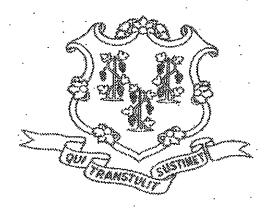
State of Connecticut





Annual Report of Long-Term Care Facility

Cost Year 2015

			-			HECEIV		
Name of Facility (as 1	icensed)							
845 Paddock Avenue	•	C, d/b/a Merio	den Center			<u> DEC_3 </u>	415	
Address (No. & Stree	t, City, State, Z	ip Code)						
845 Paddock Ave, Mo					D	EFT. OF SOCIAL S	SERVIÇES	
Type of Facility					OFFICE	E OF CON AND R	ATE SETTING	38
Chronic and Control Nursing Home			Rest Home with Supervision on (RHNS)	_		(Specify)		
Report for Year Begin 10/1/2014	nning		Report for Year 9/30/2015	r Ending				
License Numbers:		CCNH 2373	RHNS		(Specify)	Me	edicare Pro 07-5192	vider
Medicaid Provider N	umbers:	C0 000008995	CNH	RI	INS	IC	F-IID	
For Department Use	e Only							
Sequence Number Assigned	Signed and Notarized	Date Received	Sequence N Assign		Signed a	nd Notarized	Date Re	ceived

RECEIVED

JAN 05 2016

MYERS & STAUFFER LC

State of Connecticut Annual Report of Long-Term Care Facility CSP-1 Rev.9/2002

(Notary Seal)

General Information

~~				
Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
845 Paddock Avenue Operations LLC, d/b/a Meriden (2373	9/30/2015	11	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 845 Paddock Avenue Operations LLC, d/b/a Meriden Center [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

to before me: Address of Notary Public	State of	11/13/15	NWEALTH OF PENNSYLVANIA	/ /
Subscribed and Sworn	State of	Date	Signed (Notary Public)	Comm, Expires
Printed Name (Administrator) Giovanna Griffin			Printed Name (Owner) Keith Davis, V.P. of Reimb., Genes	is Healthcare
Signed (Administrator)		Date	Signed (Owner)	Date /2005

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General Information

G	Herar information			
On 11's (1's	License No.	Report for Year Ended	Page	of
Name of Facility (as licensed)	I	9/30/2015	1	37
845 Paddock Avenue Operations LLC, d/b/a Meriden	Q 2373	9/30/2013		
043 I dedoor 121 41155 OF				

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 845 Paddock Avenue Operations LLC, d/b/a Meriden Center [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

I Name (Owner) Davis, V.P. of Reimb., Genesis Healthcare	
I (Notary Public) Comm. Expir	es
	(Notary Public) Comm. Expire

(Notary Seal)

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

State of Connecticut Department of Social Services

25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjust	me	ent		Page 1A	of 37
Name of Facility		Period Cove	ered:	From	То
845 Paddock Avenue Operations LLC, d/b/a Meriden Center				10/1/2014	9/30/2015
Address of Facility 845 Paddock Ave, Meriden, CT 06450					
Report Prepared By		Phone Num		Date	
Thomas Farnan		978-247-50	29	12/21/2015	
Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$	527,363	527,363		
2. Laundry wages paid	\$				
3. Housekeeping wages paid	\$				<u>.</u>
4. Nursing wages paid	\$	3,883,745	3,883,745		
5. All other wages paid	\$	470,172	470,172	ļ	
6. Total Wages Paid	\$	4,881,280	4,881,280		
7. Total salaries paid	\$	200,519	200,519		
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$	5,081,798	5,081,798	<u> </u>	<u> </u>

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

	F.	Pho	e No of Faci	lity	Report for Year	Ended	Page	-	of
			-238-2645		9/30/2015		2		37
Name of Facility (as shown on license)	<u>_</u>				Street, City, State,	Zip)			
845 Paddock Avenue Operations LLC, d/b/a Meride	n Cen	ter			e, Meriden, CT				
CCN	H		RHNS		(Specify)	_	Medicare P	rovid	ler No.
•	2373						07-5192		
Type of Facility (Check appropriate box(es))									
Chronic and Convalescent			t Home with I			Specify))		
Nursing Home only (CCNH)	<u></u>	Sup	ervision only	(RHI	NS)	rJ,			
Type of Ownership (Check appropriate box)									
O Proprietorship O LLC O Partnersh	ıip	0	Profit Corp.	0,	Non-Profit Corp.	0	Government	0	Trust
				Date	e Opened D	ate Clo	sed		
If this facility opened or closed during report year page 1	rovide	:							
				<u> </u>					
Has there been any change in ownership		_	**	^	NI. Y	e 1157 11	avnlair £-11-	r	
or operation during this report year?	•	_0	Yes		No If	ı res,	explain fully	y •	
Administrator									
Name of Administrator					Nursing Hor				
Giovanna Griffin					Administrato	1	1196		
· ·			<u> </u>		License No	o.:			
Other Operators/Owners who are assistant administ	rators	(full	or part time)	of th	us facility.				
Name					License N	0.:			
			<u></u>						· · · · · · · · · · · · · · · · · · ·
·									
1									
				***************************************					_

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-3 Rev. 10/2005

General Information and Questionnaire Partners/Members

Name of Facility 845 Paddock Avenue Operation			Report for Y 9/30/2015		Page of 3 37
Legal Name of Parts		Business A	ddress		or Town(s) in egistered
Name of Partners/Members	Business Ad	ddress	•	l'itle	% Owned
			-		

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

General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year	Ended	Page	of
845 Paddock Avenue Operations LLC, d/b/a	2373	9/30/2015		3A	37
If this facility is owned or operated as a corpo	oration, provide	the following infor	mation:		
Legal Name of Corporation	Busin	ness Address	State(s) in W	hich Incor	porated
845 Paddock Avenue Operations	101 East State		PA		
LLC, d/b/a Meriden Center	Square, PA 19	348			
,					
	Dugi	ness Address	Title	No. S	
Name of Directors, Officers	Dusi	ness Address	71110	Held b	y Each
See Attached					
		·	<u>.</u>		
Names of Stockholders Owning at Least 10%	6				
of Shares					
See Attached					
		,			
			i.		
				-	<u> </u>

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-3B Rev. 10/2005

General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page of 3B 37
845 Paddock Avenue Operations LLC, d/b/a Mer	i 2373	9/30/2015	
If this facility is owned or operated as an individu	al proprietorship,	brovide me following informs	anom.
Ow	ner(s) of Facility		
,			
		•	
•			

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

General Information and Questionnaire Related Parties*

Name of Facility 845 Paddock Avenue Op	Name of Facility 845 Paddock Avenue Operations LLC, d/b/a Meriden C	License No.	No. 2373	Report for Year Ended 9/30/2015		Page 4	of 37
Commence of the Commence of th							
Are any individuals rece	Are any individuals receiving compensation from the facility related through	icility rel	ated throug	gh No	If "Yes," provide the Name/Address and	ne Name/Add	fress and
marriage, abinty to con	marriage, abuity to control, ownersing, fainty of dustices association:	222 42500		S I		ממתוסת סדי דים	
Are any individuals or c	Are any individuals or companies which provide goods or services,	or servi	es,				
including the rental of p	including the rental of property or the loaning of funds to this facility,	to this fa	cility,				
related through family a	related through family association, common ownership, control, or business association to any of the owners onerators or officials of this facility?	, control, of this fa	or busines cility?	s O Yes O No	If "Yes." provide the following information:	e following	information:
association to the state of the			G				
		Also	Provides		Indicate Where		
		Goods/	/Services to				
Name of Related		Non-Re	스	Description	.=	Cost	Actual Cost to the
Individual or Company		Yes	No %**	* Provided	Page #/ Line #	Keported	Noialcu r al ly
Genesis Health Ventures	101 East State Street, Kennett Square, PA 19348	•	0	Home Office	Pg 16/m12	472,945	472,945
Genesis ElderCare	101 East State Street, Kennett	0	0		200	750 137	760 105
Rehabilitation Services	Square, PA 19348	,	+	63% PT/OT/ST- Direct and indirect Cost	Fg 13/BS, 9,10	071,46/	071,60/
Genesis ElderCare Statting Services	101 East State Street, Kennett Square, PA 19348	•	0	55% Staffing Pool	Pg 10/A12	12,568	12,568
Genesis ElderCare Physician	Genesis ElderCare Physician 101 East State Street, Kennett	0	0		4 of 10	90	000
Services	Square, PA 19348	,		85% Case Management	Pg 13/B8, Pg 10/A12	78,680	78,680
Career Staffing	101 East State Street, Kennett Square, PA 19348	•	0	Staffing Pool	Pg 13/B11 a,b,c		
	515 Fairmount Ave, 6th Floor, Suite	0	0	1	() () () () () () () () () ()		
Respiratory Health Services 600, Towson, MD 21286	600, Towson, MD 21286	,		43% Respiratory Therapy	Pg 13/B12, Pg 20/C5E	52,711	52,/11
Liberty Health (Insurance)	101 East State Street, Kennett Square, PA 19348	•	0	Capital Interest	Page 17, page 26-12A	44,784	44,784
	101 East State Street, Kennett	•	_				
Genesis Healthcare Corp.	Square, PA 19348)	,)	· AND CONTROL OF CONTR			
		0	0				
* Tree additional chaete if necessary	te if necessari						

^{*} 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 of
845 Paddock Avenue Operations LLC, d/b/a M	2373		9/30/2015	5 37
If the facility is licensed as CDH and/or RCH of	or provides All	S or TB	I services with special Medic	aid rates, costs
must be allocated to CCNH and RHNS as follo	ws:			
Item			Method of Allocatio	n
Dietary	N	ımber of	meals served to residents	
Laundry	N	umber of	pounds processed	
Housekeeping	N	umber of	square feet serviced	
1104504000	N ¹	umber of	hours of routine care provide	ed by EACH
Nursing	er	nployee	classification, i.e., Director (c	or Charge Nurse),
ranging	$ \mathbf{R} $	egistered	Nurses, Licensed Practical N	Jurses, Aides and
	A	ttendants		
Direct Resident Care Consultants	N	umber o	f hours of resident care provide	led by EACH
Direct Resident Sur Communication	sp	ecialist	(See listing page 13)	
Maintenance and operation of plant	Se	quare fee	et	
Property costs (depreciation)	S	quare fee	ek e e e e e e e e e e e e e e e e e e	
Employee health and welfare	G	ross sala	ries	
Management services			te cost center involved	
All other General Administrative expenses			irect and Allocated Costs	
The preparer of this report must answer the fo	llowing questic	ns appli	cable to the cost information	provided.
1. In the preparation of this Report, were all			If "No," explain fully why s	uch allocation was
costs allocated as required?	⊙ Yes (ON C	not made.	
Costs anocated as required.				-
2. Explain the allocation of related company	expenses and a	tach con	y of appropriate supporting d	ata.
2. Explain the allocation of related company	expenses and a	tuon cop) 02 opp - 1	
3. Did the Facility appropriately allocate and	-alf digallow d	irect and	Lindirect costs to non-nursing	home cost centers?
3. Did the Facility appropriately allocate and	sell-disallow u	neciano A Ante D	ox Care Services etc.)	, 110,1110 00,000 00,1110
(e.g., Assisted Living, Home Health, Outp.	attent services,	Adult D		111
	⊙ Yes	O No	If "No," explain fully why a not made.	such allocation was

Annual Report of Long-Term Care Facility State of Connecticut 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.				1			
Name of Facility		Г	License No.	Report for Year Ended	ear Ended		_ 13
845 Paddock Avenue Operations LLC, d/b/a Meriden Center	Meriden	Center	2373	9/30/2015			6 3/
A	Related * to	d * to			•		
	Owners,	ers,				\ lower	
	Operators, Officers	itors,		Date of	Term of	Amount	Amount
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	ofLease	Claimed
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
o all injury 11 to and East 12 to 12 to 13 to 14 to 15	T paged 7	Johinles	O Yes		O No	Total ***	

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.

^{**} 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
45 Paddock Avenue Operations	L 2373	9/30/2015		7 37
he records of this facility for the	period covered by this I	eport were maintained on the following bas	sis:	
	Modified Cash			
s the accounting basis for this			······································	
	Yes	If "No," explain.		
, O110 G 1110 G 1111	O No	, .		
revious period:				
TV	e Bron Bron		<u> </u>	
Independent Accounting Firm Name of Accounting Firm		Address (No. & Street, City, State, 2	Zip Code)	
		1600 Market Street, Philadelphi	ia, PA 19103	
=				
2 3			•	
3 4				50
Services Provided by This Firm ((describe fully)			
1 Year end financial audit			\$	
2			\$	
3			\$	
4			<u> </u>	
			Charge for S	Services Provided
			\$	
Are These Charges Reflected in the Ex	penditure Portion of This Re	port? If Yes, Specify Expense Classification and L	ine No.	
O Yes O No	·			<u>u</u>
Legal Services Information				
Name of Legal Firm or Independ	lent Attorney		Telephone l	
1 Connecticut State Marshal J	oe Marinan		203-213-55	
2 Morrow Morgan Smith Inc			860-678-15	30
3				
4				
5				
Address (No. & Street, City, Sta	te, Zip Code)			
1 149 Cariati Blvd Meriden, (CT, 06451	22		
2 11 Talcott Notch Road 2nd	FL Farmington, CI UOU	52		
3				
4				
5 Services Provided by This Firm	(describe fully)			
			\$	
Probate Court for the conservato Real Estate Tax Abatement-redu		Real Estate Tax	\$	2,250
2 Real Estate Tax Production 7000			\$	
4			\$	
			\$	
5			Charge for	Services Provided
			\$	2,250
		enort? If Ves Specify Evnence Classification and I		
Are These Charges Reflected in the B	Legal Fees pg. 15	eport? If Yes, Specify Expense Classification and		
⊙ Yes O No	Legal rees pg. 13	1-V		

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

Schedule of Resident Statistics

Paddock Avenue Operations LLC, dlva Meriden Center Total	MALAURAN ALIAN MALAURAN MALAURA							3 1	X con Unde	7		Расе	υţ
Total Total Total CCNH RHNS (Specify) Total Level (Specify) Total CCNH RHNS (Specify) Total 130	Name of Facility	on to		License N	lo. 373			Keport 10. 9/30/2015	I car card	2	•	8	37
Certified Bed Capacity	845 Paddock Avenue Operanous LLC, wwa internet	Counce					Period 10/	1 Thru 6/	30		Period 7/1	Thru 9/3	0
Certified Bed Capacity A. On last day of PREVIOUS report period B. On last day of PREVIOUS report period A. On last day of PREVIOUS report period B. On last day of PREVIOUS report period A. As of midnight of PREVIOUS report period A. Medicare B. As of midnight of PREVIOUS report period A. Medicare B. As of midnight of PREVIOUS report period A. Medicare B. As of midnight of PREVIOUS report period A. Medicare B. As of midnight of PREVIOUS report period A. Medicare B. As of midnight of PREVIOUS report period A. Medicare B. As of midnight of PREVIOUS report period A. Medicare B. As of midnight of PREVIOUS report period A. Medicare B. As of midnight of PREVIOUS report period A. Medicare B. Other Role states) C. Medicaid Gode states) C. Medicaid Gode report period (Arthur IP) C. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds A. Medicaid Bod Reserve Days A. Medicaid Bod Reserve													
Certified Bed Capacity 130		Total All Levels	Total CCNH Level	Level	Total (Specify)	Total	CCNH	REINS	(Specify)	Total	CCNH	RHINS	(Specify)
Number of Residents 130	1. Certified Bed Capacity	130	130			130	130			130	130		
Number of Residents 115 115 115 115 115 116 119	A. On last day of THIS report period	130	130			130	130			130	130		
A. As of midnight of PREVIOUS report period 115 113 119	1					71	115			114	114		
B. As of midnight of THIS report period 119	A. As of midnight of PREVIOUS report period	115	115			CIT							
Total Number of Days Care Provided During Period 3,867 3,867 3,867 2,758 1,109 A. Medicare B. Medicare B. Medicare 2,4861 24,861 8,083 C. Medicaid (Conn.) C. Medicaid (Conn.) 2,837 2,837 2,302 2,302 8,083 D. Private Pay E. State SSI for RCH 2,458 2,458 1,877 1,877 31,798 10,308 F. Other (Specify) 4,2106 42,106 42,106 31,798 31,798 10,308 G. Total Care Days During Period (3A thru F) 42,106 42,106 42,106 31,798 31,798 10,308 A. Medicaid Bed Reverbe Days A. Medicaid Bed Reverbe Days 4 4 4 4 4 4 B. Other Bed Reserve Days A. Medicaid Bed Reserve Days 4	B. As of midnight of THIS report period	119	119			114	114			119	119		
A. Medicare A. Medicare 3,867 3,867 2,758 1,109 B. Medicard (Conn.) 32,944 32,945 32,302 31,807 31,807													
B. Medicaid (Conn.) 32,944 32,942 32,32 <	A. Medicare	3,867				2,758	2,758			1,109			
C. Medicaid (other states) 2,837 2,837 2,837 2,302 2,302 2,302 535 D. Private Pay E. State SSI for RCH E. State SSI for RCH 581 581 F. Other (Specify) 2,458 2,458 1,877 1,877 1,877 G. Total Care Days During Period (3A thru F) 42,106 42,106 31,798 10,308 Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds 4 4 4 A. Medicaid Bed Reserve Days 4 4 4 4 4 B. Other Bed Reserve Days 4 4 4 4 4	B. Medicaid (Conn.)	32,944				24,861	24,861			8,083	8,083		
D. Private Pay 2,837 2,837 2,837 2,837 2,837 2,837 2,837 2,837 2,837 3,377 3,377 3,877 3,877 3,817 3,81 F. Other (Specify) C. Other (Specify) 42,106 42,106 42,106 31,798 31,798 10,308 G. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds 4<	l												
E. State SSI for RCH E. Other (Specify) 2,458 2,458 2,458 1,877 1,877 1,877 581 G. Total Care Days During Period (3A thru F) 42,106 42,106 42,106 10,308 10,308 Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received Beds A. Medicaid Bed Reserve Days 4 4 4 4 A. Medicaid Bed Reserve Days 4 4 4 4 4 4 B. Other Bed Reserve Days 4 4 4 4 4 4 4		2,837				2,302				535	535		
F. Other (Specify) 2,458 2,458 2,458 1,877 1,877 1,877 581 G. Total Care Days During Period (3A thru F) 42,106 42,106 42,106 10,308 10,308 Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received Beds A. Medicaid Bed Reserve Days 4													
G. Total Care Days During Period (3A thru F) 42,106 42,106 42,106 42,106 42,106 10,308 10,308 Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds A. Medicaid Bed Reserve Days 4		2,458	2,45			1,877	1,877			581	581		
for Which Revenue Was Received for Reserved Beds A. Medicaid Bed Reserve Days B. Other Bed Reserve Days A. Other Bed Reserve Days A. Other Bed Reserve Days A. Medicaid Bed Reserve Days A. Medicaid Bed Reserve Days B. Other Bed Reserve Days A. Medicaid Bed Reserve Days A. Medic		42,106	42,10			31,798				10,308			
A. Meucau Deu Reserve Days B. Other Bed Reserve Days 4 4 4 4 4 4 4 10.308													
10.308	B. Other Bed Reserve Days	4				4							
Total Resident Days (3G + 4A + 4B)	1.5	42,110	42,110			31,802	31,802			10,308			

Schedule of Resident Statistics (Cont'd)

Name of Faci	-	04			se No. 2373				_	for Year 9/30/201			Page 9	of 37
845 Paddock	Avenue	Operati	ons LLC, d/b/a		23/3					7/30/201				<u> </u>
			in the certified b		pacity du	ring th	ie repoi	t year	:?	0	Yes	© 1	No	
If "YES.	 -		lowing informa	1011;	Cit		in Bed			Car	pacity Afte	r Change	_ "-	
			Change			ange			1	Ca	pacity 711to	Change		!
Date of	CCNH	RHNS	(Specify)		Lost			Gaine	1					
Change	(1)	(2)	(2)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	Reason fo	r Change
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	COM	Adinto	(Special)	1144001111	
						-		<u> </u>						
								-						
	1		.,											
			in certified bed o			the re	eport ye	ear (as	report	ed in item	4 above) p	provide the num	ber of	
KESIDI	ENI DA	113 101	30 days lollown	ig inc	change.					1				
			Change in R	esider	nt Days					CC	CNH	RHNS	(Spe	cify)
1 st chan														
2nd char 3rd char		·												
4th chan														
6. Number	of Resi	dents an	d Rates on Septe	ember	30 of Co	st Ye	ar							
			Medicare		Medi	caid				S	elf-Pay		Other Stat	e Assisted
								ļ						
	Item		CCNH		CCNH	R	HNS	C	CNH	RI	HNS	(Specify)	R.C.H.	ICF-IID
No. of F	Resident	s	13	13 91 392.0										
	f Residents 13 91 iem Rate 29 39													
	Per Diem Rate a. One bed rm. 392													
a. One bed rm. 392 b. Two bed rms. 519.58 203.68 385								385.29						
c. Three or more							22		·					
bed	rms.		<u> </u>	<u>. </u>		<u> </u>		<u> </u>						
]														
7 Total N	imber o	f Physic	al Therapy Trea	fment	s					TO)TAL	CCNH	RHNS	(Specify)
		are - Par			•						3,222	3,222		
В	. Medic	aid (Exc	lusive of Part B)										
			e Treatments								···-			
			Treatments								1,584	1,584		
C	. Other										12,348	12,348 17,154		
D	. Total	Physical	Therapy Treat	ments	· · · · · · · · · · · · · · · · · · ·						17,154	17,134		
			h Therapy Treat	ments							497	497		
A	Medic	are - Par	clusive of Part B											
P			ce Treatments	,						***************************************			***************************************	
			Treatments			_					213	213		
	. Other						-				1,551	1,551		
			Therapy Treatm								2,261	2,261		
9. Total N	umber o	of Occup	ational Therapy		ments									
A	. Medic	are - Par	rt B								2,549	2,549		
B	. Medic	aid (Exc	clusive of Part B)										
			ce Treatments							+	906	906		
			Treatments							+	11,549	11,549		
	C. Other		tional Therapy	Treat	nents				_,-	 	15,004	15,004		
<u></u>	, ioim	Jecupu								<u> </u>		 	·A	

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.		Report for Year 9/30/2015	Ended	Page 10	of 37
845 Paddock Avenue Operations LLC, d/b/a Meriden Cente			<u> </u>		No	
Are time records maintained by all individuals receiving co	ompensation?		Yes		140	
	<u> </u>		Total Cost a	na Hours		
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
 Operators/Owners (Complete also Sec. I 						
of Schedule A1)						_
2. Administrator(s) (Complete also Sec. III	103,287	1,806				
of Schedule A1) 3. Assistant Administrator (Complete also Sec. IV	103,267	1,000				
of Schedule A1)	11,463	264				
4. Other Administrative Salaries (telephone	11,403					
operator, clerks, receptionists, etc.)	133,794	6,165				
5. Dietary Service						
a. Head Dietitian	37,884	1,059				
b. Food Service Supervisor	58,466 431,012	2,189 25,074				
c. Dietary Workers 6. Housekeeping Service	431,012	47,074				
a. Head Housekeeper	200000000000000000000000000000000000000	*************		***************		
b. Other Housekeeping Workers					***************************************	
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	54,335					<u> </u>
b. Other Maintenance Workers	15,989	1,095		1		
8. Laundry Service						***************************************
a. Supervisor b. Other Laundry Workers	- 		+			
9. Barber and Beautician Services	 					
10. Protective Services						
11. Accounting Services						
a. Head Accountant				<u> </u>	 	-
b. Other Accountants 12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	85,768	1,53	7	300000000000000000000000000000000000000		3503030030333
b. RN	05,700	2,50				
1. Direct Care	885,893	22,72	9			
2. Administrative**	153,504	4,16	4			
c. LPN						
1. Direct Care	1,041,277	35,44	1	 		
Administrative** d. Aides and Attendants	1,721,661	100,79	5	-	-	<u> </u>
d. Aides and Attendants e. Physical Therapists	1,721,002	100,12	<u>-</u>			
f. Speech Therapists						
g. Occupational Therapists					<u> </u>	
h. Recreation Workers	95,710	5,50	1			
i. Physicians			1			
Medical Director Utilization Review		 				
3. Resident Care***						
4. Other (Specify)						
		 	<u> </u>	 	-	-
j. Dentists		 		1	 	
k. Pharmacists	 	 	+		 - -	1
Podiatrists M. Social Workers/Case Management	170,345	6,55	66			
n. Marketing						
o. Other (Specify)						
See Attached Schedule	81,410				-	
A-13, Total Salary Expenditures	5,081,79	220,75	υ <u> </u>		<u> </u>	ــــــــــــــــــــــــــــــــــــــ

^{*} 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)

	CCN	H	RH	INS	(Sp	ecify)
Position	\$	Hours	\$	Hours	\$	Hours
Ward Clerks 0	\$ 38,008.74	1,964			\$	
Central Supply 0	\$ 15,800.53	1,006			\$.	-
Medical Records 0	\$ 27,600.75	1,235			S	
Total	\$ 81,410.01	4,206	\$ -		\$ -	

Schedule of Other Fees (Page 13)

		CC	NH	R	eins	(Sp	ecify)
Service		\$	Hours	\$	Hours	\$	Hours
1020620010	Consulting Fees	\$ 148.85	n/a				
1020620010	Consulting Fees	\$ 409.70	n/a				
3010620020	Purchased Services	\$ 180,00	n/a				
3015620020	Purchased Services	\$ 12,019.10	n/a				
3155620020	Purchased Services						
3155620020	Purchased Services	\$ 9,127,97	1/a				
1020620010	Consulting Fees	\$ 347.50	n/a				
	0 0	ş .	0				
	0 0	S -	- 0				
	0 0	s -	- 0				
Total		\$ 22,175	-	s -	-	S	-

State of Connecticut Annual Report of Long-Term Care Facility CSP-11 Rev. 10/2005

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

Assistant Administrators and Other Related Parties*

		J	Topicica	Table tallet	27077				Doge	-
1 T				License No.		Report for	Report for Year Ended		rage	5 5
Iname of radius, by some Operations I.I.C. d/b/a Meriden Center	r.r.C. d/b/a	Meriden Ce.		2373		9/30/2015			11	3/
845 Faddock Avenue Operations	nio m (comm									
		Salary Paid		Hange Renefits						
				and/or Other	9 · · · · · · · · · · · · · · · · · · ·	Total	Line Where	Name and Address of All	Total Hours	Compensation
Name	CCNH	RHINS	(Specify)	Payments (describe fully)	Full Description of Services Rendered	Worked	Page 10	Other Employment**	Worked	Received
Section I - Onerators/Owners										
								- Children		
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).										
					<u> </u>	. "				

										_
						-				

^{*} 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*

		(A ANDARD STATE OF THE STATE OF		Denort for Veer Ended	sar Ended		Раяе	οf
Name of Facility (as licensed)				License No.		venor nodav	אח דיחתאים			t t
845 Paddock Avenue Operations LLC, d/b/a Meriden Center	C, d/b/a M	eriden Cen	ter	2373		9/30/2015			12	37
A		Salary Paid	Į.							
				Fringe Benefits and/or Other Payments	Full Description of	Total Hours	Line Where	Name and Address of All	Total Hours	Compensation
Name	CCNH	RHINS	(Specify)	(describe fully)	Services Rendered	Worked	\rightarrow	Other Employment**	Worked	Received
Section III - Administrators***										
					Management of					
Giovanna Griffin 8/3/15-9/30/15	17,325				Center	326	2			
Courtney Young 12/21/11-	CY0 58				Management of Center	1.480	N			
C1 1-1 10								- Charles		
Section IV - Assistant Administrators				,						
Townsend, Patrick Aaron 6/15/15-	11 462				Management of	764	c			
0/2/12	504,11				POTEN					
	:				A CONTRACTOR OF THE PROPERTY O					

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

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

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

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility 845 Paddock Avenue Operations LLC, d/b/a Meride	License No.		Report for Y 9/30/2015	ear Ended	Page 13	of 37
8431 addock Avenue Operations 2233			Total Cost a	nd Hours		
		U.A. #10.810				
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee						
for service basis in lieu of salary						
(For all such services complete Schedule B1)						
1. Dietitian	693	19				
2. Dentist	14,118	97				
3. Pharmacist	11,310	231				ļ
4. Podiatrist			i		<u> </u>	
5. Physical Therapy						
a. Resident Care	605,803	8,299				<u> </u>
b. Other						
6. Social Worker						<u></u>
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	43,080	228				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting		***************************************				<u> </u>
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee		***************************************				
(Quarterly meetings)		<u> </u>		<u> </u>		
2. Pharmaceutical Committee						
(Quarterly meetings)	 		<u> </u>	 		
3. Staff Development Committee (Once annually)						
0.4 (0 :0.)						
e. Other (Specify)						
O C I Therewith						
9. Speech Therapist	61,098	783	3			
a. Resident Care	01,000	<u> </u>				
b. Other						
10. Occupational Therapist	121,707	1,66	7			
a. Resident Care	121,707					
b. Other 11. Nurses and aides and attendants	-					
§						
a. RN						
1. Direct Care		 				
2. Administrative***						
b. LPN	29,330	69	3	***************************************		
Direct Care 2. Administrative***	27,550	 				
		1				
c. Aides		 				
d. Other						
12. Other (Specify) See Attached Schedule	22,175					
	909,314		6			
B-13 Total Fees Paid in Lieu of Salaries	303,314		m M-12 and support	and last appropriate design	formation Page 17	

^{*} 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 Y	Year Ended Page of
845 Paddock Avenue Operations LLC, d/b/s	, i		9/30/2015	14 37
Name & Address of Individual	Full Explanation of Service		* to Owners, rs, Officers No	Explanation of Relationship
Genesis Eldercare Hospitality Services, 101 East State Street, Kennett Square, PA 19348	Dietary Services	• • • • • • • • • • • • • • • • • • •	0	Common Ownership
Genesis Eldercare Rehabilitation Services, 101 East State Street, Kennett Square, PA 19348	Physical, Occupational, and Speech Therapy	•	0	Common Ownership
Genesis Eldercare Physician Services, 101 East State Street, Kennett Square, PA 19348	Medical Director	•	0	Common Ownership
Genesis Eldercare Staffing Services, 101 East State Street, Kennett Square, PA 19348	Nursing Pool	0	0	Common Ownership
Respiratory Health Services, 515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	Respiratory and Oxygen Supplies	•	0	Common Ownership
		0	0	
		0	0	
		0	0	
		0	0	
		0	0	
		0	0	
		0	0	,
		0	0	
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		0	0	
		0	0	
		0	0	
		0	0	
		0	0	
		0	0	
		0	0	
		0	0	

^{*} 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 Ye 9/30/2015	ar Ended	Page 15	of 37
845 Paddock Avenue Operations LLC, d/b/a Meri 2373		7/30/2013		13	37
					İ
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
Workmen's Compensation	\$	216,643	216,643		
Disability Insurance	\$				
3. Unemployment Insurance	\$	97,018	97,018		
4. Social Security (F.I.C.A.)	\$	372,529	372,529		
5. Health Insurance	\$	552,229	552,229		
6. Life Insurance (employees only)					
(not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory)	\$	141,058	141,058		
(not-owners and not-operators)					
8. Uniform Allowance	\$			<u> </u>	
9. Other (Specify)	\$	27,626	27,626		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and	\$				
Profit Sharing Plans for Owners and	00000				
Operators (Discriminatory)*					
c. Bad Debts*	\$	130,024	130,024		
d. Accounting and Auditing	\$				ļ <u> </u>
e. Legal (Services should be fully described on Page 7)	\$	2,250	2,250		
f. Insurance on Lives of Owners and	\$				
Operators (Specify)*					
g. Office Supplies	\$	23,821	23,821		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	20,532	20,532		
2. Cellular Phones	\$				
i. Appraisal (Specify purpose and	\$		***************************************		
attach copy)*					
j. Corporation Business Taxes (franchise tax)	\$				
k. Other Taxes (Not related to property - See Page 22)					
1. Income*	\$				
2. Other (Specify)	\$	786	786		
See Attached Schedule					
3. Resident Day User Fee	\$	759,411	759,411		
Subtotal	\$	2,343,927	2,343,927	<u>]</u>	

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

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

845 Paddock Avenue Operations LLC, d/b/a Meriden Center 9/30/2015

Attachment Page 15

Schedule of Other Employee Benefits

Description			 CCNH	RHNS	(Specify)
3005520020		Union Health & Welfar	\$ 45	\$ +	
3030520020		Umon Health & Welfar	\$ (3,819)	\$ -	
3225520020		Union Health & Welfar	\$ 31,401	\$ -	
	0	0	\$ -	\$ -	
	0	0	\$	\$ -	
	0	0	\$ -	\$ -	
	0	0	\$ -	\$ -	
	0	0	\$ -	\$ -	
	0	0	\$ -	\$ -	
	0	0	\$ -	\$ -	
	0	0	\$ -	\$ -	
	0	0	\$ -	\$ -	
	0		\$ -	\$ -	
	0	0	\$ -	\$ -	
	0	0	\$ -	\$ -	
	0	0	\$ -	\$ -	
	0	0	\$	\$ -	
	0	0	\$ -	\$ -	
Total			\$ 27,626	\$ -	\$ -

Schedule of Other Taxes

Description		CCNH	RHNS	(Specify)
1020640110	Sales Tax \$	786 \$	- \$	-
0	0 \$	- \$	- \$	
0	0	0	0	0
0	0	0	0	0
Total	\$	786 \$	- \$	-

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

Name of Facility	License No.]	Report for Y	ear Ended	Page	of
845 Paddock Avenue Operations LLC, d/b/a Meriden 2373			9/30/2015		16	37
75 I addook 11 voldo o potentoro ====,		\neg				
Item			Total	CCNH	RHNS	(Specify)
	s Brought Forward	d:	2,343,927	2,343,927		
1. Travel and Entertainment						
1. Resident Travel and Entertainment		\$				
2. Holiday Parties for Staff		\$				
3. Gifts to Staff and Residents		\$				
4. Employee Travel		\$	1,806	1,806		
5. Education Expenses Related to Seminars ar	nd Conventions	\$	215	215		
6. Automobile Expense (not purchase or depre	eciation)	\$				
7. Other (Specify)		\$				
See Attached Schedule						
m. Other Administrative and General Expenses						
1. Advertising Help Wanted all such expenses	s)	\$				
2. Advertising Telephone Directory all such e	xpenses)***	\$				<u> </u>
3. Advertising Other (Specify)***		\$	6,857	6,857		
See Attached Schedule						
4. Fund-Raising***		\$				
5. Medical Records		\$				
6. Barber and Beauty Supplies (if this service	is supplied	\$		*******************		
directly and not by contract or fee for servi	ce)***					
7. Postage		\$	3,081	3,081		<u> </u>
* 8. Dues and Membership Fees to Professiona	1	\$	10,500	10,500		
Associations (Specify)						
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other Non-A	Allowable Org.***	\$				<u> </u>
9. Subscriptions		\$		562		
10. Contributions***		\$	1,941	1,941		
See Attached Schedule						
11. Services Provided by Contract Specify and		\$	3,566	3,566		
Schedule C-2, Page 21 for each firm or inc						
12. Administrative Management Services**	\$		464,982			
13. Other (Specify)		\$	29,561	29,561		
See Attached Schedule						
C-14 Total Administrative & General Expenditures	3	\$	2,866,998	2,866,998	<u> </u>	

^{*} 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)
			0
	***************************************		0
	500		0
			ſ
			r
	-		ði.
Total Other Travel and Entertainment		3	D

Schedule of Other Advertising

Description	-	CCNH	RHNS	(Specify)
1020630020	Advertising	\$ 41	\$	\$
1020630020	Advertising	\$ 385	S -	\$ -
1020630020	Advertising	\$ 1,016	\$ -	\$ -
1020630330	Marketing Expense	\$ 2,490.19	s -	\$ -
1020630330	Marketing Expense	\$ 25.57	\$ -	8 -
1020630330	Marketing Expense	\$ 481.06	S -	\$
1020630331	Marketing Exp- Corpo	\$ 878.08	\$ -	\$ -
1020630331	Marketing Exp-Corpo	S 1,540.72	S -	\$ -
	0 0	\$ -		
Total Other Adver	fising	\$ 6,857	\$ -	\$ -

Schedule of Dues

Description		CCNH	RHNS	(Specify)
1020630310	Licenses and Certificat	\$ 10,500	S .	\$.
1020630310	0	\$ -	\$ -	s -
1020630310	0	\$ -	\$ -	\$
1020630310	0	s -	\$ -	S -
1020630310	0	\$ -	\$ -	\$ -
1020630310	0	S -	\$ -	\$ -
(0	\$ -	\$ -	\$
(0	s -	s -	S -
(0	\$ -	\$ -	\$ -
(0	S -	\$ -	\$ -
(\$ -	\$ -	\$ -
(0	\$ -	S -	\$ -

|--|

Schedule of Contributions

	CCNH	RHNS	(Specify)
Description 1020630135 Political Contributions	\$ 1,941	\$.	\$
0 0	S -	S -	5 +
0 0	\$.	\$ -	s ·
Total Contributions	\$ 1,941	\$ -	\$.

Schedule of Other Administrative and General

Description		(CCNH	RHNS	(Specify)
1020630060	Bank Service Charges	S	4,302	\$ -	\$
1020630120	Collection Fees	8	9,413	disallowed	\$ -
1020630120	Collection Fees	S	23	disallowed	\$ -
1020630120	Collection Fees	8	66	disallowed	\$ -
1020630140	Education Expense	\$	42	\$	S -
1020630140	Education Expense	8	39	8 -	\$ -
1020630180	Employee Physicals	\$	7,279	s -	\$
1020630200	Employee Relations	8	2,867	\$ -	\$
1020630200	Employee Relations	S	212	\$ -	\$ -
1020630380	Printing	\$	36	\$	\$
1020630380	Printing	S	21	5 .	\$
1020630380	Printing	\$	161	\$ -	\$ -
1020630610	Training Expense	\$	38	\$ -	S -
1020630610	Training Expense	\$	84	\$	\$ -
1020630610	Training Expense	\$	652	\$ -	\$ -
1020640080	Fines & Penalties	8	2,385	disallowed	S -
1020640090	Miscellaneous	\$	(103)	\$ -	\$ -
1020640090	Miscellaneous	8	(4)	\$ -	\$
1020660080	Rental Expense	\$	5,412	\$ -	\$ -
1020660990	Accrued Expense Est		(355)	disallowed	\$ -
5095720020	Cap Stk/Franchise Ta	x S	175	\$ -	\$:
3080630440	Foreign Recruitment	\$	(3,982)		\$ -
1020630120	Collection Fees	\$	796	\$ -	\$ -
		3 \$	<u> </u>	\$ -	\$
	*******) \$		S -	\$ -
	0	8	-	\$ -	\$ -
	0) \$	-	S -	\$
			_		
Total Other Adm	inistrative and General	\$	29,561	\$ -	S -

State of Connecticut Annual Report of Long-Term Care Facility CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

I dillo of I dolling		Report for Year Ended	Page of 17 37
845 Paddock Avenue Operations LLC, d/b	2373	9/30/2015	11 31
Name & Address of Individual or Company Supplying Service Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	Cost of Management Service	Assisting, MIS, Personnel,	Indicate Where Costs are Included in Annual Report Page #/Line # pg 16 m-12
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	44,784	Compliance Capital Interest	pg 26 12-A-1
		-	

^{*} 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)

	e of Facility		Licenso				ear Ended	Page	of
845	Paddock Avenue Operations LLC, d/b/a Meride	n Q		2373	9/	30/2015		18	37
	Item			Total	C	CNH	RHNS	(Sp	ecify)
2.	Dietary a. In-House Preparation & Service 1. Raw Food	_	\$	200,818		200,818			
	2. Non-Food Supplies		\$		<u> </u>	23,021		<u> </u>	
	3. Other (Specify)		\$	(1,410)		(1,410)			
	 b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) c. Management Services** 		\$ \$						
	d. Other (Specify)		\$			202 400			
2E.	Total Dietary Expenditures $(2a+b+c+d)$	• •		222,429	<u> </u>	222,429			· · · · · ·
2F. G.	Dietary Questionnaire Resident Meals: Total no. of meals served per	r day	y:*	Total	(CCNH	RHNS	(S)	pecify)
H.	Is cost of employee meals included in 2E?	0	Yes	•	No				
I.	Did you receive revenue from employees?		Yes		No		If yes, specify amt.		<u> </u>
J.	Where is the revenue received reported in the	Co	st Repo	rt? (Page/Line	Item	ı)			
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	0	Yes	•	No		If yes, specify cost.		
L.	Is any revenue collected from these people?				No		If yes, specify amt.		
M.	Where is the revenue received reported in the	Co	st Repo	rt? (Page/Line	Iten	1)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?		Yes		No		If yes, specify cost.		
0.	Is any revenue collected from employees?	0	Yes	. •	No		If yes, specify amt.		
P.	Where is the revenue received reported in the	Co	st Repo	ort? (Page/Line	e 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)

ame of Facility	Lice		No. 373		oort for Y 30/2015	ear Ended	Page 19	of 37
45 Paddock Avenue Operations LLC, d/b/a Meriden Ce	<u> </u>	7	313	<u> </u>				
Item	_		Total	_	CCNH	RHNS	(S	pecify)
 Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, 	Lb				5.500			
gowns and other resident care items washed, ironed, and/or processed.***	Am		5,509		5,509			
 Employee items including uniforms, gowns, etc. washed, ironed and/or 	Lb	s.		-				
processed.***	Am	t. \$						
3. Personal clothing of residents	Lt	s.		ļ.,				
washed, ironed, and/or processed.***	Am	t. \$						
4. Repair and/or purchase of linens.***	LI	os.		-	\			· · · · · · · · · · · · · · · · · · ·
	An	ıt. \$	4,52		4,521			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	206,075)	206,075			
c. Management Services**	<u> </u>	\$					 	
d. Other (Specify)		\$						
3E. Total Laundry Expenditures (3a+b+c+d)		\$	216,10	5	216,105		<u> </u>	<u> </u>
3F. Laundry Questionnaire) Ye	<u> </u>) N	0	If yes, specify cost.		
G. Is cost of employee manary morates =	Ye) N	o	If yes,		
H. Did you receive revenue from emproyees:					(Page/Lin	specify amt. e Item)		
at 1 1 1 1 4 to moreons other) Ye) N	ĺo	If yes, specify cost		
) Ye	es	() N		If yes, specify amt.		
L. Where is the revenue received reported in the Co	st Re	port	?		(Page/Lin	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)

Nan	ne of Facility	License No.	Rep	ort for Year E	nded	Page	of
	Paddock Avenue Operations LLC, d/b/a Me	2373		9/30/2015		20	37
			,				
	Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced					
	a. In-House Care	by Personnel					
	 Supplies - Cleaning (Mops, 	Amt.	\$	23,848	23,848		
	pails, brooms, etc.)			·			
Г	b. Purchased Services (by contract other	Sq. Ft. Serviced					
	than through Management Services)	by Personnel					
	(Complete Schedule C-2 att.	Amt.	\$	308,301	308,301	<u></u>	
	Page 21)				_,		
	c. Management Services*		\$				
	d. Other (Specify)		\$				
4E.	Total Housekeeping Expenditures (4a +	b+c+d	\$	332,149	332,149		
5.	Resident Care (Supplies)**						
	a. Prescription Drugs***						
	1. Own Pharmacy		\$				ļ
	2. Purchased from		\$	225,164	225,164		
	b. Medicine Cabinet Drugs		\$		26,017		
	c. Medical and Therapeutic Supplies		\$		130,625		ļ
	d. Ambulance/Limousine***		\$	22,946	22,946		
	e. Oxygen						
<u></u>	For Emergency Use		\$			<u> </u>	<u> </u>
	2. Other***		\$		19,766		
	f. X-rays and Related Radiological		\$	14,039	14,039		
	Procedures***						
	g. Dental (Not dentists who should be inc	luded under	\$				
	salaries or fees)						
	h. Laboratory***		\$		28,357		<u> </u>
	i. Recreation		\$		20,629		
	j. Other (Specify)****		\$	80,422	80,422		
	See Attached Schedule						1
5K	. Total Resident Care Expenditures (5a - :	5j)	\$	567,965	567,965	<u> </u>	1

^{*} 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)
3060610160	Incontinency	\$	38,069	-	
3060610161	Incontinency - Rebates	\$	(2,635)		1
3080630030	Advertising-Help Wai	\$	1,385	-	<u>-</u>
3080630030	Advertising-Help Wai	\$	907		-
3080630080	Books, Dues & Subsc	\$	(152)	-	-
3080630140	Education Expense	8	488	-	-
3080630140	Education Expense	\$	156	<u>.</u>	-
3080630140	Education Expense	\$	604	-	-
3080630550	T&E-Lodging/Fransp	\$	38	-	-
3090630535	Office Supplies	\$	360	-	-
3120630530	Supplies	\$	1,914	-	
3120660080	Rental Expense	S	1,865		
3120660080	Rental Expense	\$	1,438		-
3155630530	Supplies	\$	4,633	-	-
3155630530	Supplies	\$	11,793	•	-
3155660080	Rental Expense	\$	(54)	<u>u</u>	
3155660080	Rental Expense	8	11,633		-
3170630530	Supplies	\$	334		
3010610300	Consolidated Billing	8	7,646	ŧ	-
3010010300	0 0	S	-		-
	0 0	\$	+		-
	0 0	\$	-	-	
	0 0		-	-	+
Total Other Resident Care		\$	80,422	\$ -	\$ -

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

Name of Facility	Meride	n Center		License No. 2373	Report for Year Ended 9/30/2015				Page of 21 37
845 Paddock Avenue Operanous LLC, wola meanum	OIIS LLLC, WU/a Mucalua			The state of the s					
		Related ** to	** to Owners,			į.	Potel Cost	Total Cost/Dage Ref ***	
		Operators, Officers	Officers				Carron Table	-	
Name of Individual or Commany	Address	Yes	Š.	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHINS	(Specify)	Pg Line
Traditions Consider Ground	Drive, Bensalem, PA	0	•	Vendor Contracted	Laundry Purchased Services	206,075			19 3b
Healthcare Services Group	Drive, Bensalem, PA 19020	0	0	Vendor Contracted	Housekeeping Purchased Services	308,301			20 4b
		0	0						
		0	0	,					
		0	0						
		0	0						
		0	0						
		0	0						
		0	0						
		0	0						
		0	0						
		0	0						
		0	0						
		0	0						

^{*} 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 Yo	ear Ended		Page	of
845 Paddock Avenue Operations LLC, d/b/a N 2373		9/30/2015			22	37
Item		Total	CCNH	RHNS	(Sp	ecify)
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	152,179	152,179			
b. Heat	\$	59,170	59,170			
c. Light & Power	\$	142,725	142,725			
d. Water	.\$	47,865	47,865			
e. Equipment Lease (Provide detail on page 6)	\$					
f. Other (itemize)	\$					
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	401,939	401,939			
7. Depreciation (complete schedule page 23*)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$	261,423	261,423			
c. Non-Movable Equipment	\$	8,380	8,380			
d. Movable Equipment	\$	80,302	80,302			
*7e. Total Depreciation Costs (7a+b+c+d)	\$	350,105	350,105			
8. Amortization (Complete att. Schedule Page 24*)		,				
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other (Specify)	\$					
*8e. Total Amortization Costs (8a+b+c+d)	\$				-	
9. Rental payments on leased real property less					}	
real estate taxes included in item 10b	\$	269,283	269,283			
10. Property Taxes						
a. Real estate taxes paid by owner	\$				ļ	
b. Real estate taxes paid by lessor	\$	120,957	120,957			
c. Personal property taxes	\$					
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	740,345	740,345			

^{*} 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)
2 story pro-			
			di di
Total Other Repairs and Maintenance	<u>\$</u> -	\$ -	\$:

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Depreciation Schedule

			Depreciation Schedule	ation oct						
Name of Facility 845 Paddock Avenue Onerations LLC. d/b/a Meriden Center	eriden Center	<u> </u>	License No. 2373			Report for Year Ended 9/30/2015	nded		Page 23	ot 37
	The state of the s					Accumulated	Method of			
			Cost Exclusive of	Salvage	Cost to Be	Beginning of	Computing	Useful	Depreciation	
Property Item			Land	Value	Depreciated	Year's Operations	~	Life	for This Year	Totals
A. Land Improvements								·		
1. Acquired prior to this report period			•				S/L	Various		
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	schedule)									
A-4. Subtotal										
B. Building and Building Improvements										
1. Acquired prior to this report period			3,021,314		3,021,314	714,572 S/L	S/L	Various	261,163	
2. Disposals (attach schedule)		•								
3. Acquired during this report period (attach schedule)	schedule)		16,240		16,240				260	
B-4 Subtotal										261,423
C. Non-Movable Equipment										
			63,988		63,988	26,520	S/L	Various	8,380	
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	schedule)		7,295		7,295					
C-4. Subtotal										8,380
	Is a mileage									
		Date of	Historical	i		Accumulated				
E	maintained?/ Acqu	Acquisition	Cost	Less		Depreciation to	Memod of			
<u>}</u>	Vec No Month	Vear	Exclusive of	Salvage Vatue	Cost to Be Depreciated	Beginning of Year's Operations	Computing Depreciation	Useful Life	Depreciation for This Year	Totals
D. Movable Equipment										
and year of each vehicle)									****	
a.							S/L	Various		
, q										
ಲೆ										
d.										
2. Movable Equipment										
a. Acquired prior to this report period			581,982		581,982	259,447	S/L	Various	77,539	
b. Disposals (attach schedule)										
c. Acquired during this report period										
(attach schedule)			43,062	AND THE SECOND S	43,062			200200000000000000000000000000000000000	2,763	
D-3. Subtotal										80,302
E. Total Depreciation										350,105

845 Paddock Avenue Operations LLC, d/b/a Meriden Center 9/30/2015

Schedule of Land Improvements Acquired during this report period

	rovements Acquired during in	Cost	Useful Life	Depreciation
Acquisition Date	Description of Item	T	Lite	
Additions:				
		<u> </u>		0
Total additions for La	and Improvements			
Deletions:				
Deictions.				
				di .
Total deletions for La	and Improvements	S -		\$

^{*}Ties to Page 23, Line A3

Schedule of Building Improvements Acquired during this report period

	Description of Item	Cost		Useful Life	Depreciation
8/31/2015	Description of Item 10 fire doors 2 hall door and 3 patient Eyewash Deck Mount, Left/Right Har Door frame and replacement glass	\$ 10 \$,271 \$ 877 \$ 9092 \$	20 20 15	\$ 257 \$ 4

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

Fotal additions fo	or Building Improvements	\$ 16,240	\$ 260
Deletions:			
Fotal deletions f	or Building Improvements	\$ -	\$

^{*}Ties to Page 23, Line B3

Schedule of Non-Movable Equipment Acquired during this report period

	Cost	Useful Life	Depreciation
Description of Item	Cost	13110	~~ · P
First install on stage compressor and fl	3,647.50		-
	3,647.50	10.00	-
<u> </u>			
	Ф 7305		\$ -
· Non-Movable Equipment	\$ 7,295		y .
			<u> </u>
Nor Movable Raginment	S -		\$ -
	Description of Item	Pirst install on stage compressor and f Final install on stage compressor and f Final install on stage compressor and f Final on stage compressor and f Final install	Description of Item Cost Life First install on stage compressor and f Final install on stage compressor and f Non-Movable Equipment S 7,295

^{*}Ties to Page 23, Line C3

Schedule of Movable Equipment Acquired during this report period

Schedille of Movas	to Education	_			Useful		
Acquisition Date	Description of Item	<u> </u>	Cost		Life	Depre	eciation
Additions:		**********		*******		de .	203
3/31/2015	8 Deluxe 32-Gallon Double Hamper	S	2,837	b		\$	
	6 RCA 32i Long Term Care TVs wire		3,642	\$	7	\$	217
	6 Zoneline PTAC Resistance Heat	\$	3,956	8	7	S	235
	Trapeze, Bariatric, 600lb Capacity	8	907	S	7	\$	54
	Attendant Vital Signs Monitor and car	8	2,156	\$	7	\$	103
3/31/2013	Auciliant vita Digio ilio	<u> </u>					

^{**}Ties to Page 23, Line B2

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

		an announce		000000	
12/31/2014 1.6 cu ft medical grade refrigerator	\$ 528	\$	10		40
4/30/2015 Quick Ship 208V 6 Well, Portable Sta	\$ 5,372	8			224
6/30/2015 15 Tracer EX2 Wheelchairs	\$ 2,385	8	10	8	60
10/31/2014 Mobile 5 Drawer Tool Cart	\$ 323	8	5	\$	59
5/31/2015 15 MATTRESS GENESIS VISCO S	1 4,705.99		3,00		522.89
6/30/2015 6 GENESIS ONLY DermaFloat LA			3,00		1,040.70
6/30/2015 2 HON Volt Synchro-Tilt Task Chair			10.00		5 94
9/30/2015 Booster heater	3,524.55		10.00		-
		+			
Total additions for Movable Equipment	\$ 43,062			8	2,763 *
Deletions:					
		4			
		4			
				-	
		4			
	0	4		3	
Total deletions for Movable Equipment	\$ -				

^{*}Ties to Page 23, Line D2c

Schedule of Leasehold Improvements Acquired during this report period

			Coorar	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
Tatal additions for L	easehold Improvement	\$ -		\$ -
Total additions for Ex	naction 2.11p			
Deletions:				
	L. Id Improvement	\$ -		S -
I otal deletions for Lo	easehold Improvement			

Useful

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

^{*}Ties to Page 24, Line C3

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

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Amortization Schedule*

	-						Dogo	Of
Name of Facility	- 2	License No.	73	Report for Year Ended 9/30/2015	r Ended		rage 24	37
845 Paddock Avenue Operations LLC, d/b/a Menden Center				Accumulated		-		
	Date of			Amort. to				
	Acquisition			Beginning of		F	A section to the section of	
		Length of	Cost to Be	Year's	Computing		AHIOLIZATION	Totals
Item	Month Year	Amortization	Amortized	Operations	Amortization**	\$	tor ims rear	LOIGIS
A. Organization Expense		· ·						
1.								
2.								
3.								
A-4. Subtotal								
B. Mortgage Expense								
1.								
2.								
3.								
B-4. Subtotal								
C. Leasehold Improvements and Other								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period								
(attach schedule)								
C-4. Subtotal								
D. Total Amortization								
* Straight-line method must be used.								

* Straight-line memod must be use

** Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.

B. Life of mortgage; OR

C. Remaining Life of Lease; OR D. Actual Life if owned by Related Party.

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

Name of Facility 345 Paddock Avenue Operations LLC,	cense No. 2373		Report for Year End 9/30/2015	led			Page 25]	of 37
Property Questionnaire								
Part A								
Is the property either owned by the I	acilitv	. .		@ ·	Mo		' complete	
or leased from a Related Party?*	dominy	0.1	Yes	②]	NO	If "No,"	complete	Part C.
*If any owner or operator of this facil	ity is related by f	family, m	arriage, ownership, abi	lity to control or				
business association to any person or	oreanization from	m whom	buildings are leased, th	en it is considered	a			
related party transaction.	o <u>.B</u>							,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Description			Total					
Date Land Purchased								
Date Structure Completed								
3. If NOT Original Owner, Date o	f Purchase							
4. Date of Initial Licensure								
5. Total Licensed Bed Capacity			130					
6. Square Footage								
7. Acquisition Cost								
a. Land		Ī						
b. Building								
Part B - Owner and Related Parti	A8		1 st Mortgage	2nd Mortgage	3rd Mortgage	4	th Mortg	age
	.63		1001120108080	3.0				
1. Financing	ad wariahle)				***************************************		***************************************	
a. Type of Financing (e.g., fixe	cu, variable)		****					
b. Date Mortgage Obtained	207							
c. Interest Rate for the Cost Ye								
d. Term of Mortgage (number	or years)	· · · · ·	, , , , , , , , , , , , , , , , , , ,					
e. Amount of Principal Borrov	veu					-		
f. Principal balance outstanding			<u> </u>	<u></u>				
Complete if Mortgage was Re	dinanced							
During Current Cost Year	<u> </u>				l			
g. Type of Financing (e.g., fix	ed, variable)		<u> </u>					
h. Date of Refinancing								
i. New Interest Rate				 -		-		
j. Term of Mortgage (number	of years)			<u> </u>				
k. Amount of Principal Borro	wed			<u></u>				
Principal Outstanding on N	ote Paid-Off		<u> </u>	<u> </u>		<u> </u>		
Part C - Arms-Length Leases	for Real Pro	perty L	mprovements Only	7	T _m ar	- 1 A	1 4	4 of Tage
Name and Address of Lessor			perty Leased	Date of Lease		se Annua	II Amoun	Of Leas
Healthcare REIT, Inc	Bui	ilding ar	nd Equipment	04/01/11	20			269,2
0 1 1000							-	
Address: One Seagate Suite 1500								
Toledo, OH 43603-1475								. <u>.</u>
								-
					1			

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

A. Building, Land Improvement & Non-Movable Equipment 1. First Mortgage Name of Lender 2. Second Mortgage Name of Lender Address of Lender Address of Lender 3. Third Mortgage Name of Lender		Report for Year Ended			Page of
845 Paddock Avenue Operations LLC 2373		9/30/2015			26 37
Item		Total	CCNH	RHNS	(Specify)
A. Building, Land Improvement & Non-Movable Equipment	\$	44,784	44,784		
Name of Lender	Rate				
Address of Lender					
	\$				
Name of Lender	Rate				
Address of Lender					
	\$				
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage	\$				
Name of Lender	Rate				
Address of Lender	•				
B. CHEFA Loan Information					
Original Loan Amount	\$				
2. Loan Origination Date					
3. Interest Rate %					
4. Term					
5. CHEFA Interest Expense					
12 B7. Total Building Interest Expense (A1 - A4 + B5)	\$		44,784		

(Carry Subtotals forward to next page)

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

Name of Facility License 1			Report for Year Ended			Page of 27 37
345 Paddock Avenue Operations LI 23	73		9/30/2015			21 31
Item			Total	CCNH	RHNS	(Specify)
Suk	totals Brou	ight Forward	44,784	44,784		
	TOTAL DIE				, 	
12. C. Movable Equipment 1. Automotive Equipment		\$		<u> </u>		
A. Item	Rate	Amount				
A. Itali						
Lender						
Address of Lender						
2. Other (Specify)		9				
A. Item	Rate	Amount				
Lender	<u> </u>	1				
			-			
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Int	erest					
Expense (C1 + 2)			\$	<u> </u>		
12. D. Other Interest Expense (Specify)			\$			
13. Total All Interest Expense (12B7 + 1	2C3 + 12I	<u>))</u>	\$ 44,784	44,784		
		,				
14. Insurance a. Insurance on Property (buildings	only)		\$ 7,578	7,578		
b. Insurance on Automobiles	,		\$			
11 Alega Decoratez (as	specified	above)				
c. Insurance other than Property (a: 1. Umbrella (Blanket Coverage)) ^	•	\$ 153,780	153,780	ļ	
2. Fire and Extended Coverage	·		\$			
3. Other (Specify)			\$			
J. Carrie Option /						
					-	
14d. Total Insurance Expenditures (14a	+b+c		\$ 161,35			
15. Total All Expenditures (A-13 thru	C-14)		\$ 11,545,18	7 11,545,187	<u></u>	

D. Adjustments to Statement of Expenditures

Name	of Fa	cility		Li	cense No.	Report for Ye	ar Ended	Page	of
845 F	addoc	k Ave	enue Operations LLC, d/b/a Meriden Center		2373	9/30/2015		28	37
					Total				
Item	Page	Line			Amount of				
	No.		Item Description		Decrease	CCNH	RHNS	(Spe	ecify)
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	\$	9,680	9,680	-		
Page	13 - H		sional Fees						
5.	13	8-c	Resident Care Physicians **	\$					
6.			Occupational Therapy	\$					
7.			Other - See attached Schedule	\$	809,877	809,877			
Page:	s 15 &	16 -	Administrative and General						
8.			Discriminatory Benefits	\$					
9.	15	1-c	Bad Debts	\$	130,024	130,024			
10.	·		Accounting & Legal	\$					
11.			Telephone	\$					
12.			Cellular Telephone	\$					
13.			Life insurance premiums on the life						
			of Owners, Partners, Operators	\$,,,,,,,
14.			Gifts, flowers and coffee shops	\$					
15.			Education expenditures to colleges or						
			universities for tuition and related costs						
			for owners and employees	\$					
16.			Travel for purposes of attending						
			conferences or seminars outside the						
			continental U.S. Other out-of-state						
			travel in excess of one representative	\$					
17.			Automobile Expense (e.g. personal use)	\$					
18.	16	m-2 &	Unallowable Advertising *	\$	6,857	6,857			
19.			Income Tax / Corporate Business Tax	\$					
20.			Fund Raising / Contributions	\$	1,941	1,941			
21.			Unallowable Management Fees	\$	509,766	509,766			
22.			Barber and Beauty	\$					·
23.			Other - See attached Schedule	\$	12,328	12,328			. ,
Page	18 - L	Dietar	y Expenditures						
24.			Meals to employees, guests and others						
			who are not residents	\$					
Page	19 - L	aund	ry Expenditures						
25.			Laundry services to employees, guests						
			and others who are not residents	\$					
Page	20 - I	Iouse	keeping Expenditures						
26.			Housekeeping services to employees, guests						
			and others who are not residents	\$					
			Subtotal (Items 1 - 26)	\$	1,480,473	1,480,473			
			Wanted*	_	(0.	rry Subtotal fo	7		

^{*} 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

n Def I inc De	£	Description	CCNH	RHNS	(Specify)
Page Ref Line Re	2 Administrator's salary disallowed		0 \$ 9,680	\$ <u>-</u>	\$ -
10	Z Administrators same, district	1	08 -	\$ -	\$ -
U A	0 1	ı .	0 \$ -	\$ -	\$ -
0	0	1	0 \$ -	\$	\$ -
- 0	0 I	1	0 \$ -	S -	S -
U			08 -	S -	\$ -
- 0	0				
	<u> </u>	-	\$ 9,680	\$	8
Total Other Salarie	s Adjustment			110,000	

Schedule of Fees Adjustments

Page Ref Line F) of	Description	CCNH	RHNS	(Specify)
Page Ref Line F	5 Rehabilitation Services	3120620020	\$ 149,024	0	0
13	5 Rehabilitation Services	3195620020	\$ 456,779	0	0
13	9 Speech Therapist	3170620020	\$ 61.098	0	
13	10 Occupational Therapist	3105620020	\$ 121,707	0	(
13	12 Other	3010620020	\$ 180	0	1
13	12 Other	3015620020	\$ 12,019	0	
13	12 Respiratory Purchased Servics	3155620020	\$ 9,070	0	1
				0	(
				0	- 1
				0	
				0	
				0	
Total Other Fees	Adjustments		\$ 809,877	\$	\$ -

Schedule of Other A&G Adjustments

Description	CCNH	RHNS	(Specify)
Chamber of Commer	8 -	0	0
Collection Fees	\$ 10,299	0	(
Estimated Accrual	\$ (355)	0	
Non-recurring Charg	e S -	0	
Penalty and Fines	\$ 2,385	0	· · · · · · · · · · · · · · · · · · ·
	8 -	0	
0 () S	0	
0 (\$ -	0	
0 () \$ -	0	
	\$ 12,328	\$ -	S .
	Chamber of Commer Gollection Fees Estimated Accrual Non-recurring Charg Penalty and Fines	Chamber of Comment S	Chamber of Commerc \$ 0 Collection Fees \$ 10,299 0 Estimated Acorual \$ (355) 0 Non-recurring Charge \$ 0 Penalty and Fines \$ 2,385 0 0 \$ 0 \$ 0 0 0 \$ 0 0

State of Connecticut Annual Report of Long-Term Care Facility CSP-29 Rev. 10/2006

D Adjustments to Statement of Expenditures (cont'd)

			D. Adjustments to Statemen	IT (от Ехрепа	nures (co	niu)	70	- 6
Vame	of Fa	cility		Lic		Report for Year Ended		Page	of
45 P	45 Paddock Avenue Operations LLC, d/b/a Merid		nue Operations LLC, d/b/a Meriden Center		2373	9/30/2015		29	37
					Total				
tem	Page	Line			Amount of	.		40	
No.		No.	Item Description		Decrease	CCNH	RHNS	(Spe	ecify)
			Subtotals Brought Forward	\$	1,480,473	1,480,473			Alta and sections
Page	20 - K	eside.	nt Care Supplies***					A CONTRACTOR OF THE	
27.	20	5-a-2	Prescription Drugs	\$	225,164	225,164			
28.			Ambulance/Limousine	\$	22,946	22,946			
29.	20	5-f	X-rays, etc	\$	14,039	14,039			
30.			Laboratory	\$	28,357	28,357			
31.			Medical Supplies	\$					
32.	20	5-e-2	Oxygen (non emergency)	\$		19,766		<u> </u>	
33.			Occupational Therapy	\$					
34.	<u> </u>		Other - See Attached Schedule	\$	47,233	47,233		3896 370 565 5	Name of the State
	22 - 1	Maint	enance and Property			Selection of the Selection			
35.			Excess Movable Equipment Depreciation						
			See Attached Schedule	\$			SALVE SALVE SALVE SALVE SALVE SALVE	200 000 000 000	www.com
36.	 		Depreciation on Unallowable		en bestellig	10:10-9-0		\$2,50,800	1 6 62 6
			Motor Vehicles	\$			a Legger Ad FA J. Double Selland	Total Company of the	6.4.5.27.15
37.			Unallowable Property and Real		10.0				
			Estate Taxes	\$					
38.			Rental of Building Space or Rooms	\$		<u> </u>		<u> </u>	
39.			Other - See Attached Schedule	\$				e ersennettiva	SANARO A STUGE
Page	e 27	Insur	ance			Harries and the			(A)
40.	-		Mortgage Insurance	\$				<u> </u>	
41		1	Property Insurance	\$	3			v Dogovaraniem	030046622449
	er - M	iscella	ineous						
42		1	Research or Experimental Activities	9					
43		1	Radio and Television Revenue	9					
44		†	Vending Machine Revenue	9				<u> </u>	
45		1 -	Purchase Discounts and Allowances		<u> </u>		<u> </u>		
46		 	Duplications of functions or services		B			2 24 175 3 6 6 6	
47		1 -	Expenditures made for the protection,		100			1000	
			enhancement or promotion of the						
			providers interest		\$			_	
48	.	 	Interest Income on Accounts Rec	_ :	\$	and the second s			
49		1	Other (include personnel and other			60.000			
			costs unrelated to resident care) - See		100 图 图 图				
			Attached Schedule	_ ;	\$ 71,672	71,672		ST SEX SECTION	
Not	For I	Profit	Providers Only			2007-04	transation d	6900.00	a daviate
50		Ţ <u></u>	Building/Non Movable Eq. Depreciation						
``			Unallowable Building Interest -			2.2.5.35.2			
			See Attached Schedule		\$				
51	Tot	al Am	ount of Decrease (Items 1 - 50)		\$ 1,909,650	1,909,650			

^{***} 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

ge Ref Line Ref	Description	CCNH	RHNS	(Specify)
	Consolidated Billing	\$ 7,646.11	3010610300	\$ -
20 5-1		\$ 16,426.00	3155630530	\$ ~
20 5-i		\$ 11,579.15	3155660080	\$ -
20 5-i		\$ 11,582.04	3005660130	allow \$3600
		\$ +	\$ -	\$ -
		S -	\$ -	\$ -
		\$ -	S -	S -
		\$	\$ -	S -
		\$ -	\$ -	\$ -
		\$	\$.	\$
tal Other Ancillar	v. Costs	\$ 47,233	8 .	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref Line Ref Description	CCNH	RHNS	(Specify)
0 0	0 \$ -	\$ -	S -
0 0	0 5	\$ -	S -
0 0 m	0 S -	\$ -	8 -
0 0 0 0	0 S -	\$ -	5 -
A 0	0 \$ -	S -	\$.
0 0	0 8 -	\$ -	\$ -
	0 S -	\$	\$ -
0 0	0 \$ -	\$	\$ -
0 0	0 \$ +	S -	S -
Total Excess Movable Equipment Depreciation	\$	\$ -	\$ -
444444444444444444444444444444444444444			

Schedule of Other Property Adjustments

Page Ref	Line Ref Description	CCNH	RHNS	(Specify)
, , , , , , , , , , , , , , , , , , ,	0	0 \$ -	s -	\$ -
n	0	0 \$ -	S -	\$ -
······································	ß	0 S -	\$.	\$ -
	fi fi	0 S -	\$ ·	\$ -
- 0	6	0 \$ -	\$ -	S -
- 0	0	0 \$ -	S -	S -
0		0.5 -	\$ -	\$
<u> </u>	0	0 S -	s ·	\$ -
U	0	0 \$	S -	\$.
	U or Property Adjustments	8 -	S -	\$ -
Total Oth	r Froperty Adjustments			

~ ~ ~	Y 4 Y) - 6	Description	CCNH	RHNS	(Specify)
		Description	\$ 71,671.97	\$ -	\$ -
27	14 cl	General liability Insurance Adjust		\$ -	s -
0	(0	ς .	s -	\$ -
0	(0	S -	\$ -	S -
0		0	ς .	S +	S -
0		G G	Ç	S	\$ -
- 0	()	ς .	8 .	\$ -
- 0		0	<u> </u>	S -	\$ -
0)	\$	ς .	\$
0	<u> </u>		Ç .	\$ -	\$ -
0		3	\$ 71.672	\$ -	8 -
Total Oth	er Adiusti	nents	**************************************		

Schedule of Unallowable Building Interest

	L. Dof Dogovintian	CCNH	RHNS	(Specify)
age Kei	Line Ref Description	0 \$	S -	S -
U	0	0.8 -	S -	\$ -
- 0	0	0.8 -	8	\$ -
0	0	0 \$ -	8 -	\$
- 0	0	0.8	S	S -
0	0	0.0	6	s -
0	0	0 0	e e	Q .
0	0	U 35 -	e e	g .
0	0	U 5	e e	6
0	0	0 8	3 "	100
0	0	0 \$	3	Ø -
otal Ilnali	owable Building Interest	<u> 5 - </u>	<u> </u>	a

F. Statement of Revenue

F. Statement of Review of Facility License No.	1	Report for Ye	ar Ended		Page	of
fame of Facility License No. 45 Paddock Avenue Operations LLC, d/ 2373		9/30/2015			30	37
45 Paddock Avenue Operations LDC, the 2575						
Item		Total	CCNH	RHNS	(S	pecify)
Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (CT only)	\$	12,164,267	12,164,267			
b. Medicaid Room and Board Contractual Allowance **	\$	(5,576,652)	(5,576,652)			
2. a. Medicaid (All other states)	\$					
b. Other States Room and Board Contractual Allowance **	\$				<u> </u>	
3. a. Medicare Residents (all inclusive)	\$	1,617,961	1,617,961		ļ	
b. Medicare Room and Board Contractual Allowance **	\$	(421,029)	(421,029)		<u> </u>	
Medicare Room and Board Commodule a. Private-Pay Residents and Other	\$	2,118,394	2,118,394			
b. Private-Pay Room and Board Contractual Allowance **	\$	(522,376)	(522,376)			
I. Other Resident Revenue	\$	158,243	158,243	***************************************		
1. a. Prescription Drugs - Medicare	\$	(41,178)	(41,178)			
b. Prescription Drugs - Medicare Contractual Allowance **	\$	103,581	103,581			
c. Prescription Drugs - Non-Medicare	\$	(28,227)	(28,227)			· · · · · · · · · · · · · · · · · · ·
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$	21	21			
2. a. Medical Supplies - Medicare	\$		(5)	1		
b. Medical Supplies - Medicare Contractual Allowance **	\$	145	145	-	†	
c. Medical Supplies - Non-Medicare	\$	(53)	(53)		\top	
d. Medical Supplies - Non-Medicare Contractual Allowance **	<u> </u>		536,758	1		
3. a. Physical Therapy - Medicare			1		+-	
b. Physical Therapy - Medicare Contractual Allowance **	\$		353,585	T		
c. Physical Therapy - Non-Medicare	\$		+		+-	
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$		 		+-	
4. a. Speech Therapy - Medicare	\$	1	154,294		+-	
b. Speech Therapy - Medicare Contractual Allowance **	\$		T		╁┈╴	
c. Speech Therapy - Non-Medicare					+-	
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$		T		+	
5. a. Occupational Therapy - Medicare	\$		T***		+	
b. Occupational Therapy - Medicare Contractual Allowance **	\$		T		+-	
c. Occupational Therapy - Non-Medicare	\$	1		- 	-	
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (Specify) - Medicare	\$					
b. Other (Specify) - Non-Medicare			1			
III. Total Resident Revenue (Section I. thru Section II.)		11,113,482	11,113,482	2		
IV. Other Revenue*						
1. Meals sold to guests, employees & others	9	<u> </u>				
2. Rental of rooms to non-residents		ß				
3. Telephone		\$				
Rental of Television and Cable Services		8,941	8,94	1		
Nethal of Television that Guest Section Interest Income (Specify)		\$ 349	34	9		
6. Private Duty Nurses' Fees		\$				
7. Barber, Coffee, Beauty and Gift shops		\$ 11,932	11,93	2		
		\$ 538	3 53	8		
8. Other (Specify)		\$ 21,760	21,76	0		
V. Total Other Revenue (1 thru 8)						
VI. Total All Revenue (III+V)		\$ 11,135,24	2 11,135,24	4		

^{*} 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		(CNH	RHNS	(Specify)
∐-6-a	Medicare Part A	X-Ray	\$	9,181	nnnnnnnnnnaaddddddddddddddd	\$.
1-6-a	Medicare Part A	Laboratory	\$	10,399	\$ •	S -
I-6-a	Medicare Part A	Respiratory Therapy & Supplie	\$	5,378	\$ -	S -
I-6-a	Medicare Part A	Nursing Treatment Supplies	\$		\$	\$ -
I+6-a	Medicare Part A	Audiology	S	•	5 -	\$ -
I-6-a	Medicare Part A	Incontinency	\$		\$ +	\$ -
I-6-a	Medicare Part A	Oxygen & Supplies	\$	1,847	\$ +	\$ -
I-6-a	Medicare Part A	Physician Visit	8	.	\$ -	S
I-6-a	Medicare Part A	Ambulance	8	-	\$ -	\$ -
1-6-a	Medicare Part A	Flu Shot	\$	5,045	\$ -	S -
I-6-a	Contractual MedA	X-Ray	\$	(2,389)		\$ -
[-6-a	Contractual MedA	Laboratory	8	(2,706)	\$ -	S.
[]-6-a	Contractual MedA	Respiratory Therapy & Supplie	S	(1,399)	5 -	\$ -
I-6-a	Contractual MedA	Nursing Treatment Supplies	\$		\$ +	\$ -
П-6-а	Contractual MedA	Audiology	\$	•	S -	\$ -
1-6-a	Contractual MedA	Incontinency	\$		S -	5 -
[]-6-a	Contractual MedA	Oxygen & Supplies	8	(481)	\$.	5 -
П-6-а	Contractual MedA	Physician Visit	8	+	\$ -	5 -
II-6-a	Contractual MedA	Ambulance	3		\$ -	S -
∐-6-a	Contractual MedA	Flu Shot	\$	(1,313)	\$ -	\$ -
	0	0 0	\$		\$ -	\$ -
	0	0 (\$		\$ -	\$ -
Tatel Off	ier Resident Revenue -	Medicare	\$	23,561	\$ -	\$

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Reiated E. Page Ref	Description		CCNH	RHNS	(Specify)
I-6-b	Medicaid	X-Ray	\$ 336	\$ <u>-</u>	\$ <u>-</u>
I-6-b	Medicaid	Laboratory	\$ 1,047	\$ -	\$ -
I-6-b	Medicaid	Respiratory Therapy & Supplie	\$ 10,546	S -	\$ -
I-6-b	Medicaid	Nursing Treatment Supplies	\$ -	\$ -	\$ -
I-6-b	Medicaid	Audiology	\$ -	\$ -	S
I-6-b	Medicaid	Incontinency	\$ -	\$ -	\$ -
1-6-b	Medicaid	Oxygen & Supplies	\$ 7,170	\$.	\$ -
I-6-b	Medicaid	Physician Visit	S -	<u> 5 - </u>	\$ -
I-6-b	Medicaid	Ambulance	\$ -	<u>s -</u>	\$
I-6-b	Medicaid	Flu Shot	\$ -	\$ -	\$ -
1-6-b	Contractuals- Medicaid	X-Ray	\$ (154)	774770000000000000000000000000000000000	\$ <u>-</u>
1-6-b	Contractuals- Medicaid	Laboratory	\$ (480)	S -	S
I-6-b	Contractuals- Medicaid	Respiratory Therapy & Supplie	\$ (4,835)	\$ -	S -
I-6-b	Contractuals- Medicaid	Nursing Treatment Supplies	\$ -	\$ -	S -
II-6-b	Contractuals- Medicaid	Audiology	\$ -	\$ -	<u> </u>
II-6-b	Contractuals- Medicaid	Incontinency	S -	\$	\$
II-6-b	Contractuals- Medicaid	Oxygen & Supplies	\$ (3,287)		S -
II-6-b	Contractuals- Medicaid	Physician Visit	\$.	S -	\$ -

П-6-в	Contractuals- Medicaid A	Ambulance	8	-	\$ •	\$
∏-6-b	Contractuals- Medicaid I	lu Shot	\$		\$ -	S
11-6-b	Private Insurance and Other	(-Ray	S	5,007	\$ -	S
1 I-6-b	Private Insurance and Other I	abotatory	\$	5,754	\$ -	S
Ш-6-b	Private Insurance and Other I	Respiratory Therapy & Supplie	S	2,762	S -	\$ -
II-6-b	Private Insurance and Other 1		\$		\$ -	\$
II-6-b	Private Insurance and Other		\$		S -	\$ -
II-6-b	Private Insurance and Other I		\$	•	\$ -	\$ -
II-6-b	Private Insurance and Other (8	2,456	S -	\$
II-6-b	Private Insurance and Other I		S	+	\$	S -
11-6-b	Private Insurance and Other 2		\$	-	\$ -	\$ -
II-6-b	Private Insurance and Other I		S	-	\$ -	\$ -
II-6-b	Private Insurance and Other		S	79,121	\$ -	\$
II-6-b	Contractuals+ NonMedicaid		\$	(1,235)		\$ -
II-6-b	Contractuals NonMedicaid		\$	(1,419)	S -	\$
II-6-b	Contractuals- NonMedicaid	Respiratory Therapy & Supplie	\$	(681)	s -	5 -
II-6-b	Contractuals- NonMedicaid		S		\$ -	S -
II-6-b	Contractuals- NonMedicaid		\$		\$ -	\$ -
II-6-b	Contractuals- NonMedicaid		\$		\$ -	S -
II-6-b	Contractuals-NonMedicaid		S	(606)	\$ -	\$
II-6-b	Contractuals-NonMedicaid		S		S -	\$
II-6-b	Contractuals+ NonMedicaid		\$	-	S -	\$ -
II-6-b	Contractuals+ NonMedicaid		\$	•	S -	\$
П-6-b	Contractuals- NonMedicaid		\$	(19,510)	S -	5
II-6-b	0	C	\$		\$ -	\$
7	ther Resident Revenue		\$	81,992	\$ -	5 -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Page Ref	Account	<u> </u>) CCNH	RHNS	(Specify)
TV-5	Interest On Overdue Acc	oui L) 349	<u> </u>	
0		0	J		
0	<u> </u>	0	J 65 240	· e	e .
Total Inte	rest Income			104	0 1034-00000000000000000000000000000000000

Schedule of Other Revenue

Page Ref	Description		CCNH	RHNS	(Specify)
Page Ref	Description	0	CCNH	RHN8	(Specify)
	Medical Record	0	538	-	-
0	0	0	•	-	-
0	0	0		-	-
		•			
				<u> </u>	
Total Oth	er Revenue		\$ 538	\$ +	\$ -

G. Balance Sheet

Name of Facility	License No.		port for Year 1 0/2015	Ended	Page 31	of 37
845 Paddock Avenue Operations LLC		913	0/2013			mount
	Account				11	·
Assets						
A. Current Assets	`				\$	12,238
Cash (on hand and in banks Resident Accounts Receival)	for Ra	1 Dehte)		\$	1,089,004
	(Evoluding Owners	or Pela	ted Parties)		\$	2,000
	(Excluding Owners	OI KCIA	terr arres)		\$	37,582
4 Inventories					\$	3,147
5. Prepaid Expenses					Ψ	2,2
a. Prepaid Expenses						
b. Prepaid Prop Taxes	nto				-	
c. Prepaid Escrow Real Est			3,147			
d. Prepaid Personal Propert6. Interest Receivable	y lax				\$	
6. Interest Receivable7. Medicare Final Settlement I	Paceirzahla				\$	
8. Other Current Assets (itemi:					\$	
8. Other Current Assets (nemi.	<i>ie)</i>				Ÿ	
					-	
1.0 Tetal Comment Aggets (Tipog A	1 then 2)				\$	1,143,972
A-9. Total Current Assets (Lines A	пппој				 	
B. Fixed Assets					\$	830,000
1. Land	*Historical Cost				\$	
2. Land Improvements	Accum, Depreci			Net	*	
2 Duildings	*Historical Cost		3,037,554	1100	\$	2,061,559
3. Buildings	Accum. Depreci		975,995	Net		, ,
4. Leasehold Improvements	*Historical Cost		<i>510,55<u>0</u></i>		\$	
4. Leasenoid improvements	-Accum. Depreci			Net		_
5. Non-Movable Equipment	*Historical Cost		71,283		\$	36,383
5. Non-Movable Equipment	Accum. Depreci		34,900	Net]`	•
6. Movable Equipment	*Historical Cost		625,044		\$	285,29:
0. Movable Equipment	Accum. Depreci		339,749	- Net		•
7. Motor Vehicles	*Historical Cost				\$	
/, Motor venicles	Accum, Depreci			Net		
8. Minor Equipment-Not Dep				<u> </u>	\$	
9. Other Fixed Assets (itemize	·)				\$	
9. Other Fixed Assets (itemize	·)					
	D1 (hara 0)	-			\$	3,213,23
B-10. Total Fixed Assets (Lines	BI mru 9)				ΙΦ	دعرد دعود

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

G. Balance Sheet (cont'd)

	e of Facility	License No.	Report for Year Ended 9/30/2015	Page 32	of 1 37		
845]	Paddock Avenue Operations LLC		9/30/2013		Amount		
		Account	Total Brought Forv		4,357,209		
		1 10 77 11 70		vatu. p	4,551,207		
C.	Leasehold or like property reco	 \$					
	1. Land	4771 . 10 .		_			
	2. Land Improvements	*Historical Cost	tion Net	\$			
		Accum, Deprecia	tion Net		<u> </u>		
	3. Buildings	*Historical Cost	tion Net	\$			
		Accum. Deprecia	tion inci	Ψ			
	4. Non-Movable Equipment	*Historical Cost		\$			
		Accum. Deprecia	tion Net	3			
	Movable Equipment	*Historical Cost	NT. /	l _e			
		Accum. Deprecia	tion Net	\$			
	6. Motor Vehicles	*Historical Cost		6			
		Accum. Deprecia	tion Net	\$ \$			
	7. Minor Equipment-Not Dep	7. Minor Equipment-Not Depreciable					
C-8		erties (C1 thru 7)		\$			
D.	Investment and Other Assets						
	Deferred Deposits			\$			
	2. Escrow Deposits			\$			
	3. Organization Expense	*Historical Cost					
		Accum. Deprecia	ation Net	\$			
	4. Goodwill (Purchased Only	\$ \$					
	5. Investments Related to Re-	5. Investments Related to Resident Care (temize)					
ļ							
	6. Loans to Owners or Relate	d Parties (temize)		\$			
	Name and Address	Amount	Loan Date				
1							
	7. Other Assets (itemize)			\$	779,932		
	Intercompany		779,932				
D-8	3. Total Investments and Other	\$	779,932				
D-0). Total All Assets (Lines A9 +	B10 + C8 + D8)		\$	5,137,142		

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

G. Balance Sheet (cont'd)

Traine of two		License No. Report for Year Ended		nded	Page	of	
845 Paddock	Aver	nue Operations LLC, d/b/a M	2373	9/30/2015	 	33	37
		Ą	ccount			Am	ount
Liabilities					1		•
A.	Cu	rrent Liabilities					269 201
	1.	Trade Accounts Payable			3) <u> </u>	368,201
	2.	Notes Payable (itemize)			1)	
•							
		T D 11 C T inner	-t (Carmont noution	(itamiza)	- 9	3	
	3.	Loans Payable for Equipment Name of Lender	Purpose	Amount	Date Due		
		Name of Lender	1 ai pose	7 miouni	1		
	4.	4. Accrued Payroll(Exclusive of Owners and/or Stockholders only)					222,09
	5.						
	6.						
	7.	Medicare Final Settlement				\$ \$	
	8.						
	9.	Mortgage Payable (Current				\$	
	- 10). Interest Payable (Exclusive	of Owner and/or 1	Related Parties) —		\$	
		. Accrued Income Taxes*				\$	
		2. Other Current Liabilities (it	emize)		ļ	\$	370,93
		Acer Exp Water and Sewer	1	4,945 Deferred Revenue	31,895		
		Accr Exp Gas		2,505 Accrued Provider/Bed			
		Accr Exp Electricity		5,546 Acer Exp Suspense	(4,842)		
		Accr Exp Other		2,252 A/R Credit Gross Up I			0/1.00
A-1	3. T	otal Current Liabilities (Line	es A1 thru 12)			\$	961,22

^{*} 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 34	37
845 Paddock Avenue Operations LLC, d/b/a		9/30/2015		1 34 Amo	<u> </u>
	Account	Total Brough	ht Forward:	Aiii0	961,227
		Total Brough	iii roiwaiu.		701,221
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment	Purpose	Amount	\$ Date Due		
Name of Lender	1 uipooe				
		ľ			
		ļ			
		ļ			
D 11			\$	}	
Mortgages Payable Loans from Owners or Re	Inted Parties fitemize	<u>. </u>	9		
	Amount	Loan I			
Name and Address of Lender	2 Milount				
		•			
		}			
4. Other Long-Term Liability	k.	\$	2,986,949		
LT Debt-Financing Oblig	ation	2,986,949	<u> </u>		
	(T * T) (1 4)			\$	2,986,949
B-5. Total Long-Term Liabilities	(Lines B1 thru 4)			\$ \$	3,948,176
C. Total All Liabilities (Lines A	7-12 # B-2)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Ψ	292 109210

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

	ne of Facility License No. Report for Year Ended	Page	of
845	Paddock Avenue Operations LLC, 2373 9/30/2015	35	37
A.	Account Reserves	A	mount
A.		φ.	
	Reserve for value of leased land	\$	
	2. Reserve for depreciation value of leased buildings and appurtenances		
	to be amortized	\$	
	3. Reserve for depreciation value of leased personal property Equity)	\$	
	4. Reserve for leasehold real properties on which fair rental value is based	\$	
	5. Reserve for funds set aside as donor restricted	\$	
	6. Total Reserves	\$	
B.	Net Worth		
	1. Owner's Capital	\$	
:	2. Capital Stock	\$	
	3. Paid-in Surplus	\$	2,461,560
	4. Treasury Stock	\$	
-	5. Cumulated Earnings	_ \$	(862,654)
	6. Gain or Loss for Period 10/1/2014 thru 9/30/2015	\$	(409,943)
	7. Total Net Worth	\$	1,188,963
C.	Total Reserves and Net Worth	\$	1,188,963
D.	Total Liabilities, Reserves, and Net Worth	\$	5,137,139

H. Changes in Total Net Worth

	e of Facility	License No.	Report for Year I	Ended	Page 36	of 37
845	Paddock Avenue Operations LLC, d/	Account	9/30/2015			
			mount			
A	Balance at End of Prior Period as s	hown on Report o	£09/30/2014		<u>\$</u>	1,598,907
В.	Total Revenue (From Statement of	Revenue Page 30)		\$	11,135,242
C.	Total Expenditures (From Statemer	nt of Expenditures	Page 27)		\$	11,545,186
D.	Net Income or Deficit				\$	(409,944)
E.	Balance				\$	1,188,963
F.	Additions 1. Additional Capital Contributed 2. Other (itemize)	(temize)				
F-3.	Total Additions				\$	
G.	Deductions Deductions					
Ju	Drawings of Owners/Operators	s/Partners (<i>Specify</i>)		\$	
 	Name and Address (Vo., City,		Title	Amount		
	2. Other Withdrawings (Specify)		Amou	ınf	\$	
	Purpose		2 mol	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
					-	
	3. Total Deductions				\$	
H.	Balance at End of Period	09/3	30/15		\$	1,188,963

I. Preparer's/Reviewer's Certification

Name of Facility			License No.		Report for Year Ended	Page	of			
845 Paddock Avenue Operations LLC,			2373	9/30/2015	37	37				
	Check appropriate category									
Ø	Chronic and Convalescent Nursing Home only (CCNH)	П	Rest Home with Nursing Supervision only (RHNS)	I (Specify)						
		Prep	arer/Reviewer Certificat	ion						
	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.									
Signat	ture of Preparer		Title		Date Signed					
	Tromas Jaman		Sr. Director of Reimbursame	,T	12/28/	2015				
Printe	d Name of Preparer	•			•					
Thom	as Farnan - Sr Director of Reimburser	nent								
	es Address		Phone Number							
	crickstone Square, Andover, MA, 0181	10			978-247-5029					