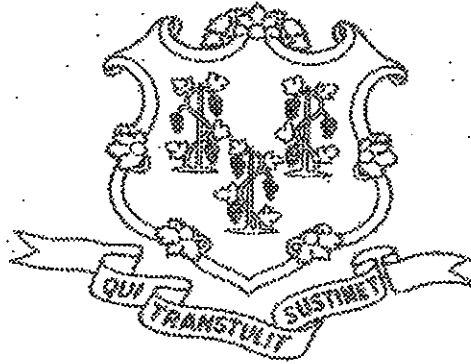


State of Connecticut



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Annual Report of Long-Term Care Facility Cost Year 2015

RECEIVED

DEC 21 2015

DEPT. OF SOCIAL SERVICES
OFFICE OF CON AND RATE SETTINGS

Name of Facility (as licensed) 845 Paddock Avenue Operations LLC, d/b/a Meriden Center	
Address (No. & Street, City, State, Zip Code) 845 Paddock Ave, Meriden, CT 06450	
Type of Facility <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH 2373	RHNS	(Specify)	Medicare Provider 07-5192
------------------	--------------	------	-----------	------------------------------

Medicaid Provider Numbers:	CCNH 000008995	RHNS	ICF-IID
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For Department Use Only

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

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General Information

Name of Facility (as licensed) 845 Paddock Avenue Operations LLC, d/b/a Meriden C	License No. 2373	Report for Year Ended 9/30/2015	Page 1	of 37
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Administrator's/Owner's Certification

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

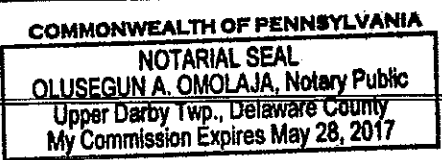
I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for 845 Paddock Avenue Operations LLC, d/b/a Meriden Center [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, 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.

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) Giovanna Griffin			Printed Name (Owner) Keith Davis, V.P. of Reimb., Genesis Healthcare		11/23/2015
Subscribed and Sworn to before me:	State of PA	Date 11/13/15	Signed (Notary Public)		Comm. Expires / /

Address of Notary Public



(Notary Seal)

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General Information

Name of Facility (as licensed) 845 Paddock Avenue Operations LLC, d/b/a Meriden C	License No. 2373	Report for Year Ended 9/30/2015	Page 1	of 37
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Administrator's/Owner's Certification

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

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

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Giovanna Griffin			Printed Name (Owner) Keith Davis, V.P. of Reimb., Genesis Healthcare	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

State of Connecticut
Department of Social Services
 25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility 845 Paddock Avenue Operations LLC, d/b/a Meriden Center		Period Covered:	From 10/1/2014	To 9/30/2015
Address of Facility 845 Paddock Ave, Meriden, CT 06450				
Report Prepared By Thomas Farnan		Phone Number 978-247-5029	Date 12/21/2015	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$ 527,363	527,363		
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$ 3,883,745	3,883,745		
5. All other wages paid	\$ 470,172	470,172		
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		

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire

Type of Facility - Organization Structure

	Phone No. of Facility 203-238-2645	Report for Year Ended 9/30/2015	Page 2	of 37
Name of Facility (as shown on license) 845 Paddock Avenue Operations LLC, d/b/a Meriden Center		Address (No. & Street, City, State, Zip) 845 Paddock Ave, Meriden, CT 06450		
License Numbers:	CCNH 2373	RHNS (Specify)	Medicare Provider No. 07-5192	
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?				
<input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Giovanna Griffin		Nursing Home Administrator's License No.:	1196	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

General Information and Questionnaire Corporate Owners

Name of Facility 845 Paddock Avenue Operations LLC, d/b/a M	License No. 2373	Report for Year Ended 9/30/2015	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation 845 Paddock Avenue Operations LLC, d/b/a Meriden Center	Business Address 101 East State Street, Kennett Square, PA 19348	State(s) in Which Incorporated PA		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
See Attached				
Names of Stockholders Owning at Least 10% of Shares				
See Attached				

General Information and Questionnaire Related Parties*

Name of Facility 845 Paddock Avenue Operations LLC, d/b/a Meriden C	License No. 2373	Report for Year Ended 9/30/2015	Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input type="radio"/> Yes <input checked="" type="radio"/> No						
If "Yes," provide the Name/Address and complete the information on Page 11 of the report.						
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? <input checked="" type="radio"/> Yes <input type="radio"/> No						
If "Yes," provide the following information:						
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No			
Genesis Health Ventures	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	Home Office	472,945	472,945
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	63% PT/OT/ST- Direct and Indirect Cost	759,126	759,126
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	55% Staffing Pool	12,568	12,568
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	85% Case Management	28,680	28,680
Career Staffing	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	Staffing Pool		
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	<input checked="" type="radio"/>	<input type="radio"/>	43% Respiratory Therapy	52,711	52,711
Liberty Health (Insurance)	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	Capital Interest	44,784	44,784
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>			

* Use additional sheets if necessary.

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

General Information and Questionnaire Basis for Allocation of Costs

Name of Facility 845 Paddock Avenue Operations LLC, d/b/a Me	License No. 2373	Report for Year Ended 9/30/2015	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility 845 Paddock Avenue Operations LLC, d/b/a Meriden Center		License No. 2373	Report for Year Ended 9/30/2015			Page 6	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
Total ***							

Is a Mileage Log Book Maintained for All Leased Vehicles ?
 Yes No

* 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 845 Paddock Avenue Operations L	License No. 2373	Report for Year Ended 9/30/2015	Page 7	of 37
The records of this facility for the period covered by this report were maintained on the following basis:				
<input checked="" type="radio"/> Accrual <input type="radio"/> Cash <input type="radio"/> Modified Cash				
Is the accounting basis for this period the same as for the previous period? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain.				
Independent Accounting Firm				
Name of Accounting Firm 1 KPMG Peat Marwick 2 3 4		Address (No. & Street, City, State, Zip Code) 1600 Market Street, Philadelphia, PA 19103		
Services Provided by This Firm (<i>describe fully</i>)				
1	Year end financial audit		\$	
2			\$	
3			\$	
4			\$	
			Charge for Services Provided	\$
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. <input type="radio"/> Yes <input checked="" type="radio"/> No				
Legal Services Information				
Name of Legal Firm or Independent Attorney 1 Connecticut State Marshal Joe Marinar 2 Morrow Morgan Smith Inc 3 4 5			Telephone Number 203-213-5535 860-678-1530	
Address (<i>No. & Street, City, State, Zip Code</i>) 1 149 Cariati Blvd Meriden, CT. 06451 2 11 Talcott Notch Road 2nd FL Farmington, CT 06032 3 4 5				
Services Provided by This Firm (<i>describe fully</i>)				
1	Probate Court for the conservatorship		\$	
2	Real Estate Tax Abatement-reduced the assessment values of Real Estate Tax		\$	2,250
3			\$	
4			\$	
5			\$	
			Charge for Services Provided	\$ 2,250
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. <input checked="" type="radio"/> Yes <input type="radio"/> No Legal Fees pg. 15 1-e				

Schedule of Resident Statistics

Name of Facility 845 Padlock Avenue Operations LLC, d/b/a Meriden Center	License No. 2373		Report for Year Ended 9/30/2015				Page 8	of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Period 10/1 Thru 6/30		Period 7/1 Thru 9/30			
				Total	CCNH	RHNS			(Specify)
1. Certified Bed Capacity									
A. On last day of PREVIOUS report period	130	130							
B. On last day of THIS report period	130	130							
2. Number of Residents									
A. As of midnight of PREVIOUS report period	115	115							
B. As of midnight of THIS report period	119	119							
3. Total Number of Days Care Provided During Period									
A. Medicare	3,867	3,867							
B. Medicaid (Conn.)	32,944	32,944							
C. Medicaid (other states)									
D. Private Pay	2,837	2,837							
E. State SSI for RCH									
F. Other (Specify)	2,458	2,458							
G. Total Care Days During Period (3A thru F)	42,106	42,106							
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds									
A. Medicaid Bed Reserve Days									
B. Other Bed Reserve Days	4	4							
5. Total Resident Days (3G + 4A + 4B)	42,110	42,110							
			31,802	31,802					
			4	4					
			31,798	31,798					
			1,877	1,877					
			2,302	2,302					
			24,861	24,861					
			2,758	2,758					
			114	114					
			115	115					
			130	130					
			130	130					
			130	130					
			130	130					
			114	114					
			119	119					
			1,109	1,109					
			8,083	8,083					
			535	535					
			581	581					
			10,308	10,308					
			10,308	10,308					

Schedule of Resident Statistics (Cont'd)

Name of Facility 845 Paddock Avenue Operations LLC, d/b/a			License No. 2373			Report for Year Ended 9/30/2015			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days								CCNH	RHNS	(Specify)			
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-IID				
No. of Residents	13		91		15								
Per Diem Rate													
a. One bed rm.					392.00								
b. Two bed rms.	519.58		203.68		385.29								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								3,222	3,222				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								1,584	1,584				
C. Other								12,348	12,348				
D. Total Physical Therapy Treatments								17,154	17,154				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								497	497				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								213	213				
C. Other								1,551	1,551				
D. Total Speech Therapy Treatments								2,261	2,261				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								2,549	2,549				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								906	906				
C. Other								11,549	11,549				
D. Total Occupational Therapy Treatments								15,004	15,004				

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
845 Paddock Avenue Operations LLC, d/b/a Meriden Center	2373	9/30/2015	10	37		
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes <input type="radio"/> No				
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	103,287	1,806				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	11,463	264				
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	133,794	6,165				
5. Dietary Service						
a. Head Dietitian	37,884	1,059				
b. Food Service Supervisor	58,466	2,189				
c. Dietary Workers	431,012	25,074				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	54,335	2,169				
b. Other Maintenance Workers	15,989	1,095				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	85,768	1,537				
b. RN						
1. Direct Care	885,893	22,729				
2. Administrative**	153,504	4,164				
c. LPN						
1. Direct Care	1,041,277	35,441				
2. Administrative**						
d. Aides and Attendants	1,721,661	100,795				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	95,710	5,501				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	170,345	6,556				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	81,410	4,206				
A-13, Total Salary Expenditures	5,081,799	220,750				

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.
 ** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.
 *** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

Schedule of Other Salaries and Wages (Page 10)

Position		CCNH		RHNS		(Specify)	
		\$	Hours	\$	Hours	\$	Hours
Ward Clerks	0	\$ 38,008.74	1,964			\$ -	
Central Supply	0	\$ 15,800.53	1,006			\$ -	
Medical Records	0	\$ 27,600.75	1,235			\$ -	
Total		\$ 81,410.01	4,206	\$ -		\$ -	

Schedule of Other Fees (Page 13)

Service		CCNH		RHNS		(Specify)	
		\$	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	\$ (57.95)	n/a				
3155620020	Purchased Services	\$ 9,127.97	n/a				
1020620010	Consulting Fees	\$ 347.50	n/a				
	0	\$ -	0				
	0	\$ -	0				
	0	\$ -	0				
Total		\$ 22,175		\$ -		\$ -	

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*

Name of Facility (as licensed)		License No.		Report for Year Ended		Page	of		
845 Paddock Avenue Operations LLC, d/b/a Meriden Center		2373		9/30/2015		12	37		
Name	Salary Paid		Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS (Specify)							
Section III - Administrators***									
Giovanna Griffin	8/3/15-9/30/15	17,325		Management of Center	326	2			
Courtney Young	12/21/11-6/14/15	85,962		Management of Center	1,480	2			
Section IV - Assistant Administrators									
Townsend, Patrick Aaron	6/15/15-8/2/15	11,463		Management of Center	264	2			

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
845 Paddock Avenue Operations LLC, d/b/a Meride	2373	9/30/2015	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian	693	19				
2. Dentist	14,118	97				
3. Pharmacist	11,310	231				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	605,803	8,299				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	43,080	228				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	61,098	783				
b. Other						
10. Occupational Therapist						
a. Resident Care	121,707	1,667				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care	29,330	693				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	22,175					
B-13 Total Fees Paid in Lieu of Salaries	909,314	12,016				

* 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.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
845 Paddock Avenue Operations LLC, d/b/a Meri	2373	9/30/2015		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 216,643	216,643			
2. 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) (not-owners and not-operators)	\$ 141,058	141,058			
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$ 27,626	27,626			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 130,024	130,024			
d. Accounting and Auditing	\$				
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 2,250	2,250			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 23,821	23,821			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 20,532	20,532			
2. Cellular Phones	\$				
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$ 786	786			
3. Resident Day User Fee	\$ 759,411	759,411			
Subtotal	\$ 2,343,927	2,343,927			

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended		Page	of
845 Paddock Avenue Operations LLC, d/b/a Meriden	2373	9/30/2015		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:		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 and Conventions	\$ 215	215			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$				
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 6,857	6,857			
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 3,081	3,081			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 10,500	10,500			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 562	562			
10. Contributions*** See Attached Schedule	\$ 1,941	1,941			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 3,566	3,566			
12. Administrative Management Services**	\$ 464,982	464,982			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 29,561	29,561			
C-14 Total Administrative & General Expenditures	\$ 2,866,998	2,866,998			

* 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
			0
			0
			0
			0
			0
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

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

Schedule of Dues

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

Total Dues		\$ 10,500	\$ -	\$ -
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Schedule of Contributions

Description		CCNH	RHNS	(Specify)
1020630135	Political Contributions	\$ 1,941	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
Total Contributions		\$ 1,941	\$ -	\$ -

Schedule of Other Administrative and General

Description		CCNH	RHNS	(Specify)
1020630060	Bank Service Charges	\$ 4,302	\$ -	\$ -
1020630120	Collection Fees	\$ 9,413	disallowed	\$ -
1020630120	Collection Fees	\$ 23	disallowed	\$ -
1020630120	Collection Fees	\$ 66	disallowed	\$ -
1020630140	Education Expense	\$ 42	\$ -	\$ -
1020630140	Education Expense	\$ 39	\$ -	\$ -
1020630180	Employee Physicals	\$ 7,279	\$ -	\$ -
1020630200	Employee Relations	\$ 2,867	\$ -	\$ -
1020630200	Employee Relations	\$ 212	\$ -	\$ -
1020630380	Printing	\$ 36	\$ -	\$ -
1020630380	Printing	\$ 21	\$ -	\$ -
1020630380	Printing	\$ 161	\$ -	\$ -
1020630610	Training Expense	\$ 38	\$ -	\$ -
1020630610	Training Expense	\$ 84	\$ -	\$ -
1020630610	Training Expense	\$ 632	\$ -	\$ -
1020640080	Fines & Penalties	\$ 2,385	disallowed	\$ -
1020640090	Miscellaneous	\$ (103)	\$ -	\$ -
1020640090	Miscellaneous	\$ (4)	\$ -	\$ -
1020660080	Rental Expense	\$ 5,412	\$ -	\$ -
1020660990	Accrued Expense Estm	\$ (355)	disallowed	\$ -
5095720020	Cap Stk/Franchise Tax	\$ 175	\$ -	\$ -
3080630440	Foreign Recruitment C	\$ (3,982)	\$ -	\$ -
1020630120	Collection Fees	\$ 796	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
Total Other Administrative and General		\$ 29,561	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility 845 Paddock Avenue Operations LLC, d/b	License No. 2373	Report for Year Ended 9/30/2015	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	472,945	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	44,784	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)

Name of Facility		License No.	Report for Year Ended		Page	of
845 Paddock Avenue Operations LLC, d/b/a Meriden C		2373	9/30/2015		18	37
Item		Total	CCNH	RHNS	(Specify)	
2. Dietary						
a. In-House Preparation & Service						
1.	Raw Food	\$ 200,818	200,818			
2.	Non-Food Supplies	\$ 23,021	23,021			
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) _____						
		\$				
2E. Total Dietary Expenditures (2a + b + c + d)		\$ 222,429	222,429			
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)	
G. Resident Meals: Total no. of meals served per day:*						
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No						
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.						
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.						
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.						
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.						
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.						
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)						

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

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

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

Name of Facility		License No.	Report for Year Ended	Page	of
845 Paddock Avenue Operations LLC, d/b/a Meriden Ce		2373	9/30/2015	19	37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*		Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$	5,509	5,509	
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***		Lbs.			
		Amt. \$			
3. Personal clothing of residents washed, ironed, and/or processed.***		Lbs.			
		Amt. \$			
4. Repair and/or purchase of linens.***		Lbs.			
		Amt. \$	4,521	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**		\$			
d. Other (Specify)		\$			
3E. Total Laundry Expenditures (3a + b + c + d)		\$	216,105	216,105	
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
H. Did you receive revenue from employees?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
I. Where is the revenue received reported in the Cost Report?		(Page/Line Item)			
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K. Did you receive revenue from these people?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L. Where is the revenue received reported in the Cost Report?		(Page/Line Item)			

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
 All allocations should add to total recorded in 3E.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
 *** Pounds of Laundry only required for multi-level facilities.

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

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

* 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 - Rebate	\$ (2,635)	-	-
3080630030	Advertising-Help Wa	\$ 1,385	-	-
3080630030	Advertising-Help Wa	\$ 907	-	-
3080630080	Books, Dues & Subsc	\$ (152)	-	-
3080630140	Education Expense	\$ 488	-	-
3080630140	Education Expense	\$ 156	-	-
3080630140	Education Expense	\$ 604	-	-
3080630550	T&E-Lodging/Transp	\$ 38	-	-
3090630535	Office Supplies	\$ 360	-	-
3120630530	Supplies	\$ 1,914	-	-
3120660080	Rental Expense	\$ 1,865	-	-
3120660080	Rental Expense	\$ 1,438	-	-
3155630530	Supplies	\$ 4,633	-	-
3155630530	Supplies	\$ 11,793	-	-
3155660080	Rental Expense	\$ (54)	-	-
3155660080	Rental Expense	\$ 11,633	-	-
3170630530	Supplies	\$ 334	-	-
3010610300	Consolidated Billing	\$ 7,646	-	-
	0	0 \$ -	-	-
	0	0 \$ -	-	-
	0	0 \$ -	-	-
	0	0 \$ -	-	-
Total Other Resident Care		\$ 80,422	\$ -	\$ -

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

Name of Facility 845 Paddock Avenue Operations LLC, d/b/a Meriden Center		License No. 2373		Report for Year Ended 9/30/2015		Page of 21 37				
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	(Specify)	Pg	Line
		Yes	No							
Healthcare Services Group	Drive, Bensalem, PA 19020	○	⊙	Vendor Contracted	Laundry Purchased Services	206,075			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	○	⊙	Vendor Contracted	Housekeeping Purchased Services	308,301			20	4b
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
845 Paddock Avenue Operations LLC, d/b/a N	2373	9/30/2015			22	37
Item	Total	CCNH	RHNS	(Specify)		
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 (<i>Provide detail on page 6</i>)	\$					
f. Other (<i>itemize</i>)	\$					
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 401,939	401,939				
7. Depreciation (<i>complete schedule page 23*</i>)						
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 (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*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	\$					
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.

Total additions for Building Improvements		\$ 16,240		\$ 260 *
Deletions:				
Total deletions for Building Improvements		\$ -		\$ - **

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
9/30/2015	First install on stage compressor and f	3,647.50	10.00	-
9/30/2015	Final install on stage compressor and f	3,647.50	10.00	-
Total additions for Non-Movable Equipment		\$ 7,295		\$ - *
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
3/31/2015	8 Deluxe 32-Gallon Double Hamper	\$ 2,837	\$ 7	\$ 203
4/30/2015	6 RCA 32" Long Term Care TVs wired	\$ 3,642	\$ 7	\$ 217
4/30/2015	6 Zoneline PTAC Resistance Heat	\$ 3,956	\$ 7	\$ 235
4/30/2015	Trapeze, Bariatric, 600lb Capacity	\$ 907	\$ 7	\$ 54
5/31/2015	Attendant Vital Signs Monitor and car	\$ 2,156	\$ 7	\$ 103

Amortization Schedule*

Name of Facility 845 Paddock Avenue Operations LLC, d/b/a Meriden Center		Date of Acquisition		License No. 2373	Report for Year Ended 9/30/2015	Basis for Computing Amortization**	Rate %	Amortization for This Year	Page 24	of 37
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.

** 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 845 Paddock Avenue Operations LLC,	License No. 2373	Report for Year Ended 9/30/2015	Page 25	of 37																																																																											
11. Property Questionnaire																																																																															
Part A																																																																															
Is the property either owned by the Facility or leased from a Related Party?*																																																																															
<input type="radio"/> Yes			<input checked="" type="radio"/> No																																																																												
			If "Yes," complete Part B. If "No," complete Part C.																																																																												
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.																																																																															
Description	Total																																																																														
1. Date Land Purchased																																																																															
2. Date Structure Completed																																																																															
3. If NOT Original Owner, Date of Purchase																																																																															
4. Date of Initial Licensure																																																																															
5. Total Licensed Bed Capacity	130																																																																														
6. Square Footage																																																																															
7. Acquisition Cost																																																																															
a. Land		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Part B - Owner and Related Parties</td> <td style="text-align: center;">1st Mortgage</td> <td style="text-align: center;">2nd Mortgage</td> <td style="text-align: center;">3rd Mortgage</td> <td style="text-align: center;">4th Mortgage</td> </tr> <tr> <td>1. Financing</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> a. Type of Financing (e.g., fixed, variable)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> b. Date Mortgage Obtained</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> c. Interest Rate for the Cost Year</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> d. Term of Mortgage (number of years)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> e. Amount of Principal Borrowed</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> f. Principal balance outstanding as of</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Complete if Mortgage was Refinanced During Current Cost Year</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> g. Type of Financing (e.g., fixed, variable)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> h. Date of Refinancing</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> i. New Interest Rate</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> j. Term of Mortgage (number of years)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> k. Amount of Principal Borrowed</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> l. Principal Outstanding on Note Paid-Off</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>			Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage	1. Financing					a. Type of Financing (e.g., fixed, variable)					b. Date Mortgage Obtained					c. Interest Rate for the Cost Year					d. Term of Mortgage (number of years)					e. Amount of Principal Borrowed					f. Principal balance outstanding as of					Complete if Mortgage was Refinanced During Current Cost Year					g. Type of Financing (e.g., fixed, variable)					h. Date of Refinancing					i. New Interest Rate					j. Term of Mortgage (number of years)					k. Amount of Principal Borrowed					l. Principal Outstanding on Note Paid-Off				
Part B - Owner and Related Parties	1st Mortgage				2nd Mortgage	3rd Mortgage	4th Mortgage																																																																								
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Part C - Arms-Length Leases for Real Property Improvements Only																																																																															
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease																																																																											
Healthcare REIT, Inc	Building and Equipment	04/01/11	20	269,283																																																																											
Address: One Seagate Suite 1500																																																																															
Toledo, OH 43603-1475																																																																															

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
845 Paddock Avenue Operations LLC		2373	9/30/2015		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$ 44,784	44,784		
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$ 44,784	44,784		

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
845 Paddock Avenue Operations LI		2373		9/30/2015		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				44,784	44,784		
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$			
12. D. Other Interest Expense (Specify)				\$			
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$ 44,784	44,784		
14. Insurance							
a. Insurance on Property (buildings only)				\$ 7,578	7,578		
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$ 153,780	153,780		
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. Total Insurance Expenditures (14a + b + c)				\$ 161,358	161,358		
15. Total All Expenditures (A-13 thru C-14)				\$ 11,545,187	11,545,187		

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
845 Paddock Avenue Operations LLC, d/b/a Meriden Center				2373	9/30/2015	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 9,680	9,680		
Page 13 - Professional Fees							
5.	13	8-c	Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 809,877	809,877		
Pages 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 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 1,480,473	1,480,473		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	2	Administrator's salary disallowed	0 \$ 9,680	\$ -	\$ -
0	0		0 \$ -	\$ -	\$ -
0	0		0 \$ -	\$ -	\$ -
0	0		0 \$ -	\$ -	\$ -
0	0		0 \$ -	\$ -	\$ -
0	0		0 \$ -	\$ -	\$ -
Total Other Salaries Adjustment			\$ 9,680	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	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	0
13	10	Occupational Therapist	3105620020 \$ 121,707	0	0
13	12	Other	3010620020 \$ 180	0	0
13	12	Other	3015620020 \$ 12,019	0	0
13	12	Respiratory Purchased Services	3155620020 \$ 9,070	0	0
				0	0
				0	0
				0	0
				0	0
				0	0
Total Other Fees Adjustments			\$ 809,877	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m-8a	1020630310 Chamber of Commerce	\$ -	0	0
16	m-13	1020630120 Collection Fees	\$ 10,299	0	0
16	m-13	1020660990 Estimated Accrual	\$ (355)	0	0
16	m-13	7010800030 Non-recurring Charge	\$ -	0	0
16	m-13	1020640080 Penalty and Fines	\$ 2,385	0	0
16	m-12	7010670040	0 \$ -	0	0
0	0		0 \$ -	0	0
0	0		0 \$ -	0	0
0	0		0 \$ -	0	0
Total Other A&G Adjustments			\$ 12,328	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
845 Paddock Avenue Operations LLC, d/b/a Meriden Center			2373	9/30/2015	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,480,473	1,480,473		
Page 20 - Resident Care Supplies***							
27.	20	5-a-2	Prescription Drugs	\$ 225,164	225,164		
28.	20	5-d	Ambulance/Limousine	\$ 22,946	22,946		
29.	20	5-f	X-rays, etc	\$ 14,039	14,039		
30.	20	5-h	Laboratory	\$ 28,357	28,357		
31.			Medical Supplies	\$			
32.	20	5-e-2	Oxygen (non emergency)	\$ 19,766	19,766		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 47,233	47,233		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$ 71,672	71,672		
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51. Total Amount 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.

F. Statement of Revenue

Name of Facility		License No.		Report for Year Ended		Page of	
845 Paddock Avenue Operations LLC, d/ 2373				9/30/2015		30 37	
Item				Total	CCNH	RHNS	(Specify)
I. 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 **	\$				
3.	a.	Medicare Residents (all inclusive)	\$	1,617,961	1,617,961		
	b.	Medicare Room and Board Contractual Allowance **	\$	(421,029)	(421,029)		
4.	a.	Private-Pay Residents and Other	\$	2,118,394	2,118,394		
	b.	Private-Pay Room and Board Contractual Allowance **	\$	(522,376)	(522,376)		
II. Other Resident Revenue							
1.	a.	Prescription Drugs - Medicare	\$	158,243	158,243		
	b.	Prescription Drugs - Medicare Contractual Allowance **	\$	(41,178)	(41,178)		
	c.	Prescription Drugs - Non-Medicare	\$	103,581	103,581		
	d.	Prescription Drugs - Non-Medicare Contractual Allowance **	\$	(28,227)	(28,227)		
2.	a.	Medical Supplies - Medicare	\$	21	21		
	b.	Medical Supplies - Medicare Contractual Allowance **	\$	(5)	(5)		
	c.	Medical Supplies - Non-Medicare	\$	145	145		
	d.	Medical Supplies - Non-Medicare Contractual Allowance **	\$	(53)	(53)		
3.	a.	Physical Therapy - Medicare	\$	536,758	536,758		
	b.	Physical Therapy - Medicare Contractual Allowance **	\$	(139,676)	(139,676)		
	c.	Physical Therapy - Non-Medicare	\$	353,585	353,585		
	d.	Physical Therapy - Non-Medicare Contractual Allowance **	\$	(104,661)	(104,661)		
4.	a.	Speech Therapy - Medicare	\$	154,294	154,294		
	b.	Speech Therapy - Medicare Contractual Allowance **	\$	(40,151)	(40,151)		
	c.	Speech Therapy - Non-Medicare	\$	81,652	81,652		
	d.	Speech Therapy - Non-Medicare Contractual Allowance **	\$	(25,617)	(25,617)		
5.	a.	Occupational Therapy - Medicare	\$	520,696	520,696		
	b.	Occupational Therapy - Medicare Contractual Allowance **	\$	(135,497)	(135,497)		
	c.	Occupational Therapy - Non-Medicare	\$	324,354	324,354		
	d.	Occupational Therapy - Non-Medicare Contractual Allowance **	\$	(90,899)	(90,899)		
6.	a.	Other (Specify) - Medicare	\$	23,561	23,561		
	b.	Other (Specify) - Non-Medicare	\$	81,992	81,992		
III. Total Resident Revenue (Section I. thru Section II.)				\$	11,113,482	11,113,482	
IV. Other Revenue *							
1.	Meals sold to guests, employees & others			\$			
2.	Rental of rooms to non-residents			\$			
3.	Telephone			\$			
4.	Rental of Television and Cable Services			\$	8,941	8,941	
5.	Interest Income (Specify)			\$	349	349	
6.	Private Duty Nurses' Fees			\$			
7.	Barber, Coffee, Beauty and Gift shops			\$	11,932	11,932	
8.	Other (Specify)			\$	538	538	
V. Total Other Revenue (1 thru 8)				\$	21,760	21,760	
VI. Total All Revenue (III+V)				\$	11,135,242	11,135,242	

* 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.

II-6-b	Contractuals- Medicaid	Ambulance	\$ -	\$ -	\$ -
II-6-b	Contractuals- Medicaid	Flu Shot	\$ -	\$ -	\$ -
II-6-b	Private Insurance and Other	X-Ray	\$ 5,007	\$ -	\$ -
II-6-b	Private Insurance and Other	Laboratory	\$ 5,754	\$ -	\$ -
II-6-b	Private Insurance and Other	Respiratory Therapy & Supplie	\$ 2,762	\$ -	\$ -
II-6-b	Private Insurance and Other	Nursing Treatment Supplies	\$ -	\$ -	\$ -
II-6-b	Private Insurance and Other	Audiology	\$ -	\$ -	\$ -
II-6-b	Private Insurance and Other	Incontinency	\$ -	\$ -	\$ -
II-6-b	Private Insurance and Other	Oxygen & Supplies	\$ 2,456	\$ -	\$ -
II-6-b	Private Insurance and Other	Physician Visit	\$ -	\$ -	\$ -
II-6-b	Private Insurance and Other	Ambulance	\$ -	\$ -	\$ -
II-6-b	Private Insurance and Other	Flu Shot	\$ -	\$ -	\$ -
II-6-b	Private Insurance and Other	Capitation Contracts	\$ 79,121	\$ -	\$ -
II-6-b	Contractuals- NonMedicaid	X-Ray	\$ (1,235)	\$ -	\$ -
II-6-b	Contractuals- NonMedicaid	Laboratory	\$ (1,419)	\$ -	\$ -
II-6-b	Contractuals- NonMedicaid	Respiratory Therapy & Supplie	\$ (681)	\$ -	\$ -
II-6-b	Contractuals- NonMedicaid	Nursing Treatment Supplies	\$ -	\$ -	\$ -
II-6-b	Contractuals- NonMedicaid	Audiology	\$ -	\$ -	\$ -
II-6-b	Contractuals- NonMedicaid	Incontinency	\$ -	\$ -	\$ -
II-6-b	Contractuals- NonMedicaid	Oxygen & Supplies	\$ (606)	\$ -	\$ -
II-6-b	Contractuals- NonMedicaid	Physician Visit	\$ -	\$ -	\$ -
II-6-b	Contractuals- NonMedicaid	Ambulance	\$ -	\$ -	\$ -
II-6-b	Contractuals- NonMedicaid	Flu Shot	\$ -	\$ -	\$ -
II-6-b	Contractuals- NonMedicaid	Capitation Contracts	\$ (19,510)	\$ -	\$ -
II-6-b		0	\$ 0	\$ -	\$ -
Total Other Resident Revenue			\$ 81,992	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Page Ref	Account	0	CCNH	RHNS	(Specify)
IV-5	Interest On Overdue Account	0	349	-	-
0	0	0	-	-	-
0	0	0	-	-	-
Total Interest Income			\$ 349	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)	
Page Ref	Description	0	CCNH	RHNS	(Specify)
IV-8	Medical Record	0	538	-	-
0	0	0	-	-	-
0	0	0	-	-	-
Total Other Revenue			\$ 538	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
845 Paddock Avenue Operations LLC,	2373	9/30/2015	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (on hand and in banks)			\$	12,238
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,089,004
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	2,000
4 Inventories			\$	37,582
5. Prepaid Expenses			\$	3,147
a. Prepaid Expenses				
b. Prepaid Prop Taxes				
c. Prepaid Escrow Real Estate				
d. Prepaid Personal Property Tax		3,147		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (itemize)			\$	
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,143,972
B. Fixed Assets				
1. Land			\$	830,000
2. Land Improvements	*Historical Cost		\$	
	Accum. Depreciation			Net
3. Buildings	*Historical Cost	3,037,554	\$	2,061,559
	Accum. Depreciation	975,995		Net
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation			Net
5. Non-Movable Equipment	*Historical Cost	71,283	\$	36,383
	Accum. Depreciation	34,900		Net
6. Movable Equipment	*Historical Cost	625,044	\$	285,295
	Accum. Depreciation	339,749		Net
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation			Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (itemize)			\$	
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	3,213,237

* 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
845 Paddock Avenue Operations LLC, c		2373	9/30/2015	32	37
Account				Amount	
Total Brought Forward:				\$	4,357,209
C. Leasehold or like property recorded for Equity Purposes.					
1. Land				\$	
2. Land Improvements		*Historical Cost _____	Net	\$	
		Accum. Depreciation _____			
3. Buildings		*Historical Cost _____	Net	\$	
		Accum. Depreciation _____			
4. Non-Movable Equipment		*Historical Cost _____	Net	\$	
		Accum. Depreciation _____			
5. Movable Equipment		*Historical Cost _____	Net	\$	
		Accum. Depreciation _____			
6. Motor Vehicles		*Historical Cost _____	Net	\$	
		Accum. Depreciation _____			
7. Minor Equipment-Not Depreciable				\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)				\$	
D. Investment and Other Assets					
1. Deferred Deposits				\$	
2. Escrow Deposits				\$	
3. Organization Expense		*Historical Cost _____	Net	\$	
		Accum. Depreciation _____			
4. Goodwill (Purchased Only)				\$	
5. Investments Related to Resident Care (<i>itemize</i>)				\$	

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

7. Other Assets (<i>itemize</i>)				\$	779,932
Intercompany		779,932			
D-8. Total Investments and Other Assets (Lines D1 thru 7)				\$	779,932
D-9. 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)

Name of Facility		License No.	Report for Year Ended	Page	of
845 Paddock Avenue Operations LLC, d/b/a M		2373	9/30/2015	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	368,201
2. Notes Payable (<i>itemize</i>)				\$	
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	222,091
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	370,935
Accr Exp Water and Sewer		14,945	Deferred Revenue	31,895	
Accr Exp Gas		2,505	Accrued Provider/Bed Te	180,835	
Accr Exp Electricity		5,546	Accr Exp Suspense	(4,842)	
Accr Exp Other		2,252	A/R Credit Gross Up Lia	137,799	
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	961,227

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility 845 Paddock Avenue Operations LLC, d/b/a		License No. 2373	Report for Year Ended 9/30/2015	Page 34	of 37
Account				Amount	
Total Brought Forward:				961,227	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>temize</i>)					
Name of Lender		Purpose	Amount	Date Due	\$
2. Mortgages Payable					
\$					
3. Loans from Owners or Related Parties (<i>temize</i>)					
\$					
Name and Address of Lender		Amount	Loan Date		
4. Other Long-Term Liabilities (<i>temize</i>)					
LT Debt-Financing Obligation		2,986,949	\$ 2,986,949		
B-5. Total Long-Term Liabilities (Lines B1 thru 4)					\$ 2,986,949
C. Total All Liabilities (Lines A-13 + B-5)					\$ 3,948,176

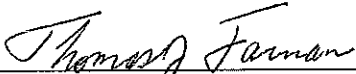
G. Balance Sheet (cont'd)
Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
845 Paddock Avenue Operations LLC,	2373	9/30/2015	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (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			\$	(409,943)
				10/1/2014 thru 9/30/2015
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

Name of Facility	License No.	Report for Year Ended	Page	of
845 Paddock Avenue Operations LLC, d/	2373	9/30/2015	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2014			\$	1,598,907
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	11,135,242
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	11,545,186
D. Net Income or Deficit			\$	(409,944)
E. Balance			\$	1,188,963
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <i>Balance at End of Period</i>			\$	1,188,963
				09/30/15

I. Preparer's/Reviewer's Certification

Name of Facility 845 Paddock Avenue Operations LLC,		License No. 2373	Report for Year Ended 9/30/2015	Page 37	of 37
<i>Check appropriate category</i>					
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)			
Preparer/Reviewer Certification					
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>					
Signature of Preparer 		Title Sr. Director of Reimbursement	Date Signed 12/28/2015		
Printed Name of Preparer Thomas Farnan - Sr Director of Reimbursement					
Address Address 200 Brickstone Square, Andover, MA 01810			Phone Number 978-247-5029		