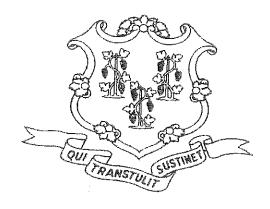
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2015

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ent			-					
		•	ly		(Specify)			
		(RHNS)						
		Report for Year	Ending					
		9/30/2015						
CCN	VН	RHNS		(Specify)		Med	dicare Provider	
2221	l-C				07-5264		07-5264	
	CC	CNH	RF	HNS ICF-IID		F-IID		
	10876							
and Da	te	Sequence N	umber	Signed a	nd Notariz	ed	Date Received	
zed Rece	ived	Assign	ed	Digited to	1101112		Date recovited	
-	CCN 2221	CCNH 2221-C CC 10876	Rest Home with Supervision on (RHNS) Report for Year 9/30/2015 CCNH RHNS 2221-C CCNH 10876	Rest Home with Nursing Supervision only (RHNS) Report for Year Ending 9/30/2015 CCNH RHNS CCNH RHNS CCNH RHNS And Date Sequence Number	Rest Home with Nursing Supervision only (RHNS) Report for Year Ending 9/30/2015 CCNH RHNS (Specify) 2221-C CCNH RHNS CCNH RHNS 10876 Sequence Number Signed a	Rest Home with Nursing Supervision only (RHNS) Report for Year Ending 9/30/2015 CCNH RHNS (Specify) 2221-C CCNH RHNS CCNH RHNS Signed and Notariz	Rest Home with Nursing Supervision only (Specify) (RHNS) Report for Year Ending 9/30/2015 CCNH RHNS (Specify) Med 2221-C CCNH RHNS ICI 10876 Rest Home with Nursing (Specify) Report for Year Ending 9/30/2015	

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Wintonbury Care Center LLC	2221-C	9/30/2015	1	37

Administrator's/Owner's Certification

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

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

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

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

	_				
Signed (Administrator)		Date	Signed (Owner)	- Date	
me -	*	2/10/16	Mis A-Will	ght 2/10/14	
Finted Name (Administrator)		1 7	Printed Name (Owner)		ĺ
Jaime Faucher			Chris Wright	Ì	
Subscribed and Sworn	State of	Date	Signed (Notary Public)	Notary Public Connected	
to before me: Fauche	er CT	2/10/16	Brende Wal	My Commission Expires February 29, 2020	ZANGEN FAREN
Address of Notary Public					
341 Ridwell	Street 1	Annches	ter CT 06040		

(Notary Seal)

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State of Connecticut **Department of Social Services**

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjust	tm	ent		Page 1A	of 37
Name of Facility		Period Cov	ered:	From	То
Wintonbury Care Center LLC				10/1/2014	9/30/2015
Address of Facility 140 Park Avenue, Bloomfield, CT 06002					
Report Prepared By Denise MacKinnon		Phone Nun 860-570-21		Date	
Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$				
2. Laundry wages paid	\$				
3. Housekeeping wages paid	\$				
4. Nursing wages paid	\$				
5. All other wages paid	\$				
6. Total Wages Paid	\$				
7. Total salaries paid	\$				
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire Type of Facility - Organization Structure

		ility Report for Year Er	nded Page	of
	860-243-9591	9/30/2015	2	37
Name of Facility (as shown on license)		o. & Street, City, State, Z		
Wintonbury Care Center LLC		venue, Bloomfield, CT 0)
CCNH	RHNS	(Specify)	07-5264	Provider No.
License Numbers: 2221-C			07-3204	
Type of Facility (Check appropriate box(es))	D 4 YT 141 1	NT L.		
Chronic and Convalescent Nursing Home only (CCNH) □	Rest Home with Supervision only		ecify)	
Type of Ownership (Check appropriate box)				
O Proprietorship • LLC O Partnership	O Profit Corp.	O Non-Profit Corp.	O Government	O Trust
		Date Opened Date	e Closed	
If this facility opened or closed during report year provid	e:			
Has there been any change in ownership				
or operation during this report year?	O Yes		Yes," explain ful	у.
Administrator				
Name of Administrator		Nursing Home		
Jaime Faucher		Administrator's	001701	
	(C 11	License No.:		
Other Operators/Owners who are assistant administrator	s (full or part time	License No.:		
Name		Electise 140.		

General Information and Questionnaire Partners/Members

Name of Facility Wintonbury Care Center LLC		License No. 2221-C	Report for \ 9/30/2015	Year Ended	Page of 3 37
Legal Name of Part Wintonbury Care Center LLC	tnership/LLC	Business 140 Park Aven Bloomfield, C	Address ue,	` '	or Town(s) in Registered
Name of Partners/Members	Business A	Business Address		Title	% Owned
V. Robert Salazar	2500 18th Street, Suit CO 80211	e 200, Denver,	Member		31.3
David Sebbag	245 South Benton Str Lakewood, CO 80226	•	Member		21.4
Ari Krausz	245 South Benton Str Lakewood, CO 80226		Member	,	21.3
Solomon Melamed	245 South Benton Str Lakewood, CO 80226		Member		1
Christopher Wright	341 Bidwell Street, N 06040	Manchester, Ct	Member		5
Premier First Investors	245 S. Benton Street, 80226	Lakewood, CO	Member		10
Global World Investors	245 S. Benton Street, 80226	, Lakewood, CO	Member		10

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General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year	Ended	Page of
Wintonbury Care Center LLC	2221-C	9/30/2015		3A 37
If this facility is owned or operated as a corpo			rmation:	
Legal Name of Corporation	Busin	ess Address	State(s) in Wh	ich Incorporated
		÷		
Name of Directors, Officers	Busin	iess Address	Title	No. Shares Held by Each
·				
				/
Names of Stockholders Owning at Least 10% of Shares				

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General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Wintonbury Care Center LLC	2221-C	9/30/2015	3B	37
If this facility is owned or operated as an individua	al proprietorship,	provide the following informa	tion:	
Ow	mer(s) of Facility			
				·
				····
	į			
1				

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

Related Parties*

Name of Facility		License No.	Report for Year Ended		Page	of
Wintonbury Care Center, LLC	O		9/3/2015		4	3/
		Also Provides	1	Indicate Where		Actual Cost to the
Momo of Delated	Business	Goods/Services to Non- Related Parties	on Description of Goods/Services	in Annual Report	Cost	Related
Individual or Company	Address	Yes No %**	_	Page # / Line #	Reported	Party
H	333 Bidwell St Manchester, CT 06040		Shared Employees		1	1
Chelsea Place Care	25 Lorraine St. Hartford, CT 06105		Shared Employees		•	1
int Care	171 Main St. East Windsor, CT		Lamdry Services	19 3		1
Chestnut Point Care	171 Main St. East Windsor, CT 06088		Shared Employees		-	ş
Farmington Care Center,	20 Scott Swamp Rd. Farmington, CT pen32		Bank Fees	16 M	800	(800)
Farmington Care Center,	20 Scott Swamp Rd. Farmington, CT 06032		Shared Employees		1,496	(1,496)
Kettle Brook Care Center,	96 Prospect Hill Rd. East Windsor, CT 06088		Laundry Services	19 3		,
Kettle Brook Care Center,	96 Prospect Hill Rd. East Windsor, CT 06088		Shared Employees		1	1
Meriden Care Center, LLC	33 Roy St. Meriden, CT 06450		Shared Employees		,	ſ
Trinity Hill Care Center,	151 Hillside Ave. Hartford, CT		Shared Employees		3,983	(£86,E)
Westside Care Center, LLC			Shared Employees		1	,
Wintonbury Care Center,	140 Park Ave. Bloomfield, CT		Shared Employees		1	•
Secure Care Center LLC	60 West Street, Rocky Hill, CT 06067		Shared Employees		1,435	(1,435)
Township of the seconds	171 Main St. East Windsor, CT		TS/T4/TO	13 5,8,10	479,183	(479,183)
Ridwell Realty II.C.	341 Bidwell St. Manchester, CT 06040		Building Lease & Rent	22,22,27 10,9,14	824,794	(824,794)
iCare Management I.I.C.	341 Bidwell St. Manchester, CT 06040		Postage & Legal	16, 15 M.E	43,909	(43,909)
iCare Health Management,	341 Bidwell St. Manchester, CT		Shared EEs not part of memt agent		118,532	
211	0,000		Management Services, Direct	20 5j		
			Management Services, Indirect			(49,481)
			Management Services, Administrative	16 MI2	287,816	(28/,816)
						1
						1
All 9 Care Centers, mgmt co,			Share Common 401k. Pension and Insurance plans, courier, legal and various other services	plans, courier, legal and va	arious other servic	S
realty cos			Share Seamon 19119			

* Use additional sheets if necessary.

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

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General Information and Questionnaire Related Parties*

recruiple, family or business association? O Yes O No If "Yes," provide the Name/Addings of the facility related through If "Yes," provide the information on Page as which provide goods or services, yor the loaning of funds to this facility. It also perators, or officials of this facility. It also Provides Also Provides Also Provides Also Provides Also Provides Also Provides Address Address Address Address Address O O O O O O O O O O O O O O O O O	Name of Facility Wintonbury Care Center LLC	LLC	License N. 227	e No. 2221-C	R 9,	Report for Year Ended 9/30/2015		Page 4	of 37
Description of Goods/Services Provided Page # / Line # Reported	Are any individuals recei marriage, ability to contr	ving compensation from the fa	ncility rel	ated thro			If "Yes," provide the complete the inform	e Name/Add nation on Pag	ress and ge 11 of the report.
The lated Business Also Provides to Company Address Non-Related Parties Description of Goods/Services to Address Yes Non-Related Parties Provided Page # / Line # Reported	Are any individuals or coincluding the rental of prielated through family as association to any of the	ompanies which provide goods operty or the loaning of funds sociation, common ownership owners, operators, or officials	or servic to this fa control, of this fa	cility, or busin	ess	• Yes O No	If "Yes," provide the	e following i	nformation:
O O O O O O O O O O O O O O O O O O O	Name of Related	Business	Also Good Non-R	o Provide s/Service elated Pa	es ss to urties	Description of Goods/Services	Indicate Where Costs are Included in Annual Report Page #/Line #	Cost	Actual Cost to the Related Party
	Individual of Company See Attached	CCOTION.	3 0			11041000			A Administration of the Control of t
			0	0					
			0	0					
			0	0					
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		A STORY OF THE STO	0	0					
		1.000	0	0				i de	

^{*} 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	
Wintonbury Care Center LLC	2221-C		9/30/2015	5	37	
If the facility is licensed as CDH and/or RCH of	r provides A	IDS or TB	I services with special Medica	id rates,	costs	
must be allocated to CCNH and RHNS as follo						
Item			Method of Allocation	<u> </u>		
Dietary		Number of	meals served to residents			
Laundry		Number of	pounds processed			
Housekeeping			square feet serviced			
		Number of	hours of routine care provide	d by EAG	CH	
Nursing	:		classification, i.e., Director (or			
-		Registered	Nurses, Licensed Practical N	urses, Ai	des and	
		Attendants				
Direct Resident Care Consultants		Number of	hours of resident care provid	ed by EA	CH	
		specialist	(See listing page 13)			
Maintenance and operation of plant		Square fee	t			
Property costs (depreciation)		Square fee		··		
Employee health and welfare		Gross sala				
Management services			te cost center involved			
All other General Administrative expenses			irect and Allocated Costs			
The preparer of this report must answer the fol	lowing ques	tions applic	eable to the cost information p	rovided.		
1. In the preparation of this Report, were all	O No	If "No," explain fully why su	ich alloca	ation was		
costs allocated as required?	O Yes	O NO	not made.	***************************************		
2. Explain the allocation of related company e	xpenses and	attach copy	y of appropriate supporting da	ta.		

3. Did the Facility appropriately allocate and	self-disallow	direct and	indirect costs to non-nursing	home cos	st centers?	
(e.g., Assisted Living, Home Health, Outpa	tient Service	s, Adult Da	ay Care Services, etc.)			
			If "No," explain fully why sa	ach alloc	ation was	
	• Yes	O No	not made.			

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General Information and Questionnaire Leases (Excluding Real Property)

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

should not be included in these amounts.

Silvaia ilot de maradada ili mode ameana:				Denort for Vear Ended	Fast Ended		Page of
Name of Facility			License No.	Nepot to	כמו דיוותכם		
Wintonbury Care Center LLC			2221-C	9/30/2015		The state of the s	6 37
and the second s	Related * to	d * to	1,1,1				
	Owners,	ers,				,	
	Operators,	ators,				Annual	
	Officers	cers		Date of	Term of	Amount	Amount
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	of Lease	Claimed
Accelerated Care Plus Corp. 4850	0	0	Omnistin Electrotherapy and Omnisound Therapeutic Ultrasound Equipment	05/18/10	automatic annual	22,343	22,343
Orive MS-100,	0	0	Time Clocks and Payroll Punch Equip	06/01/10	60 Months	8,344	8,344
GE Capital C/O Ricoh USA, P.O.Box 41564, Philadelpha PA 19101	0	0	Copier	03/04/14	48 months	14,063	14,063
Pincy-Bowes P.O. Box 856390, Louisville, K.Y 40285-6390	0	0	Postage Rental	02/01/02	Month to month	1,268	1,268
	0	0				3	
	0	0					
	0	0		i i			-1-T
	0	0					
	0	0					
	0	0					3
T NETT. T - T - T - T - T - T - T - T - T -	V begge	objoled	O Yes		o No	Total ***	46,018

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
Wintonbury Care Center LLC	2221-C	9/30/2015		7		37
	period covered by this rep	ort were maintained on the following bas	is:			
Accrual O Cash O	Modified Cash					
Is the accounting basis for this				*		A1117-
) Yes	If "No," explain.				
F	No	22 1.w,				
previous periou:				-		
Independent Accounting Firm		Address (No. & Street, City, State, 2	Zin Code)			
Name of Accounting Firm		100 Great Meadow Road, Ste 4	All Wathersfield C	r 06100		
1 O'Connor, Davies LLP		100 Great Meadow Road, Ste 4	or, wedlersheld, C.	1 00103		
2						
3						
4 Services Provided by This Firm (a	describe fulls					
					710	
1 Taxes, financial statements, accoun	ting support	La Colonia de la	\$	3,	712	
2			\$			
3			\$			
4	··		\$			
			Charge fo	or Servic	es Pro	vided
			\$	3,	712	
Are These Charges Reflected in the Exp	enditure Portion of This Report	? If Yes, Specify Expense Classification and Line	e No.			
⊙ Yes O No	15D					
Legal Services Information						
Name of Legal Firm or Independe	ent Attorney		Telephon		er	
1 iCare Health Management, L			860-570-			
2 Starble and Harris			860-678-			
3 Durant Nichols / Robinson &	ե Cole, LLP		860-275-	8200		•
		ation, Murtha Cullina,Robinson))				
5 Starble and Harris, iCare Heart						
Address (No. & Street, City, State						
1 341 Bidwell Street, Manches	ster CT					
2 32 Main Street, Avon, CT						
3 280 Trumbull St, Hartford, (CT					
4	041 D11 1101 1 M	1 CT				
5 32 Main Street, Avon, CT &	341 Bidwell Street, Man	chester C1				
Services Provided by This Firm (describe July)	- Andrew Address				
1 Lease and contract issues, general	legal advice, Labor Law		\$,362	***
2 Lease and contract issues, general	legal advice, union funds advic	e	\$,174	
3 Employment law, arbitrations, con	tract negotiations		\$,319	
4 Employment Arbitrations, healthca	are law		<u> </u>		,421	
5 Collections			\$,516	
			Charge f	or Servi	ces Pro	ovided
			\$	69	,791	
Are These Charges Reflected in the Ext	penditure Portion of This Repor	t? If Yes, Specify Expense Classification and Lir	ne No.			
	15E					
⊙ Yes O No						

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CSP-8 Rev. 9/2002

Schedule of Resident Statistics

N			License No		a de la companya de		Report for	Report for Year Ended	P		Page	Jo
Name of Facility Wintonbury Care Center I.I.C.			222	2221-C			9/30/2015				8	37
Hittorious Courses on the Hittorious and Courses on the Hittorious Cou						Period 10/1 Thru 6/30	1 Thru 6/.	30		Period 7/1 Thru 9/30	Thru 9/3	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Total	CCNH	RHNS	(Specify)	Total	CCNH	RHINS	(Specify)
Certified Bed Capacity A. On last day of PREVIOUS report period	150	150			150	150			150	150		
B. On last day of THIS report period	150	150			150	150			150	150		
2. Number of Residents A As of midnight of PREVIOUS report period	148	148			148	148			143	143		768
B. As of midnight of THIS report period	141	141			143	143			141	141		
3. Total Number of Days Care Provided During Period									,			
A. Medicare	4,453	4,453			3,784	3,784			699	699		
B. Medicaid (Conn.)	46,172	46,172			34,049	34,049			12,123	12,123		
C. Medicaid (other states)												
D. Private Pay	485	485			463	463			22	22		
E. State SSI for RCH												
F. Other (Specify) INSURANCE	359	359			277	277			82	82		
G. Total Care Days During Period (3A thru F)	51,469	51,469			38,573	38,573			12,896	12,896		
Total Number of Days Not Included in Figures in 3G 4. for Which Revenue Was Received for Reserved												
Beds A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	51,469	51,469			38,573	38,573			12,896	12,896		

Schedule of Resident Statistics (Cont'd)

Name of Faci	lity			Licer	ise No.			ļ	Report	for Year	Ended		Page	of
Wintonbury (Care Cer	iter LLC		22	221-C					9/30/201	5		9	37
	-		in the certified l		ipacity du	iring 1	the repo	ort yea	ar?	0	Yes	⊙ 1	No	
	· · · ·		Change		Cł	ange	in Bed:	s		Caj	pacity Afte	r Change		
Date of		RHNS	(Specify)		Lost		(Gaine	d					
	"		(1)			Γ			_					
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	Reason for	r Change
	<u> </u>													
			in certified bed 90 days followii			g the	report y	ear (a	s repor	ted in ite	m 4 above)	provide the nur	nber of	
KESID	DAT DE	113 101	20 days follown	ig the	onango.					-				
			Change in R	eside	nt Davs					CC	CNH	RHNS	(Spec	cify)
1st chan	nge		Change in K	o,irgo.	nc Days									
2nd cha														
3rd chai														
4th chai	nge													
6. Number	of Resi	dents an	d Rates on Sept	embe	r 30 of C	ost Y	ear			0.	alf Day		Other Stat	e Assisted
			Medicare	⊢	Med	icaid_		├		1	elf-Pay		Outer Stat	C Assisted
1														
	.		CONTI	١,		_D	HNS		CNH	ום	HNS	(Specify)	R.C.H.	ICF-MR
No. of I	Item		CCNH	/ - '	CCNH 132	+	TINO		CINII	10	11145	(бреспу)	10.0	
Per Die		.S			132	2								
a. One						10 10 10 10 10 10 10 10 10 10 10 10 10 1			Maria Maria Maria					
	bed rms	S.	385,00	1	236.00				278,00					
c. Thre	e or moi	re												
bed	rms.													
										The state of the s	NTD A T	CCNH	RHNS	(Specify)
			al Therapy Trea	itmen	ts					16	2,967	2,967	KIIKO	(Bpecity)
A	. Medic	are - Pa	rt B clusive of Part B	``	····						2,907	2,507		
			ce Treatments	7										
			Treatments								2,099	2,099		
	C. Other	5001000			***						7,633	7,633		
D). Total		l Therapy Trea								12,699	12,699		
			h Therapy Treat	ment	3									
A	. Medic	care - Pa	rt B							_	451	451		
E			clusive of Part E	3)										
			ce Treatments					-		1	110	110		
	2. Re		Treatments	•							382	382		
			Therapy Treatr	nents							943	943		
			oational Therapy											
		care - Pa									1,745	1,745		
	3. Medic	caid (Ex	clusive of Part I	3)										
			ce Treatments							-				
			Treatments								1,353	1,353 7,157		
(C. Other	-	11 1 171	T.,.	fune ave da						7,157 10,255		<u></u>	
1). Total	Оссира	tional Therapy	i rea	menis						10,400	10,200		

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility Report of Ex	License No.		Report for Year		Page	of
Wintonbury Care Center LLC	2221-C		9/30/2015		10	37
Are time records maintained by all individuals receiving con		•	Yes	0	No	
Are time records maintained by an individual re-	7		Total Cost a	nd Hours		
			Total Cost iii	Id Hours		
	ļ					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*			25000		lin	
Operators/Owners (Complete also Sec. I						
of Schedule A1)						
2. Administrator(s) (Complete also Sec. III						
of Schedule A1)	132,221	1,981				
Assistant Administrator (Complete also Sec. 1V						
of Schedule A1)						
4. Other Administrative Salaries (telephone	186,046	8,772				
operator, clerks, receptionists, etc.) 5. Dietary Service	180,040	0,114				
a. Head Dietitian						#071:070 kmp=071 squ-2 v = o
b. Food Service Supervisor	53,400	2,042				
c. Dictary Workers	450,938	23,616				
6. Housekeeping Service						
a. Head Housekeeper			ļ			-
b. Other Housekeeping Workers	338,354	17,721				
7. Repairs & Maintenance Services	74.070	1,934	i			
a. Engineer or Chief of Maintenance	74,979 34,778			 		
b. Other Maintenance Workers 8. Laundry Service	34,776	2,13	4			
a. Supervisor						3 3
b. Other Laundry Workers	62,946	2,849)			
Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents	105 101	2.52	, i			
a. Directors and Assistant Director of Nurses	185,101	3,52	3			
b. RN	634,059	15,18	R			
1. Direct Care 2. Administrative**	235,418					
c. LPN						
1. Direct Care	1,205,354	43,46	2			
2. Administrative**						
d. Aides and Attendants	2,177,984	109,54	4	<u> </u>		
e. Physical Therapists			-			
f. Speech Therapists		 		 	+	
g. Occupational Therapists h. Recreation Workers	139,04	6,76	6			
i. Physicians	155,676	3,10				
1. Medical Director		21. 29/2020/14/2020/2020/16	200	ALL PROPERTY OF THE PARTY OF TH		
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists		<u> </u>				
I. Podiatrists		1 -	4	-		
m. Social Workers/Case Management	170,41	3 5,64	4			+
n. Marketing						
o. Other (Specify) See Attached Schedule	73,09	8 4,00	10			
A-13. Total Salary Expenditures	6,154,13					

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CC	NH	RH	INS	(Spe	cify)
Position	\$	Hours	\$	Hours	\$	Hours
UNIT SECRETARIES SALARIES	\$ 32,371	1,997		1.	\$ -	
MEDICAL RECORDS SALARIES	\$ 40,699	2,002			\$	
CENTRAL SUPPLY SALARIES	\$ 28	-			\$	
					1, 34.55	
		1.14				
	i e e e					
		1 1 1 1 1 1	A 1 P			
	3 1 3 7 7 3 7					
						ANALES DE
				100000000	10 (10) (10)	1 - 4 - 4 - 4 - 4 - 4 - 4
Total	\$ 73,098	4,000			\$	

Schedule of Other Fees (Page 13)

	CC	NH	RH	NS	(Spe	cify)
Service	\$	Hours	\$	Hours	\$	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$ 3,234	18			\$ -	
ADMISSIONS C/S LABOR	\$ 29,819	652			\$ -	
CENTRAL SUPPLY CONTRACT SERVICE	\$ 647	19	A second		\$ -	
ADMINISTRATIVE CONTRACT SERVICE LABOR	\$ 90,314	2,718			\$ -	
RESPIRATORY THERAPY CONTRACT SERVICES	\$ 30,886	683			\$ -	
				3 4 3 1 1	Harata Managara	
			-	-	111	
					1,4	
			4.1			
			-	1,1,1		
Total	\$ 154,900	4,091	\$ -	_	\$ -	-

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*

	•	1	, armayant t						Dogs	. 30
Name of Facility				License No.		Report tor	Report tor Year Ended		1 48C	TO ?
Wintonbury Care Center LLC				2221-C		9/30/2015			I	3/
		Salary Paid	q							
Name	CCNH	RHNS	(Specify)	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
Section I - Operators/Owners										
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).								·		
										j

^{*} 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*

Name of Facility (as licensed)				License No.		Report for Year Ended	ear Ended		Page	Jo
Winter Cons Contact I				2271-C		9/30/2015			12	37
Wintohouly Care Center LLC				7.777			1	- Andrews		
		Salary Paid	q							
				Fringe Benefits and/or Other		Total	Line Where		Total	
Nomo	CONH	RHNS	(Specify)	Payments (describe fully)	Full Description of Services Rendered	Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours Worked	Compensation Received
Section III - Administrators***			(Curada)							
				same as						
Jaime Faucher	132,221			employees less union funds	Administrator	1,981 A2	A2			
				same as						
				employees less					•	
				union funds	Administrator		A2			
				same as						
				employees less						
				union funds	Administrator	Ī	A2			
Section IV - Assistant										
Administrators									L. V. Tille	
										-
						,				

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

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

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

Annual Report of Long-Term Care Facility

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.		Report for Y		Page	of
Wintonbury Care Center LLC	2221	C	9/30/2015		13	37
			Total Cost a	ind Hours		
	,					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
B. Direct care consultants paid on a fee	CCIVII	Hours	IGII(G	1104.5	(615)	
for service basis in lieu of salary						
(For all such services complete Schedule B1)						
1. Dietitian	41,600	832				
2. Dentist						
3. Pharmacist	10,977	242		***************************************		· · ·
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	236,394	3,291			\$10-122,50677,7 (mmm, res _c 551,617.00 (mm-	
b. Other	· · · · · · · · · · · · · · · · · · ·					
6. Social Worker	3,116	training				
7. Recreation Worker		53+Cable				
8. Physicians						
a. Medical Director (entire facility)	39,120	354				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting			24923			
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)						
Physician Care Contract Services	22,224	250				
9. Speech Therapist					0.000	
a. Resident Care	29,300	429				
b. Other						
10. Occupational Therapist	2.5				1.5	
a. Resident Care	192,493	2,647				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	53,836	685				<u> </u>
2. Administrative***	4,482	95				
b. LPN						
1. Direct Care	54,336	1,263				
2. Administrative***						
c. Aides	(2,908)	(204))		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
d. Other	and the second s					
12. Other (Specify)						
See Attached Schedule	154,900				Ļ	
B-13 Total Fees Paid in Lieu of Salaries	856,696	13,974			1	

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

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

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

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

Name of Facility	License No.		Report for	Year Ended	Page		of
Wintonbury Care Center LLC	2221-C		9/30/2015		14		37
O A 11 O Y 11 1 1	Full Europeation of Somis-		to Owners, rs, Officers		nation of	Relations	hin
Name & Address of Individual	Full Explanation of Service	Yes	No No	Lanpia	mation of	(Citations	iiip
Omnicare	Pharmacy Consulting	0	•			···	
Tocuhpoints Therapy	Therapy	0	0	Common Own			
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Shared Employees	0	0	Common Own	nership		
Healthcare Dental	Audiology, Dental and Podiatry	0	0				
Ready Nurse, Nurse Network	Nursing pool (RN, LPN,CNA)	0	0				
Bogacki Robert	Medical Director	0	0				
Paulekas Wayne	Medical Director	0	0				
		0	0				
		0	0				
		0	0				***
		0	0				
		0	0				
		0	0				
		0	0				
		0	0				
		0	0				
		0	0				
		0	0				
And		0	0				
		0	0				
		0	0				
		0	0				

^{*} Use additional sheets if necessary.

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

Annual Report of Long-Term Care Facility CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

- 1	cense No.	- 1	Report for Ye	ear Ended	Page	of
Wintonbury Care Center LLC	2221-C	9	9/30/2015		15	37
Item			Total	CCNH	RHNS	(Specify)
Administrative and General						
a. Employee Health & Welfare Benefits						
1. Workmen's Compensation		\$	394,336	394,336	206 Diggiogly community, 1 pages 5, 545 cm (2004) and 2004	A SANGER CANADA SANGER
2. Disability Insurance		\$				
3. Unemployment Insurance		\$				
4. Social Security (F.I.C.A.)		\$	578,598	578,598		
5. Health Insurance		\$	1,129,182	1,129,182		
6. Life Insurance (employees only)						
(not-owners and not-operators)		\$	ACT OF COLUMN STATE OF THE STAT	- III		
7. Pensions (Non-Discriminatory)		\$	326,049	326,049		
(not-owners and not-operators)						
8. Uniform Allowance		\$				
9. Other (Specify)		\$	30,321	30,321		
See Attached Schedule		150				
b. Personal Retirement Plans, Pensions, and		\$				
Profit Sharing Plans for Owners and		Hall No.				
Operators (Discriminatory)*		000000000000000000000000000000000000000				
		260200000				
c. Bad Debts*		\$	246,988	246,988		
d. Accounting and Auditing		\$	3,712	3,712		
e. Legal (Services should be fully described o	n Page 7)	\$	69,791	69,791		
f. Insurance on Lives of Owners and		\$				
Operators (Specify)*						
g. Office Supplies		\$	20,540	20,540		
h. Telephone and Cellular Phones						
1. Telephone & Pagers		\$	27,340	27,340		
2. Cellular Phones		\$	1,211	1,211		
i. Appraisal (Specify purpose and		\$	THE THE PARTY OF T			
attach copy)*						
·						
j. Corporation Business Taxes (franchise tax)	\$	252	252		
k. Other Taxes (Not related to property - See						
1. Income*		\$				
2. Other (Specify)		\$				
See Attached Schedule				A CONTRACT		
3. Resident Day User Fee		\$	1,081,878	1,081,878		
Subtotal		\$	3,910,201	3,910,201		

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

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

Wintonbury Care Center LLC 9/30/2015

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
UNION TRAINING	\$ 30,321		\$ -
Total	\$ 30,321	\$	\$ -

Schedule of Other Taxes

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

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

Name of Facility	License No.		Report for Y	ear Ended	Page	of
Wintonbury Care Center LLC	2221-C		9/30/2015		16	37
Item			Total	CCNH	RHNS	(Specify)
	als Brought Forwar	<u>:d:</u>	3,910,201	3,910,201		
1. Travel and Entertainment						
 Resident Travel and Entertainment 		\$				<u> </u>
2. Holiday Parties for Staff		\$				
3. Gifts to Staff and Residents		\$				
4. Employee Travel		\$	890	890		
5. Education Expenses Related to Seminars a	and Conventions	\$	4,715	4,715		
6. Automobile Expense (not purchase or dep	reciation)	\$	1,790	1,790		
7. Other (Specify)		\$	448	448		THE COLUMN TWO PROPERTY OF THE
See Attached Schedule						W.
m. Other Administrative and General Expenses						
1. Advertising Help Wanted (all such expens	ses)	\$	6,675	6,675		
2. Advertising Telephone Directory (all such	expenses)***	\$				
3. Advertising Other (Specify)***		\$	29,599	29,599		
See Attached Schedule						
4. Fund-Raising***		\$				
5. Medical Records		\$				
6. Barber and Beauty Supplies (if this service	e is supplied	\$				
directly and not by contract or fee for serv						
7. Postage		\$	4,887	4,887		
* 8. Dues and Membership Fees to Professions	al	\$	10,174	10,174		
Associations (Specify)						
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other Non-	Allowable Org,***	\$				
9. Subscriptions		\$	(19)	(19)		
10. Contributions***		\$	2,525	2,525		
See Attached Schedule						
11. Services Provided by Contract (Specify ar	nd Complete	\$	131,180	131,180		
Schedule C-2, Page 21 for each firm or in						
12. Administrative Management Services**		\$	287,816	287,816		
13. Other (Specify)		\$		26,881		
See Attached Schedule		·				
C-14 Total Administrative & General Expenditure	<u></u>	\$	4,417,763	4,417,763		

^{*} 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	CC	:NH	RHN	IS	(Speci	ify)
Description MEALS	\$	448			\$	-
Total Other Travel and Entertainment	\$	448	\$	ŭ	\$	

Schedule of Other Advertising

Description)i						CCNH	RHNS	(Sp	ecify)
		S SPECIAL I			19.00	\$	29,599	Edistrict to b	\$	1 2 4
5		54.6	10 To 3 1 1 1		1,500,500		14.11	1 1 1 1 1 1 1 1 1		3,15
		1000	1,13,147		graph bug	- 1	sayaki in	19.44 (19.47)		1.50
Total Othe	er Advertis	sing		turky est		\$	29,599	\$ -	\$	-

Schedule of Ducs

Description	CCNH	RHNS	(Specify)
Dues			
CAHCF Dues	\$ 10,173.96		\$ -
OTHER DUES	1 24 2		
3			
Total Dues	\$ 10,174	\$ -	\$ -

Schedule of Contributions

Description	 CCNH	RHNS	(Specify)
CHARITABLE CONTRIBUTIONS	\$ 2,525		\$ -
Total Contributions	 \$ 2,525	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
SOCIAL SERVICE SUPPLIES	\$		\$ -
SOC SVC MINOR EQUIPMENT	\$ -		\$ -
ADMINISTRATIVE MINOR EQUIPMENT	\$ 2,759		\$ -
EMPLOYEE RELATIONS	\$ 5,304		\$ -
EMPLOYEE RELATIONS-OTHER	\$ 31		\$ -
PERMITS & LICENSES	\$ 2,292		\$ -
VOLUNTEER EXPENSE	\$ -		\$ -
BANK FEES	\$ 10,890		\$ -
CMS REVISIT USER FEES	\$ -		\$ -
PENALTIES	\$ 3,180		\$ -
LATE FEES	\$ 2,403		\$ -
Rounding	\$ 21		
Total Other Administrative and General	\$ 26,881	\$ ~	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Wintonbury Care Center LLC	2221-C	9/30/2015	17 37
Name & Address of Individual or Company Supplying Service iCare Management, LLC/iCare Health Management, LLC	Cost of Management Service 287,816	Full Description of Mgmt. Service Provided Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Indicate Where Costs are Included in Annual Report Page #/Line # Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	139,275	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	49,481	MANAGEMENT FEES- INDIRECT CARE	Pg 20 j

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

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

			rage 5)				
Name of Facility		License	No.	Report for Ye	ear Ended	Page	of
Wintonbury Care Center LLC			2221-C	9/30/2015		18	37
Item			Total	CCNH	RHNS	(Sp	ecify)
2. Dietary							
a. In-House Preparation & Service							
1. Raw Food		\$		329,951			
2. Non-Food Supplies		\$		33,571			
3. Other (Specify)		\$	23,791	23,791			
DIETARY SUPPLEMENTS							
b. Purchased Services (by contract other		\$	(5,728)	(5,728)			41 7 247455855708778575
than through Management Services)				100 (60)			
(Complete Schedule C-2 att. Page 21)				100			
c. Management Services**		\$					
d. Other (Specify)		\$	4,741	4,741			
DIETARY MINOR EQUIPMEN	Т						
2E. Total Dietary Expenditures (2a + b + c +	+ d)	\$	386,325	386,325			
2F. Dietary Questionnaire			Total	CCNH	RHNS	(S _j	pecify)
G. Resident Meals: Total no. of meals served	d per day	y:*	423	423			
H. Is cost of employee meals included in 2E		Yes	•	No			
I. Did you receive revenue from employees	? O	Yes	•	No	If yes, specify amt.		·
J. Where is the revenue received reported in	n the Co	st Repo	rt? (Page/Line	Item)			
Is cost of meals provided to persons other K. than employees or residents (i.e., Board Members, Guests) included in 2E?		Yes	•	No	If yes, specify cost.		
L. Is any revenue collected from these peop	le? O	Yes	•	No	If yes, specify amt.		
M. Where is the revenue received reported in	n the Co.	st Repo	rt? (Page/Line	Item)			
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees include in 2E?	0	Yes		No	If yes, specify cost.		
O. Is any revenue collected from employees	? 0	Yes	•	No	If yes, specify amt.		
P. Where is the revenue received reported in	n the Co	st Repo	rt? (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)

	e of Facility		License			,	ear Ended	Page	of
Win	Wintonbury Care Center LLC			221-C	9	/30/2015		19	37
	Item			Total	,	CCNH	RHNS	(S	pecify)
3.	Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items		Lbs.	3,094		3,094			
	washed, ironed, and/or processed.*** 2. Employee items including uniforms, gowns, etc. washed, ironed and/or		Lbs.						
	processed.***		Amt, \$						
	 Personal clothing of residents washed, ironed, and/or processed.*** 		Lbs.				******		
<u></u>			Amt. \$		-				
	4. Repair and/or purchase of linens.***		Lbs. Amt. \$						
	b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$			211,613			
-	c. Management Services** d. Other (Specify) LAUNDRY SUPPLIES		\$		3	5,638			
3E.	Total Laundry Expenditures (3a+b+c+d)		\$	220,346	5	220,346			
3F. G.	Laundry Questionnaire Is cost of employee laundry included in 3E?	0	Yes	•	No	0	If yes, specify cost.		
H,	Did you receive revenue from employees?	0	Yes	•	No		If yes, specify amt.		
I.	Where is the revenue received reported in the C	ost	Report'	?	(Page/Line	Item)		
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?		Yes		N	0	If yes, specify cost.		
K.	Did you receive revenue from these people?	0	Yes	•	N		If yes, specify amt.		
Ĺ.	Where is the revenue received reported in the C	ost	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)

1		License No.	Repo	ort for Year E	nded	Page	of
Winto	nbury Care Center LLC	2221-C		9/30/2015		20	37
							<u>.</u>
			-				
	Item			Total	CCNH	RHNS	(Specify)
4. I	Housekeeping	Sq. Ft. Serviced					
a	. In-House Care	by Personnel					
	1. Supplies - Cleaning (Mops, pails, brooms, etc.)	Amt.	\$	23,712	23,712		
ŀ	p. Purchased Services (by contract other	Sq. Ft, Serviced					
	than through Management Services)	by Personnel	Ì	3.1			
	(Complete Schedule C-2 att.	Amt,	\$	42,401	42,401		
	Page 21)						
(. Management Services*		\$				
	I. Other (Specify)		\$.vaaret-arii-erriikista arii oo aaki 1365/70 jestiidi.	resume compressions, Significations		
<u> </u>	HOUSEKEEPING MINIR EQUIP						
	Total Housekeeping Expenditures (4a +	b+c+d)	\$	66,113	66,113		
	Resident Care (Supplies)**					45.0	0.0000000000000000000000000000000000000
8	a. Prescription Drugs***						
	Own Pharmacy		\$				
	2. Purchased from		\$	194,652	194,652		
	OMNICARE PHARMACY						
1	b. Medicine Cabinet Drugs		\$	24,563	24,563		
1	e. Medical and Therapeutic Supplies		\$		96,505		
	d. Ambulance/Limousine***		\$	13,194	13,194		
,	e. Oxygen						
	1. For Emergency Use		\$	4,517	4,517		
	2. Other***		\$		1 1		
	f. X-rays and Related Radiological		\$	16,415	16,415		
	Procedures***	7 7 7			24 July 200 2 San 192		
	g. Dental (Not dentists who should be inc	cluded under	\$				
	salaries or fees)				20.020		
—	h. Laboratory***		\$		20,939		
	i. Recreation	L. LEWIN	\$		0.61.504		
	j. Other (Specify)****		\$	361,704	361,704		
	See Attached Schedule	<i>(*)</i>	Φ.	700 400	722.400		
5K.	Total Resident Care Expenditures (5a -	5J) n this oxpanditur	\$	L	732,489		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
NURSING ADMIN SUPPLIES	\$ 618		\$ -
NURSING MINOR EQUIP	\$ 7,341		\$
MEDICAL RECORDS SUPPLIES	\$ 811		\$ -
MEDICAL RECORDS MINOR EQUIPMENT	\$ -		\$ -
MANAGEMENT ALLOCATIONS - DIRECT	\$ 139,275		\$ -
NON-COVERED PPS DR. VISITS	\$ 1,380		\$ -
RESIDENT CARE SUPPLIES	\$ 144		\$
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 8,481		\$ -
PERSONAL CARE SUPPLIES	\$ 11,054		\$ ***********
INCONTINENCY SUPPLIES	\$ 34,215		\$
VACCINE RESIDENTS	\$ 2,118		\$ -
PATIENT SPECIAL NEEDS	\$ 353		\$ -
PHYSICAL THERAPY SUPPLIES	\$ -		\$ -
PHYSICAL THERAPY EQUIPMENT RENT	\$ -		\$ -
PHYSICAL THERAPY MINOR EQUIPMENT	\$ -		\$ -
OCCUPATIONAL THERAPY SUPPLIES	\$ -		\$ -
OCCUPATIONAL THERAPY EQUIP RENTAL	\$ -		\$ -
OCCUPATIONAL THERAPY MINOR EQUIP	\$ -		\$ -
SPEECH THERAPY SUPPLIES	\$ -		\$ -
SPEECH THERAPY EQUIPMENT RENT	\$ -		\$ -
SPEECH THERAPY MINOR EQUIPMENT	\$ -		\$ -
RENTALS FOR NURSING EQUIPMENT NON BILLABLE	\$ 67,458		\$
EQUIPMENT RENTAL: AIDS UNIT	\$		\$
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ 4,627		\$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ 55		\$ -
HI LOW BED RENTAL & MATTRESSES	\$ 319		\$ -
IV THERAPY SUPPLIES	\$ 25,919		\$ -
IV THERAPY CONTRACT SERVICE	\$ -		\$ -
MEDICAL WASTE CONTRACT SERVICE	\$ 4,293		\$
ACTIVITIES SUPPLIES	\$ 3,763		\$ -
ACTIVITIES MINOR EQUIPMENT	\$ -		\$ -
MANAGEMENT ALLOCATION - INDIRECT	\$ 49,481	-	\$ -
ADMISSIONS SUPPLIES	\$ -	1	\$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$ -	N. A.	\$ -
Total Other Resident Care	\$ 361,704	\$ -	\$

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

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

Name of Facility Wintonbury Care Center LLC				License No. 2221-C	Report for Year Ended 9/30/2015				Page 21	of 37
		Related ** to Owners,	o Owners,				Total Cost/	Total Cost/Page Ref.***	v	
		Operators.	OTTICALS							
Name of Individual or Company	Address	Yes	Š	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	(Specify)	Pg	Line
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	0	0	VENDOR	Housekeeping Services	42,364	c		700	4p
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	0	0	VENDOR	Laundry Services	211,429			16	3b
Eagle Elevator		0	0	VENDOR	Elevator Contract				22	6F
Bioserve, Inc.		0	0	VENDOR	Medical Waste	4,293			22	6F
The Brickman Group/ Gileaus Lawn Srv		0	0	VENDOR	Snow Removal/Landscaping	22,817			22	6F
Sommers Sanítations		0	0	VENDOR	Trash removal	30,350			22	6F
American Health Tech		0	0	VENDOR	Software Maintenance Contract	17,625		ļ	16	M11
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	0	0	VENDOR	Payroll Services	51,575			16	M11
National Datacare Corp		0	0	VENDOR	Resident Trust Software	3,662			16	MII
Prime Care Technologuy services		0	0	VENDOR	Computer Consulting Services	34,581			91	M11
Priotity Express		0	0	VENDOR	Courier Services	5,613			16	MII
Point Right Inc		0	0	VENDOR	Nursing Software	4,680			16	MII
		0	0	VENDOR						
		0	0	VENDOR						

^{*} 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 Y	ear Ended		Page	of
Wintonbury Care Center LLC	2221-C	9/30/2015			22	37
Item		Total	CCNH	RHNS	(Spe	ecify)
6. Maintenance & Operation of Plant		1000	301(11		(- <u>r</u>	
a. Repairs & Maintenance	\$	20,149	20,149			
b. Heat	\$		50,483			
c. Light & Power	\$		90,247			
d. Water	\$		36,788			
e. Equipment Lease (<i>Provide detail on p</i>			46,018			
f. Other (itemize)	\$		87,670			
See Attached Schedule	4		. ,			
6g. Total Maint. & Operating Expense (6a	- 6f) \$	331,355	331,355			
7. Depreciation (complete schedule page 23						
a. Land Improvements	\$					
b. Building & Building Improvements	9		86			
c. Non-Movable Equipment	•		1,511			
d. Movable Equipment	9		80,371			
*7e. Total Depreciation Costs (7a + b + c + c			81,967			
8. Amortization (Complete att. Schedule Po						
a. Organization Expense	(;				
b. Mortgage Expense	S					
c. Leasehold Improvements			178,590			
d. Other (Specify)		3				
*8e. Total Amortization Costs (8a + b + c + c			178,590			
9. Rental payments on leased real property						
real estate taxes included in item 10b		603,744	603,744			
10. Property Taxes						
a. Real estate taxes paid by owner	•	3				
b. Real estate taxes paid by lessor		152,752	152,752			
c. Personal property taxes		19,388	19,388			
11. Total Property Expenses (7e + 8e + 9 +		1,036,441	1,036,441			

^{*} Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 24.

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
PLANT SUPPLIES	\$ 9,185		\$ -
PLANT CONTRACT SERVICE LABOR	\$ 508		\$ -
ELEVATOR CONTRACT SERVICE	\$ -		\$ -
FIRE/SPRINKLER CONTRACT SERVICE	\$ 4,125		\$ -
LANDSCAPING CONTRACT SERVICE	\$ 9,523		\$ -
SNOW REMOVAL CONTRACT SERVICE	\$ 13,294		\$ -
TRASH REMOVAL CONTRACT SERVICE	\$ 30,350		\$ -
HVAC CONTRACT SERVICE	\$ -		\$ -
SECURITY CONTRACT SERVICE	\$ -		\$ -
PLANT CONTRACT SERVICE OTHER	\$ 10,197		\$ -
PLANT MINOR EQUIPMENT	\$ 10,487		\$ -
RENT AUTO	\$ -		\$ -
RENT EQUIPMENT	\$ -		\$ -
RENT OTHER	\$ -		\$ -
		1.0	
Total Other Repairs and Maintenance	\$ 87,670	\$ -	\$

State of Connecticut

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

		Deprec	Depreciation Schedule	hedule					
Name of Facility		License No.			Report for Year Ended	Inded		Page	Jo
Wintonbury Care Center LLC		2221-C)-C		9/30/2015			23	37
		Historical			Accumulated				
		Cost Exclusive of	Less Salvage	Cost to Be	Depreciation to Beginning of	Method of Computing	Useful	Depreciation	
Property Item		Land	Value	Depreciated	Year's Operations		Life	for This Year	Totals
A. Land Improvements								200	
 Acquired prior to this report period 									
2. Disposals (attach schedule)									a a
3. Acquired during this report period (attach schedule)	chedule)								
A-4. Subtotal									
B. Building and Building Improvements									
1. Acquired prior to this report period		0		0					
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	chedule)	15,421		15,421				98	
B-4. Subtotal									98
									100 000 000 000
1. Acquired prior to this report period		12,259		12,259	9,804			1,511	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	chedule)				447				
C-4. Subtotal									1,511
8 I	Į.	1			Accommunicated				
li li	logbook Date of maintained? Acquisition	Cost	Less		Depreciation to	Method of			
		Exclusive of		Cost to Be	Beginning of		Useful	Depreciation	,
Yes	es No Month Year	r Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
D. Movable Equipment 1. Motor Vehicles (Specify name, model									
and year of each venicle) a. 1995 Dodge Van	10 2002	14,156		14,156	14,156				
b.									
		701 107		781 177	477 973			77.210	
a. Acquired prior to this report period		/01,14/		101,121	2,771				
b. Disposals (auach schedule)									
c. Acquired during this report period (affact schedule)		24.265						3,160	
D-3 Subtotal		-							80,371
D Total Darrociation									81,967

Schedule of Land Improvements Acquired during this report period

Schoolic of Land 1	mprovements Acquired during this report period		Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
1.0				
1,		9 1 121		
· · ·				
: 3.				
			10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
otal additions for	Land Improvements	\$	Charles Section	\$ -:.
Deletions:				
1:				
				North St.
- X - X - X - X - X - X - X - X - X - X		""		viete in N
<u> </u>				14.50
		11 11 11 11		N 10 1
Fotal deletions for	Land Improvements	ls -	<u> </u>	\$ -

^{*}Ties to Page 23, Line A3

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
8/30/2015	Concrete repair work - building and sidewalk	\$ 15,421	180	\$ 86
Total additions for	Building Improvements	\$ 15,421		\$ 86
Deletions:				
			HERMAN AND A	
· Name				
Total deletions for	Building Improvements	\$ -		\$ -

^{*}Ties to Page 23, Line B3

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
		<u> </u>		
				<u>.</u>
Total additions for	Non-Movable Equipment	\$		3 -
Deletions:			<u> </u>	
1, 1184, 119				
			134	
The state of				
Total deletions for l	Non-Movable Equipment	\$ -		S -

^{*}Ties to Page 23, Line C3

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

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

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

Schedule of Movable Equipment Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
10/10/2014	Food Processor : Direct Supply	\$ 3,506	60	\$ 643
10/30/2014	Intermittent Pump: Specialty Medical Equip	\$ 5,849	60	\$ 1,072
11/4/2014	Mattress, Bed Head & Footboards: Medline	\$ 3,900	60	\$ 650
1/16/2015	Reliant Series Sling: Direct Supply	\$ 1,684	60	\$ 224
8/15/2014	Replaced Dishwasher Pump Shell: Proline	\$ 2,748	120	\$ 275
4/6/2015	Digital Lift Scale & Floor Lift: Direct Supply	\$ 3,941	120	\$ 164
6/10/2015	Electric Bed: Medline	\$ 2,639	60	\$ 132
				SAME AND A
		A strain and the strain		NAME OF
Total additions for	Movable Equipment	\$ 24,265	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	\$ 3,160
Deletions:				
Total deletions for	Movable Equipment	\$ -		\$ -

^{*}Ties to Page 23, Line D2c

Schedule of Leasehold Improvements Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
1/23/2015	New Phone equipment:Comtech 21	\$ 3,188	120	\$ 213
7/14/2015	Relpaced Door: Builder Hardware	\$ 2,850	120	\$ 48
Name of the state of				

Total additions for	Leasehold Improvement	\$ 6,039		\$ 260
Deletions:				
		14, 677	1 1 1 1 1	
			1 1 1 1 1	
			1.47	11.
			1.1	
Total deletions for	Leasehold Improvement	\$ -		\$ -

^{*}Ties to Page 24, Line C3

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

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

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

Amortization Schedule*

Name of Facility		License No.		Report for Year Ended	r Ended		Page	Jo
Wintonbury Care Center LLC		2221-C	1-C	9/30/2015			24	37
				Accumulated				
	Date of			Amort. to				
	Acquisition			Beginning of	Basis for			
		Length of	Cost to Be	Year's	Computing	Rate	Amortization	
Item	Month Year	r Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
A. Organization Expense								
1.								
2.						-		
3.								
A-4. Subtotal								
B. Mortgage Expense								
2.								
3.						Company of the Compan	A TOTAL CONTRACTOR OF THE STATE	
B-4. Subtotal								
C. Leasehold Improvements and Other							440 mm 1 4 1 m	
1. Acquired prior to this report period	7		1,832,551	661,029			178,330	
2. Disposals (attach schedule)					CHARLES OF THE TAXABLE STATE OF TAXABLE STATE			
3. Acquired during this report period								
(attach schedule)			6,039	V-03100000000000000000000000000000000000	TOWNS TOWNS OF THE STATE OF THE		260	
C-4. Subtotal								178,590
D. Total Amortization				10.0				178,590
* Ctraight line method must be used								

* 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	License No.	Report for Year En	ded		Page of
Wintonbury Care Center LLC	2221-C	9/30/2015			25 37
11. Property Questionnaire					
Part A				···········	
Is the property either owned by the	ne Facility	Vac	^	Nio	If "Yes," complete Part B.
or leased from a Related Party?*	•	Yes	Ú	No	If "No," complete Part C.
*If any owner or operator of this fa	cility is related by family, r	narriage, ownership, abil	lity to control or		
business association to any person	or organization from whom	buildings are leased, the	en it is considered		
a related party transaction. Description		Total			
1. Date Land Purchased		Total	2.65		1 - 90 - 328
2. Date Structure Completed		 			
3. If NOT Original Owner, Date	e of Purchase	04/01/99			
4. Date of Initial Licensure		04/01/99	1		
5. Total Licensed Bed Capacity	,	150			
6. Square Footage		60,838			
7. Acquisition Cost					
a. Land					
b. Building		 		0.135	4.1 > 5 .
Part B - Owner and Related Pa	erties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing	fixed verichter	EIAED DIND			
a. Type of Financing (e.g., f b. Date Mortgage Obtained	uxeu, variable)	FIXED HUD 05/30/13			
c. Interest Rate for the Cost	Year	3.25%			
d. Term of Mortgage (numb		24			
e. Amount of Principal Born		3,622,200			
f. Principal balance outstan				L	
Complete if Mortgage was					
During Current Cost Y					
g. Type of Financing (e.g.,					
h. Date of Refinancing					
i. New Interest Rate			 		
j. Term of Mortgage (numb					
k. Amount of Principal Bor					
I. Principal Outstanding on		Improvement O 1	L .		<u> </u>
Part C - Arms-Length Leas				Term of Loace	Annual Amount of Lease
Name and Address of Lesso	Oi Pro	operty Leased	Date of Lease	Torm or Deast	Annual Amount of Lease
					AHA!
			 		
		•			

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

Name of Facility	License No.		Report for Ye	ar Ended		Page	of
Wintonbury Care Center LLC	2221-C	<u>.</u>	9/30/2015			26	37
Iter	n		Total	CCNH	RHNS	(Spec	ify)
12. Interest							
A. Building, Land Improv	ement & Non-Movabl	e					
Equipment		dt.					
1. First Mortgage		Rate					
Name of Lender		Kate					
Address of Lender							
2. Second Mortgage	· HILLIAN AND THE ·	\$					
Name of Lender		Rate					
		<u>l</u>			34520		
Address of Lender							
3. Third Mortgage		\$					
Name of Lender		Rate					
Address of Lender					E il		
4. Fourth Mortgage		9	3				
Name of Lender		Rate			40.0		
	***				100000		
Address of Lender							
B. CHEFA Loan Informa	ation						
1. Original Loan Amo	ount	9	\$				
2. Loan Origination D							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Ex	xpense						
12 B7. Total Building Interest Ex	xpense (A1 - A4 + B5) 5	B				

(Carry Subtotals forward to next page)

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

the sub-River constitution in the contract of the contract of

Item	Name of Facility Wintonbury Care Center LLC	License No. 2221-C		Report for Ye 9/30/2015	ear Ended	•	Page of 27 37
Subtotals Brought Forward:	willondary Care Center ELC	2221-0		7/30/2013			
Subtotals Brought Forward:	l Ite	m		Total	CCNH	RHNS	(Specify)
12. C. Movable Equipment			ught Forward:	1 2 3 3 3 3			
1. Automotive Equipment	12. C. Moyable Equipment		<u> </u>				
A. Item	_ :	ent	\$	<u> </u>			
Address of Lender S	The state of the s		Amount				
Address of Lender S							
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) NTEREST 13. Total All Interest Expense (12B7 + 12C3 + 12D) 14. Insurance a. Insurance on Property (buildings only) b. Insurance on Automobiles c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) 2. Fire and Extended Coverage 3. Other (Specify) \$ 63.866 \$ 63.866	Lender						
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) INTEREST 13. Total All Interest Expense (12B7 + 12C3 + 12D) 14. Insurance a. Insurance on Property (buildings only) b. Insurance on Automobiles c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) 2. Fire and Extended Coverage 3. Other (Specify) \$ 3,221 3,221 14d. Total Insurance Expenditures (14a + b + c) \$ 63,866 63,866	Address of Lender						
A. Item	2. Other (Specify)		\$	A STOREGO CONTRACTOR CONTRACTOR OF THE STOREGO	Caralis (I. secondonisticani) (I. secondonisticani) (I. secondonisticani) (I. secondonisticani) (I. secondonis	and the second s	
Address of Lender Rate Amount		Rate	Amount				
Address of Lender Rate Amount							
B. Item Rate Amount	Lender			10.00			200 100
B. Item Rate Amount						Grand Co.	
Lender Address of Lender	Address of Lender						
Lender Address of Lender							100
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) \$ 14. Insurance a. Insurance on Property (buildings only) \$ 11,424 11,424 b. Insurance on Automobiles \$ 2,291 2,291 c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) \$ 2. Fire and Extended Coverage \$ 3. Other (Specify) \$ 3,221 3,221	B. Item	Rate	Amount				200
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) \$ 14. Insurance a. Insurance on Property (buildings only) \$ 11,424 11,424 b. Insurance on Automobiles \$ 2,291 2,291 c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) \$ 2. Fire and Extended Coverage \$ 3. Other (Specify) \$ 3,221 3,221							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)	Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)	Address of Lander			-			
Expense (C1 + 2)	Address of Lender			Programme Alberta			
Expense (C1 + 2)	12. C. 3. Total Moyable Equit	oment Interest					
12. D. Other Interest Expense (Specify) \$ 55,802 55,802 13. Total All Interest Expense (12B7 + 12C3 + 12D) \$ 55,802 55,802 14. Insurance			9				
13. Total All Interest Expense (12B7 + 12C3 + 12D) \$ 55,802 55,802 14. Insurance a. Insurance on Property (buildings only) \$ 11,424 11,424 b. Insurance on Automobiles \$ 2,291 2,291 c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) \$ 46,929 46,929 2. Fire and Extended Coverage \$ 3 3. Other (Specify) \$ 3,221 3,221		(Specify)	9	55,802	55,802		
14. Insurance a. Insurance on Property (buildings only) \$ 11,424 11,424 b. Insurance on Automobiles \$ 2,291 2,291 c. Insurance other than Property (as specified above) 46,929 46,929 1. Umbrella (Blanket Coverage) \$ 46,929 46,929 2. Fire and Extended Coverage \$ 3,221 3,221 3. Other (Specify) \$ 3,221 3,221 14d. Total Insurance Expenditures (14a + b + c) \$ 63,866 63,866							
14. Insurance a. Insurance on Property (buildings only) \$ 11,424 11,424 b. Insurance on Automobiles \$ 2,291 2,291 c. Insurance other than Property (as specified above) 46,929 46,929 1. Umbrella (Blanket Coverage) \$ 46,929 46,929 2. Fire and Extended Coverage \$ 3,221 3,221 3. Other (Specify) \$ 3,221 3,221 14d. Total Insurance Expenditures (14a + b + c) \$ 63,866 63,866				ar arab is			
a. Insurance on Property (buildings only) b. Insurance on Automobiles c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) 2. Fire and Extended Coverage 3. Other (Specify) \$ 3,221 14d. Total Insurance Expenditures (14a + b + c) \$ 63,866		(12B7 + 12C3 + 12)	D) \$	55,802	55,802		
b. Insurance on Automobiles \$ 2,291 2,291 c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) \$ 46,929 46,929 2. Fire and Extended Coverage \$ 3, Other (Specify) \$ 3,221 3,221					11.10.		
c. Insurance other than Property (as specified above) 1. Umbrella (Blanket Coverage) \$ 46,929 2. Fire and Extended Coverage \$ 3,221 3. Other (Specify) \$ 3,221 14d. Total Insurance Expenditures (14a + b + c) \$ 63,866							
1. Umbrella (Blanket Coverage) \$ 46,929 46,929 2. Fire and Extended Coverage \$ 3, Other (Specify) \$ 3,221 3,221				2,291	2,291		
2. Fire and Extended Coverage \$ 3, Other (Specify) \$ 3,221 3,221 14d. Total Insurance Expenditures (14a + b + c) \$ 63,866 63,866				46 020	46 020		
3. Other (Specify) \$ 3,221 3,221 14d. Total Insurance Expenditures (14a + b + c) \$ 63,866 63,866					40,729		
14d. Total Insurance Expenditures (14a + b + c) \$ 63,866 63,866		overage			3 221		
114, 2000 1,000	3. Outer (apecity)			5,221	5,221		
114, 2000 1,000						1000	100000000000000000000000000000000000000
114, 2000 1,000							
	14d. Total Insurance Expenditu	res(14a+b+c)		63,866	63,866		
, ,							

D. Adjustments to Statement of Expenditures

	e of Fa		Center LLC	Lic	ense No. 2221-C	Report for Yes 9/30/2015	ar Ended	Page 28	of
Winte	onoury	/ Care	Center LLC	<u></u>	Total	7/30/2013		20	
τ,		τ,			Amount of				
	Page		Itaan Daariinti		Decrease	CCNH	RHNS	(Sr	ecify)
	No.		Item Description		Decrease	CCNH	KIINS	(3)	(Cerry)
Page	10 - 5		es and Wages	Φ.				-	
1.			Outpatient Service Costs	\$				_	
2.			Salaries not related to Resident Care	\$					
3.			Occupational Therapy	\$					
4.	Arana Larra		Other - See attached Schedule	\$					
	13 - I		sional Fees						
5.			Resident Care Physicians **	\$					
6.			Occupational Therapy	\$					
7.			Other - See attached Schedule	\$					
Page	s 15 &	t 16 -	Administrative and General						
8.			Discriminatory Benefits	\$				<u> </u>	
9.			Bad Debts	\$	246,988	246,988	· · · · · · · · · · · · · · · · · · ·		
10.		<u> </u>	Accounting & Legal	\$				ļ	
11.			Telephone	\$				ļ	
12.			Cellular Telephone	\$					
13.			Life insurance premiums on the life		70.00				
			of Owners, Partners, Operators	\$	1	·			
14.			Gifts, flowers and coffee shops	\$					H-112-12-12-12-12-12-12-12-12-12-12-12-12
15.			Education expenditures to colleges or						
			universities for tuition and related costs						
			for owners and employees	\$		İ			
16.			Travel for purposes of attending				100		
			conferences or seminars outside the				100		
İ			continental U.S. Other out-of-state						
			travel in excess of one representative	\$		204 (1990)			
17.			Automobile Expense (e.g. personal use)	\$					
18.		 	Unallowable Advertising *	\$		29,599			
19			Income Tax / Corporate Business Tax	\$					•
20.	+		Fund Raising / Contributions	\$		*			
21.		<u> </u>	Unallowable Management Fees	\$					
22		1	Barber and Beauty	\$					
23			Other - See attached Schedule	9		97,714			
		Dietar	ry Expenditures						
24		Dicius	Meals to employees, guests and others						
<u>4</u> -T	'		who are not residents	9				50 100 00 00 00 00 00 00 00 00 00 00 00 0	
Dag	a 10	Laura	dry Expenditures	- 4					
25		Luuni	Laundry services to employees, guests						
23	'		and others who are not residents	9					
D.	- 20	77		4					
		TOUSE	ekeeping Expenditures						
26	•		Housekeeping services to employees, guests						
		<u> </u>	and others who are not residents		§ 374,301	374,301		 	
Ĺ			Subtotal (Items 1 - 20)) :	. 1	Carry Subtotal			

^{*} 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)
		V F F F F F F F F F F F F F F F F F F F		1 4.51.41
Total Othe	r Salaries Adjustment	\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
	.\\ *.*****************************				
16		Management fee over cost	\$ -		\$ -
	- 11				
	,				1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -
Total Othe	r Fees Adi	ustments	\$ -	\$ -	\$

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	(CCNH	RHNS	(Specify)
16a	******	PENALTIES	\$	3,180		\$
16a		LATE FEES	\$	2,403		\$ -
16a		PRIOR PERIOD EXPENSES		1		
	1	rounding		21		
7.7		Provider Use Medicare Days	1940	92,109.80		
Total Othe	r A&G Ad	justments	\$	97,714	\$ -	\$

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

Name	of Fa	cility	D. Adjustments to Statemen		ense No.	Report for Y		Page	of
			Center LLC		2221-C	9/30/2015		29	37
					Total				
Item	Page	Line			Amount of				
No.	No.		Item Description		Decrease	CCNH	RHNS	(S ₁	pecify)
1101		1.01	Subtotals Brought Forward	\$	374,301	374,301			***
Page	20 - K	Reside	nt Care Supplies***						
27.			Prescription Drugs	\$			<u> </u>	***************************************	
28.			Ambulance/Limousine	\$	13,194	13,194			
29.			X-rays, etc	\$	16,415	16,415			
30.			Laboratory	\$	20,939	20,939			
31.			Medical Supplies	\$					
32.			Oxygen (non emergency)	\$					
33.			Occupational Therapy	\$					
34.			Other - See Attached Schedule	\$	1,364	1,364			
	22 - A		enance and Property						
35.			Excess Movable Equipment Depreciation						
			See Attached Schedule	\$,	
36.			Depreciation on Unallowable						
00.			Motor Vehicles	\$					2200222.2.2.0
37.			Unallowable Property and Real						
0,,			Estate Taxes	\$					COLUMN TO SERVICE SERV
38.			Rental of Building Space or Rooms	\$					
39.			Other - See Attached Schedule	\$					
	27 - 1	nsura							
40.	<u> </u>	1	Mortgage Insurance	\$					***************************************
41.		 	Property Insurance	\$					
	r - Mi	scella		-					
42.			Research or Experimental Activities	\$					
43.			Radio and Television Revenue	\$	 				
44.			Vending Machine Revenue	\$					
45.			Purchase Discounts and Allowances	\$					
46.		<u> </u>	Duplications of functions or services	\$					
47.	-		Expenditures made for the protection,						
			enhancement or promotion of the						
			providers interest	\$	# STORY TO SELECTED \$55 dillaries of seguine we had become vice with	Co. 1 (Virginially) (Cillings As presented Spaces (200-) (2007) secured (11)	AND TO SERVE STREET, S		
48.			Interest Income on Accounts Rec	\$					***
49.		Ì	Other (include personnel and other		-	1000 1000			
, - ,			costs unrelated to resident care) - See		40000	100			
			Attached Schedule	\$	(0	(0)			
Not .	For P	rofit P	roviders Only						
50.		[Building/Non Movable Eq. Depreciation						
1			Unallowable Building Interest -						
1			See Attached Schedule	\$		Company (in Carporal September Communication)	Value (V) Homes (V) (V)		The state of the s
51	Total	Amo	unt of Decrease (Items 1 - 50)	\$		426,213			

^{***} Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5J	NON-COVERED PPS DR. VISITS	1,379.59		
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	(15)	\$ N. 13 12 12 12 12 12 12 12 12 12 12 12 12 12	
13	B9A	ST- Resident Care (for outpatent therapy - see schedule)			
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)			
Total Othe	r Ancillary	Costs	\$ 1,364	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref Description	CCNH	RHNS	(Specify)
1				
				*
Total Exce	ss Movable Equipment Depreciation	\$ National States	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
				* :	
Total Othe	r Property	Adjustments	\$	\$	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	4A1	Houskeeping Supplies (for Outpatient Therapy - see schedule)	(0)		
20	4B	Housekeeping purchased services (for Outpatient Therapy see schedule)	(0)		
22	6B	Heat (for outpatient Therapy see schedule)	(0)		
	6C	Light and Power (for outpatient therapy see schedule)	(0)		
22	6D	water (for outpatient therapy see schedule)	(0)		
22	6A	Repair&Maint (for outpatient therapy see schedule)	(0)		
7.5					
100				1	
	4 3 4 7				
Total Othe	r Adjustm	ents	\$ (0)	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
	40			***	
71.00.177			 		9.4.
	11 11 11 11				
Total Una	lowable B	uilding Interest	 \$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility Wintonbury Care Center LLC License No. 2221-C		Report for Ye 9/30/2015	ear Ended		Page 30	of 37
Thinking of the content and						
Item		Total	CCNH	RHNS	(Spec	ify)
. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (CT only)	\$	10,920,744	10,920,744			
b. Medicaid Room and Board Contractual Allowance **	\$					
2. a. Medicaid (All other states)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (all inclusive)	\$	1,897,397	1,897,397			
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$	296,631	296,631			
b. Private-Pay Room and Board Contractual Allowance **	\$					
11. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$	170,326	170,326			
b. Prescription Drugs - Medicare Contractual Allowance **	\$	(170,326)	(170,326)			
c. Prescription Drugs - Non-Medicare	\$		31,006			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$	(31,006)	(31,006)			
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$	+			1	
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$	 	326,590			
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	-		108,967			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$		(108,967)			
4. a. Speech Therapy - Medicare	\$	· · · · · · · · · · · · · · · · · · ·	60,383			
b. Speech Therapy - Medicare Contractual Allowance **	\$	· 	(26,185)			
c. Speech Therapy - Non-Medicare	\$	*	13,389		****	
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$	·	(13,389)			
5. a. Occupational Therapy - Medicare	9		305,487			
b. Occupational Therapy - Medicare Contractual Allowance **	9					
c. Occupational Therapy - Non-Medicare	<u>4</u>		73,823	<u> </u>	1	
d. Occupational Therapy - Non-Medicare Contractual Allowance **	9					
6. a. Other (Specify) - Medicare	<u> </u>	*	1		 	
b. Other (Specify) - Non-Medicare	9					
III. Total Resident Revenue (Section I. thru Section II.)			13,292,341			
IV. Other Revenue*	4	13,272,341	13,272,341			
	d	,				
Meals sold to guests, employees & others						
2. Rental of rooms to non-residents	5					
3. Telephone	9		-			
4. Rental of Television and Cable Services	9		121	+		
5. Interest Income (Specify)	9		131	+	-	
6. Private Duty Nurses' Fees	- 9		<u></u>	 		
7. Barber, Coffee, Beauty and Gift shops			0.760	-	+	
8. Other (Specify)			8,368		1	
V. Total Other Revenue (1 thru 8)			8,498		 	
VI. Total All Revenue (III+V)	5	13,300,839	13,300,839			

^{*} 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

age Ref	Description				CCNH	RHNS	(Specify)
	Lab Medicare		11.0	\$	89,536	1111111111	1,44,111
	Lab Medicare CA	1997		\$	(89,536)	1344.134	1000
•	Oxygen Medicare			s	660		1. 1
	Oxygen Medicare CA			\$	(660)		
	Equipment rental			\$	7,805	1	
	Equipment rental CA	TO A VALUE		\$	(7.805)		10.00
	Pen Therapy	14		Ş	•		
	Pen Therapy CA	* * *		S	-		
	Thorapy Beds Medicare	* * * * * * * * * * * * * * * * * * * *		\$			
	Thorapy Bods Medicare CA			S			1111
	Radiology Medicare			S	14,741	· ·	
	Radiology Medicare CA			S	(14,741)		
	IV Therapy			S	28,315		
	IV Therapy CA			5	(28,315)		
	Medical Transportation			\$			
	Medical Transportation CA			S			
	Glucose testing			s	-		
	Glucose testing CA			\$			
	Outpatient therapy Medicare			\$	(1,310)		
otal Oth	er Resident Revenue - Medicare			\$	(1,310)	\$ -	\$.

Schedule of Other Non-Medicare Resident Revenue

Related Exp

f Description				CCNH	RHNS	(Specify)
Lab	17.54			5,665,03		100
Lab CA		1111	tata ea	(5,665.03)	**	
Oxygen		A HALL		\$ 1,800		\$
Oxygen CA	9.1344	5.65	1000	\$ (1,800)		\$ -
Equipment rental				\$ 18,302		
Equipment rental CA		3 N.A.		\$ (18,302)	1111	
Pen Therapy		11 Holland	10445	s -	The Charles	
Pen Therapy CA		14, 14	1.15	\$	14.	1.1
Therapy Beds	1	1111	5,5	\$	1	·
Therapy Beds CA		1.11		\$	- 3	
Radiology		1.00		\$ 1,604		3 73
Radiology CA		: 1		\$ (1,604)		
Medical Transportation				S		
Medical Transportation				s -		
Glucose Testing				S -		
Glucose Testing CA	4 15 111	100		\$	4.4	<u> </u>
IV therapy	4.4 (4.7)			\$ 25,624		\$
1V therapy CA		1000		\$ (25,624)	The second	\$
Flu shot revenue		4.744.47		s -		
Outpatient therapy		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	19.00	s -	1 1 1	
PRIOR YEAR ADJ - A	NCILLARY & OTH	IR .		\$ (720)		
				1.1		
rounding				\$ (0)		
						·
						L .
ther Resident Revenue				\$ (721)	S -	s

Interest Income

Account

Page Ref Account		Balance	CCNH	RHNS	(Specify)
INTEREST INCOME			\$ 131		
			- 1.		
Total Interest Income	4.7		\$ 131	\$	\$

Schedule of Other Revenue

ge Ref	Description			CCNR	RHNS	(Specify)
	MEALS	1.1.1		S	14.44.5	
	TELEVISION INCOME	31:3111	The State of the S	\$ 8,280	Ţ4	3.5
	CONCESSIONS / VENDING INCOME	1, 11, 11		\$ -		
	RESIDENT LATE FEE REVENUE		111	\$ 88		
	RESIDENT ATTORNEY FEE REVENUE	1.1.1		\$ -		
	TELEPHONE INCOME			\$		
	OTHER INCOME			\$ -		ļ
	OPTUM DIVIDENDS REVENUE		1	\$ -		
	14.5			1 4.11.1		
						ļ
6-1 Och	er Reyenue			\$ 8,368	\$ -	\$.

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Wintonbury Care Center LLC	2221-C	9/30/2015	31	37
	Account		An	nount
Assets				
A. Current Assets				
1. Cash (on hand and in			\$	66,875
	ceivable (Less Allowance		\$	2,441,198
	vable (Excluding Owners	or Related Parties)	\$	20,580
4 Inventories			\$	19,383
Prepaid Expenses			\$	678,626
a. Prepaid Insurance		654,492		
b. Prepaid Property T	axes	13,826		- 4
c. Prepaid Expenses	Other	10,308		
d.				35,453
6. Interest Receivable			\$	
Medicare Final Settle	ment Receivable	-	\$	
8. Other Current Assets			\$	(423,605)
Due From (to) Related		(58,965) (364,640)		
Other Owners reserves		(304,040)		
			100 100 100	2000
A-9. Total Current Assets (Li	nes A1 thru 8)		\$	2,803,056
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost		\$	
•	Accum. Deprecia	ation Net		
3. Buildings	*Historical Cost	15,421	\$	15,335
Ū	Accum. Deprecia	ation 86 Net		
4. Leasehold Improvem	ents *Historical Cost	1,838,590	\$	998,970
-	Accum, Deprecia	ation 839,619 Net		
5. Non-Movable Equipr	nent *Historical Cost	12,259	\$	944
	Accum. Deprecis	ation 11,315 Net		
6. Movable Equipment	*Historical Cost	805,392	\$	252,048
	Accum. Deprecia	ation 553,344 Net		
7. Motor Vehicles	*Historical Cost	14,156	\$	
	Accum. Depreci	ation 14,156 Net		
8. Minor Equipment-No			\$	
9. Other Fixed Assets (a	temize)		\$	
Construction in Pr	•			
B-10. Total Fixed Assets (Lines P1 thru (1)		\$	1,267,298
B-10. Total Fixed Assets (Lines DI unu 3)		Ψ	1,201,270

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

G. Balance Sheet (cont'd)

		Facility	License No.	Report for Year Ended	Page	
Wint	onb	ury Care Center LLC	2221-C	9/30/2015	32	37
			Account			Amount
				Total Brought Forward:	\$	4,070,353
C.	Lea	asehold or like property recor	ded for Equity Purpos	es.		
		Land			\$	
	2.	Land Improvements	*Historical Cost		_	
			Accum. Depreciation	on Net	\$	
	3.	Buildings	*Historical Cost			
<u></u>			Accum. Depreciation	on Net	\$	
	4.	Non-Movable Equipment	*Historical Cost			
			Accum. Depreciation	on Net	\$	
	5.	Movable Equipment	*Historical Cost			
			Accum. Depreciation	on Net	\$	
	6.	Motor Vehicles	*Historical Cost			
			Accum. Depreciation	on Net	\$	
	7.	Minor Equipment-Not Depr		\$		
C-8	To	tal Leasehold or Like Prope	rties (C1 thru 7)		\$	
D.	Inv	vestment and Other Assets				
	1.	Deferred Deposits			\$	
	2.	Escrow Deposits			\$	
	3.	Organization Expense	*Historical Cost			
			Accum. Depreciation	on Net	\$	
	4.	Goodwill (Purchased Only)			\$	
	5.	Investments Related to Resi	dent Care (itemize)	-	\$	39,982
		Patient Trust Funds		39,982		
		Long Term Deposit - pri	mecare			
	6.	Loans to Owners or Related	Parties (itemize)		\$	
		Name and Address	Amount	Loan Date		
1						
	7.	Other Assets (itemize)			\$	anno con circulation della Companya con est est est est est est est est est est
					1	- 15 (C) 1 (C)
D-8	Te	otal Investments and Other A	Issets (Lines D1 thru	7)	\$	39,982
		otal All Assets (Lines A9 + B			\$	4,110,336

^{*} 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	
Wintonbury	Care	Center LLC	2221-C	9/30/2015		33	37
			Account			An	nount
Liabilities							
A.	Cu	rrent Liabilities					
	1.	Trade Accounts Payable		\$	697,837		
	2.	Notes Payable (itemize)				\$	1,611,738
		Working Capital Line of C	Credit	1,611,73	8		
						.	
	3.	Loans Payable for Equipm			<u></u>	\$	
		Name of Lender	Purpose	Amount	Date Due		
				:			
						40.50	
	4.	Accrued Payroll (Exclusive	ve of Owners and/or	Stockholders only)		\$	259,552
	5.	Accrued Payroll (Owners			***************************************	\$	
	6.	Accrued Payroll Taxes Pa				\$	
	7.	Medicare Final Settlemen	···			\$	
	8.	Medicare Current Finance		· · · · · · · · · · · · · · · · · · ·		\$	I
	9.	Mortgage Payable (Curre	To the second se			\$	
	10	. Interest Payable (Exclusiv		Related Parties)		\$	
-		. Accrued Income Taxes*				\$	
		. Other Current Liabilities	(itemize)			\$	2,455,334
		Related Party Payables	1,511	,390			
		Accrued Expenses	153	,448			
		Accrued Resident User Fees	256	,981			
		Accrued Workers Comp Expense		,514			
A-1	$\overline{3}$ Tc	otal Current Liabilities (Li	nes A1 thru 12)	,,		\$	5,024,462

^{*} 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		Ended	Page		of
Wintonbury Care Center LLC	2221-C	9/30/2015		34		37
	Account			An	nount	
		Total Broug	ht Forward:		5,02	4,462
Liabilities (cont'd)			77			
B. Long-Term Liabilities						
 Loans Payable-Equipment 			\$			
Name of Lender	Purpose	Amount	Date Due			
		ļ				
2. Mortgages Payable			\$			
3. Loans from Owners or Re	lated Parties (itemize	g)	\$			
Name and Address of Lender	Amount	Loan I	Date			
				5.00		
4. Other Long-Term Liabilit	ies (itemize)		\$		-	39,982
Patient Trust Funds	(· · · · · · · · · /	39,982	2000			
		· · · · · · · · · · · · · · · · · · ·				
	A STATE OF THE STA					
B-5. Total Long-Term Liabilities	(Lines B1 thru 4)		\$			39,982
C. Total All Liabilities (Lines A	-13 + B-5)		\$		5,06	54,444

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

I	ne of Facility	License No.	Report for Y	ear Ended	Page	of
Win	tonbury Care Center LLC	2221-C	9/30/2015		35	mount 37
A.	Reserves	Account			/-	anount
	Reserve for value of lease	ed land			\$	
	Reserve for depreciation to be amortized	\$	-			
	3. Reserve for depreciation	value of leased perso	nal property (<i>Eq</i>	uity)	\$	
	4. Reserve for leasehold rea	\$				
	5. Reserve for funds set asic	le as donor restricted			\$	
	6. Total Reserves				\$	
В.	Net Worth 1. Owner's Capital				\$	1,000
	2. Capital Stock				\$	
	3. Paid-in Surplus				\$	
	4. Treasury Stock				\$	
:	5. Cumulated Earnings				\$	65,363
	6. Gain or Loss for Period	10/1/20	014 thru	9/30/2015	\$	(1,020,493)
	7. Total Net Worth				\$	(954,129)
C.	Total Reserves and Net Wor	th			\$	(954,129)
D.	Total Liabilities, Reserves, a	and Net Worth			\$	4,110,315

H. Changes in Total Net Worth

Name of Facility		License No.	Report for Year	Ended	Page	of	
Wintonbury Care Center LLC		2221-C	2221-C 9/30/2015		36	37	
	Account					Amount	
A.	Balance at End of Prior Period	\$					
В.	Total Revenue (From Stateme	\$	13,300,839				
C.						14,321,332	
D.	Net Income or Deficit	\$	(1,020,493)				
E.	Balance					(1,020,493)	
F.	Additions						
	1. Additional Capital Contributed (itemize)						
	2. Other (itemize)						
F-3.	Total Additions				\$		
G.	Deductions						
	1. Drawings of Owners/Operators/Partners (Specify)						
	Name and Address (No.,		Title	Amount			
	2. Other Withdrawings (Spe	\$					
	Purpose Amount		ount		Service the		
	3. Total Deductions	\$ \$					
H.	H. Balance at End of Period 09/30/15					(1,020,493)	

I. Preparer's/Reviewer's Certification

Name of Facility		License N	No.	Report for Year Ended	Page	of					
Wintonbury Care Center LLC			2221-C	9/30/2015	37	37					
Check appropriate category											
Ø	Chronic and Convalescent Nursing Home only (CCNH)		ne with Nursing on only (RHNS)	□ (Specify)							
Preparer/Reviewer Certification											
I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.											
Signature of Preparer		Title		Date Signed	Date Signed						
M		VP	France	2/10/16							
Printe	d Name of Preparer										
			· · · · · · · · · · · · · · · · · · ·								
 Denis	e MacKinnon										
Addres Address				Phone Number							
341 B	idwell Street, Manchester, CT 06040			860-570-2140 ext 15							