.			Expenditures made for the protection,						
			enhancement or promotion of the						Tale of the
			providers interest	\$					
48.			Interest Income on Accounts Rec	\$					
49.			Other (include personnel and other						
			costs unrelated to resident care) - See						
	<u> </u>	<u> </u>	Attached Schedule	\$					
		ofit P	roviders Only						
50.			Building/Non Movable Eq. Depreciation						
			Unallowable Building Interest -	_					
<u> </u>		<u> </u>	See Attached Schedule	\$		10=			
51.	Totai	Amo	unt of Decrease (Items 1 - 50)	\$	197,788	197,601	187		

^{***} 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.

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5J	NON-COVERED PPS DR. VISITS	650.34		
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	-		
13	B9A	ST- Resident Care (for outpatent therapy - see schedule)	-		
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)			
		Prince and the second s			
Total Othe	r Ancillary	Costs	\$ 650	\$	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
		·			
				[N 1 12	
otal Exec	ess Movable	Equipment Depreciation	\$ -	S -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description			CC	CNH	RI	INS	(Spec	ify)
			-			7 7 30				-
						. 1				
					1					***************************************
									-	
		1								
- ""							1 a			
Fotal Othe	r Property	Adjustments		 	\$		\$	-	\$	-

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	4A1	Houskeeping Supplies (for Outpatient Therapy - see schedule)	-		
20	4B	Housekeeping purchased services (for Outpatient Therapy see schedule)			
22	6B	Heat (for outpatient Therapy see schedule)			
22	6C	Light and Power (for outpatient therapy see schedule)			
22	6D	water (for outpatient therapy see schedule)			
22	6A	Repair&Maint (for outpatient therapy see schedule)	•		***
Total Othe	r Adjustm	ents	\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
				1.5	
				a de la Ver	
					\$18.F
			To the second		
Total Unal	lowable Bu	uilding Interest	\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility	License No.		Report for Y	ear Ended		Page of
Meriden Care Center, LLC	2153-C		9/30/2015			30 37
	There		T . 1	CCNTI	BIBIG	40 10
I. Resident Room, Board & Ro	Item		Total	CCNH	RHNS	(Specify)
·		ф	11 516 000		100 505	
1. a. Medicaid Residents (C		\$	11,716,992	11,577,287	139,705	
	oard Contractual Allowance **	\$				
2. a. Medicaid (All other sto		\$				
	Board Contractual Allowance **	\$				
3. a. Medicare Residents (a)		\$				
	oard Contractual Allowance **	\$				
4. a. Private-Pay Residents		\$	1,651,434	1,651,434	··········	
······································	Board Contractual Allowance **	\$				
II. Other Resident Revenue						
 a. Prescription Drugs - M 	ledicare	\$	52,575	52,575		<u>,</u>
b. Prescription Drugs - M	ledicare Contractual Allowance **	\$	(52,575)	(52,575)		
c. Prescription Drugs - N	on-Medicare	\$	220,470	220,470		
d. Prescription Drugs - N	on-Medicare Contractual Allowance **	\$	(220,470)	(220,470)		
2. a. Medical Supplies - Me	dicare	\$				
b. Medical Supplies - Me	dicare Contractual Allowance **	\$				
c. Medical Supplies - No	n-Medicare	\$				
d. Medical Supplies - No	n-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Me		\$	81,321	81,321		
	dicare Contractual Allowance **	\$	(46,666)	(46,666)		
c. Physical Therapy - No		\$	104,814	104,814		
	n-Medicare Contractual Allowance **	\$	(104,814)	(104,814)	7,000	
4. a. Speech Therapy - Med		\$	16,967	16,967	11.01	
	icare Contractual Allowance **	\$	(6,669)	(6,669)		
c. Speech Therapy - Non		\$	16,147	16,147		
	-Medicare Contractual Allowance **	\$	(16,147)	(16,147)		
5. a. Occupational Therapy		\$	101,191	101,191		
	- Medicare Contractual Allowance **	\$	(43,916)	(43,916)		
c. Occupational Therapy		\$	140,043	140,043		
	- Non-Medicare Contractual Allowance **	<u>\$</u>	(6,842)	(6,842)		
6. a. Other (Specify) - Medi		\$		(0,042)		
b. Other (Specify) - Non-		\$	31,416	31,416		
III. Total Resident Revenue (S		\$			100 705	
IV. Other Revenue*	ection 1. this section 11.)		13,635,272	13,495,567	139,705	
Meals sold to guests, emp		\$				
2. Rental of rooms to non-re	sidents	\$				
3. Telephone		\$				
4. Rental of Television and (Cable Services	\$				
5. Interest Income (Specify)		\$	42	42		
6. Private Duty Nurses' Fees		\$				
7. Barber, Coffee, Beauty an	d Gift shops	\$				
8. Other (Specify)		\$	480	480		
V. Total Other Revenue (1 thru	18)	\$	521	521		
VI. Total All Revenue (III +V)		\$	13,635,794	13,496,088	139,705	

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	(CONH	RHNS	(Specify)
	Lab Medicare	\$	4,349		1.5
	Lab Medicare CA	s	(4,349)	44, 14	
	Oxygen Medicare	\$	34		
	Oxygen Medicare CA	\$	(34)		
	Equipment rental	\$	954		
	Equipment rental CA	\$	(954)		
	Pen Therapy :	\$			
	Pen Therapy CA	\$			
	Therapy Beds Medicare	\$	-		
	Therapy Beds Medicare CA	\$	-		
	Radiology Medicare	ş	738		
	Radiology Medicare CA	\$	(738)		
	IV Therapy	\$	7,630		
	IV Thorapy CA	\$	(7,630)		
	Medical Transportation	\$	-	•	
	Medical Transportation CA	\$	-		
	Glucose testing	\$	-		
	Glucose testing CA	\$	-		
	Outpatient therapy Medicare	\$			
Total Oth	ter Resident Revenue - Medicare	\$		\$	<u>s</u> -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Lab	5,967.32		
	Lab CA	(5,967,32)		
	Oxygen	\$ 448		\$ -
	Oxygen CA	\$ (448)		\$ -
	Equipment rental	\$ 14,566		
	Equipment rental CA	\$ (14,566)		1
	Pen Therapy	\$ -		
	Pen Therapy CA	s -		
	Therapy Beds	s -		
	Therapy Beds CA	\$ -		
	Radiology	\$ 2,041		
	Radiology CA	\$ (2,041)		
	Medical Transportation	\$ 6,994		
	Medical Transportation CA	\$ (6,994)		
	Glucose Testing	\$ -		
	Glucose Testing CA	ş -		
	IV therapy	\$ 15,003		ş -
	IV therapy CA	\$ (15,003)		\$ -
	Fiu shot revenue	\$ 1,616		
	Outpatient therapy	\$ -		
	PRIOR YEAR ADJ - ANCILLARY & OTHER	\$ 29,801		
	rounding	\$ (1)		
Total Otl	ier Resident Revenue	\$ 31,416 \$	S	\$ -

Interest Income

Account

Page Ref A	kecount	Balance	CCNH	RHNS	(Specify)
	NTEREST INCOME	1 1	\$ 42		
Total Intere			\$ 42	s -	s -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	MEALS	-		
	TELEVISION INCOME			
	CONCESSIONS / VENDING INCOME	480		
	RESIDENT LATE FEE REVENUE			
	RESIDENT ATTORNEY FEE REVENUE	3 -		
	TELEPHONE INCOME	•		
	OTHER INCOME	-		
N T C F F T	OPTUM DIVIDENDS REVENUE	-		
Total Oth	Per Revenue	480		s -

G. Balance Sheet

		Facility	License No.	Report for Year	Ended	Page	of
Merid	en	Care Center, LLC	2153-C	9/30/2015		31	37
Assets	t1		Account			An	nount
		rrent Assets					
Δ. ·	1	Cash (on hand and in banks)		\$		(6,575)
	<u>1.</u> 2.	Resident Accounts Receivab		or Bad Debts)	\$		1,789,601
	2. 3.	Other Accounts Receivable (\$		118,233
	<u>3.</u> 4	Inventories	Zitoria di il Si di il dil d	11014104 1 411100)	\$		110,233
	 5.	Prepaid Expenses			\$		220,780
		a. Prepaid Insurance		212,359		2.7	,
		b. Prepaid Property Taxes					
		c. Prepaid Expenses Other		8,421			
		d.					
(6.	Interest Receivable			\$		
,	7.	Medicare Final Settlement R	leceivable		\$,	
į	8.	Other Current Assets (itemiz	re)		\$		(288,633)
		Due From (to) Related Parties Other Owners reserves		(20,250 (268,384			
		Other Owners reserves		(200,364	,		
		tal Current Assets (Lines Al	thru 8)		\$	I	1,833,405
		ed Assets					
		Land			\$		
	2.	Land Improvements	*Historical Cost		_ \$		
			Accum. Depreciati		Net		
	3.	Buildings	*Historical Cost	321,424	\$		305,353
		1 1 1 T	Accum Depreciati				001 140
4	4.	Leasehold Improvements	*Historical Cost	465,884	- 1		231,140
	_	New Manual Province	Accum. Depreciati *Historical Cost	on 234,744	Net		
	Э.	Non-Movable Equipment			- Net	•	
		Mayahla Equipment	Accum. Depreciati *Historical Cost	624,806			131,805
'	0.	Movable Equipment	Accum. Depreciati		- _{Not} \$	1	131,803
,	7	Motor Vehicles	*Historical Cost	011 493,000	\$		
	1.	Wiolor Verticles	Accum. Depreciati	on	- Net		
	8.	Minor Equipment-Not Depre	···············	ion .	\$		
	9.	Other Fixed Assets (itemize)		\$		
	<i>)</i>	Construction in Progress	,		l ^Ψ		
		Constitution in Fregress					
B-10.		Total Fixed Assets (Lines B	31 thru 9)	<u>-</u>	\$	·	668,298

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

G. Balance Sheet (cont'd)

Nam	Name of Facility		License No.	Report for Year Ended		Page	of
Meri	den	Care Center, LLC	2153-C	9/30/2015		32	37
			Account			Amo	unt
				Total Brought Forward	. \$		2,501,703
C.	Lea	asehold or like property recor	ded for Equity Purpose	·S.	T		
	1.	Land			\$		
	2.	Land Improvements	*Historical Cost				
			Accum. Depreciation	n Net	\$		
	3.	Buildings	*Historical Cost		T		
ļ			Accum. Depreciation	n Net	\$		
	4.	Non-Movable Equipment	*Historical Cost		T		
			Accum. Depreciation	n Net	\$		
	5.	Movable Equipment	*Historical Cost		T		
			Accum. Depreciation	n Net	\$		
	6.	Motor Vehicles	*Historical Cost				
			Accum. Depreciation	n Net	\$		
	7.	Minor Equipment-Not Depre	eciable		\$		
C-8		tal Leasehold or Like Proper			\$		
D.	lnv	vestment and Other Assets					
	1.	Deferred Deposits			\$		
	2.	Escrow Deposits			\$		1-1111111111111111111111111111111111111
	3.	Organization Expense	*Historical Cost	3,614			
			Accum. Depreciatio	n 3,614 Net	\$		
	4.	Goodwill (Purchased Only)			\$		
		Investments Related to Resid	dent Care (itemize)		\$		79,100
		Patient Trust Funds		76,545			
		Long Term Deposit - prir	necare	2,555	7		
	6.	Loans to Owners or Related			\$		
		Name and Address	Amount	Loan Date			
					7		
							9.00
	7.	Other Assets (itemize)			\$		
ļ				THE REPORT OF THE PARTY OF THE			
D-8.	To	otal Investments and Other A	ssets (Lines D1 thru 7)		\$		79,100
D-9.	To	otal All Assets (Lines A9 + B	10 + C8 + D8		\$		2,580,803

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

G. Balance Sheet (cont'd)

Name of Facility License No.		Report for Year	Ended	Page	of		
Meriden Car	e Cer	ter, LLC	2153-C	9/30/2015		33	37
			Account			An	nount
Liabilities							
A.	Cu	rrent Liabilities					
,	1.	Trade Accounts Payable				\$	630,781
	2.	Notes Payable (itemize)			i =	\$	513,577
		Working Capital Line of	Credit	513,57	7		
		-					
	3.	Loans Payable for Equip			-	\$	
		Name of Lender	Purpose	Amount	Date Due		
					12/4/15/2	144	
	4.	Accrued Payroll (Exclusi	ve of Owners and/or	 Stockholders only)		\$	351,547
	5.	Accrued Payroll (Owners	•			\$ \$	331,377
	6.	Accrued Payroll Taxes P		Omy j		\$	
	7.	Medicare Final Settlemen				\$	
	8.	Medicare Current Finance				\$ \$	
	9.	Mortgage Payable (Curre				\$	
		Interest Payable (Exclusion		Pelated Parties		\$ \$	
		Accrued Income Taxes*	ve of owner and or re	cource I to trea		\$ \$	
		Other Current Liabilities	(itemize)			\$ \$	1,316,443
	1 2	Related Party Payables	963,	151		Ψ	1,310,443
		Accrued Expenses		,751			
		Accrued Resident User Fees		,034	8		100 mg
		Accrued Workers Comp Expense		,493)			
A-13	. To	tal Current Liabilities (Li		· · · · · · · · · · · · · · · · · · ·		\$	2,812,348

^{*} 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	()f
Meriden Care Center, LLC	2153-C	9/30/2015		34	3	7
	Account			An	nount	
		Total Broug	ht Forward:		2,812,3	48
Liabilities (cont'd)						
B. Long-Term Liabilities						
 Loans Payable-Equipment 	(itemize)		\$			
Name of Lender	Purpose	Amount	Date Due			
			l as			
				A.		
Mortgages Payable			\$			
3. Loans from Owners or Re	lated Parties (itemiz	e)	\$			
Name and Address of Lender	Amount	Loan I	Date			
						1
·						
						45 45
				-25-50		
				3.77		
4. Other Long-Term Liabilit	ies (itemize)		\$		76.5	<u></u> 45
Patient Trust Funds	ies (nemize)	76,545	100000		70,5	73
ration rational		70,575				
-						
					No. 12	
B-5. Total Long-Term Liabilities	(Lines B1 thru 4)		\$		76.5	6,545
C. Total All Liabilities (Lines A			\$		2,888,8	
	,		Ψ		_,~~,0	

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

l	ne of Facility	License No.		Year Ended	Page	of
Mer	iden Care Center, LLC	2153-C	9/30/2015		35	37
Α.	Reserves	Account			A	xmount
A.		1.1			ф	
	1. Reserve for value of lease				\$	
	2. Reserve for depreciation	value of leased build	ings and appur	tenances		
	to be amortized				\$	
	3. Reserve for depreciation	value of leased perso	nal property (A	Equity)	\$	
	4. Reserve for leasehold real properties on which fair rental value is based					
	5. Reserve for funds set asid	e as donor restricted			\$	
	6. Total Reserves				\$	
B.	Net Worth					
	1. Owner's Capital				\$	25,000
	2. Capital Stock				\$	
	3. Paid-in Surplus				\$	
	4. Treasury Stock				\$	
	5. Cumulated Earnings				\$	28,643
<u> </u>	6. Gain or Loss for Period	10/1/20	014 thru	9/30/2015	\$	(361,733)
	7. Total Net Worth				\$	(308,090)
C.	Total Reserves and Net Wor	th			\$	(308,090)
D.	Total Liabilities, Reserves, a	nd Net Worth			\$	2,580,803

H. Changes in Total Net Worth

Name of Facility		License No.	Report for Year	Ended	Page	of
Meriden Care Center, LLC		2153-C	9/30/2015		36	37
	Account				A	mount
A. Balance at End of Prior Period as shown on Report of 09/30/2014						
B.	Total Revenue (From Statement				<u>\$</u> \$	13,635,794
C.						14,448,497
D.	Net Income or Deficit				\$	(812,704)
E.	Balance				\$	(812,704)
F.	F. Additions 1. Additional Capital Contributed (itemize) 2. Other (itemize)					
	Total Additions		\$			
G.	Deductions					
	1. Drawings of Owners/Operators/Partners (Specify)				\$	
	Name and Address (No., C		Title	Amount		
	2. Other Withdrawings (Specify)					
	Purpose	Purpose Amount		ount		
	3. Total Deductions				s de la company	
H. Balance at End of Period 09/30/15					\$	(812,704)

I. Preparer's/Reviewer's Certification

Name of Facility Meriden Care Center, LLC		License N	Vo.	Report for Year Ended	Page	of	_						
			2153-C	9/30/2015	37	37							
		Check a	ippropriate category										
☑	Chronic and Convalescent Nursing Home only (CCNH)		ne with Nursing on only (RHNS)	□ (Specify)									
	\ \	Preparer/R	eviewer Certificati	on									
I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.													
Signature of Preparer		Title	·····	Date Signed	Date Signed								
	in.	VP	Finance	2/10/16									
Printe	d Name of Preparer						_						
Denis	e MacKinnon												
Addre	s Address		· ·	Phone Number			-						
341 B	idwell Street Manchester, CT 06040	860-570-2140 ext 15											