State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2016

Name of Facility (as licensed) Farmington Rehab Center, LLC d/b/a Amberwoods of Farmington	
Address (No. & Street, City, State, Zip Code) 416 Colt Highway, Farmington, CT 06032	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)	
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2332			07-5419

Medicaid Provider Numbers:	CCNH	RHNS	ICF-MR
	9241		

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

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Farmington Rehab Center, LLC d/b/a Amberwoods of	2332	9/30/2016	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 Farmington Rehab Center, LLC d/b/a Amberwoods of Farmington [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 2016, 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) Martin Julmisse			Printed Name (Owner) Moshe Bernstein	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Farmington Rehab Center, LLC d/b/a Amberwoods of Farmington	Period Covered:		From 10/1/2015	To 9/30/2016
Address of Facility 416 Colt Highway, Farmington, CT 06032				
Report Prepared By Wonneberger Business Solutions, Inc.	Phone Number (203) 250-2013		Date 2/13/2017	

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

Phone No. of Facility	Report for Year Ended	Page	of
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Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Farmington Rehab Center, LLC d/b/a Amberwoods of Farming	416 Colt Highway, Farmington, CT 06032

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	2332			07-5419

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Type of Ownership (Check appropriate box)

○ Proprietorship ◉ LLC ○ Partnership ○ Profit Corp. ○ Non-Profit Corp. ○ Government ○ 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? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
Martin Julmisse		1978

Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a Amberwoods of	2332	9/30/2016	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
Farmington Rehab Center, LLC	416 Colt Highway, Farmington, CT 06032	Farmington, CT

Name of Partners/Members	Business Address	Title	% Owned
Moshe Bernstein	416 Colt Highway, Farmington, CT 06032	Sole Member	100%

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a Amber	2332	9/30/2016	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated

Name of Directors, Officers	Business 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
Farmington Rehab Center, LLC d/b/a Amberwoods	2332	9/30/2016	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a Amberwoods of F	2332	9/30/2016	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⊙ 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? ⊙ Yes ○ No

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Farmington Realty Company	2600 Nostrund Avenue, Brooklyn, NY 11210	○	⊙		Rent Expense	Pg 22 Line 9	617,218	
		○	○		Property Taxes	Pg 22 Line 10.a	148,575	
		○	○		Property Insurance	Pg 27 Line 14.a	23,072	
		○	○		General & Business Liability	Pg 27 Line 14.c.3	59,885	
		○	○			Total Rent Payments	848,750	848,750
		○	○					
		○	○					
		○	○					
		○	○					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a Amberwo	2332	9/30/2016	5	37

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 (*See listing page 13*)
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.

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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.

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a Amberwoods of Farm	2332	9/30/2016	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
De Lage Landen	○	◉	Savin Copier	04/06/15	48 Months	4,116	4,122
	○	◉					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
						Total ***	4,122

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.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b	2332	9/30/2016	7	37

The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

Is the accounting basis for this period the same as for the previous period? ⊙ Yes ○ No — If "No," explain.

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Wonneberger Business Solutions, Inc.	
2 Wonneberger Business Solutions, Inc.	
3 Whittlesey & Hadley, PC	
4	

Services Provided by This Firm (*describe fully*)

1	Monthly Accounting Services	$ 17,428
2	Medicaid & Medicaire Cost Reporting	$ 9,875
3	Pension Audit - Form 5500	$ 14,000
4		$
		Charge for Services Provided: $ 41,303

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.

⊙ Yes ○ No — Pg 15, Line 1.d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Robinson & Cole LLP	
2 Stokesbury Shipman & Fingold, LLC	
3 Murtha Cullina LLP	
4 Joseph Vitale	
5 Peter R. Blum, Esq.	

Address (*No. & Street, City, State, Zip Code*)

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	Union Negotiation / Employee Issues	$ 75,513
2	Collections (Disallowed)	$ 8,381
3	General Legal Issues	$ 505
4	Lease Negotiations (Disallowed)	$ 3,900
5	Employee Matters - Settled (Disallowed)	$ 830
		Charge for Services Provided: $ 89,129

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.

⊙ Yes ○ No — Pg 15, Line 1.e

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30 Total	Period 10/1 Thru 6/30 CCNH	Period 10/1 Thru 6/30 RHNS	Period 10/1 Thru 6/30 (Specify)	Period 7/1 Thru 9/30 Total	Period 7/1 Thru 9/30 CCNH	Period 7/1 Thru 9/30 RHNS	Period 7/1 Thru 9/30 (Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	130	130			130	130						
B. On last day of THIS report period	130	130							130	130		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	97	97			97	97						
B. As of midnight of THIS report period	97	97							97	97		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,721	1,721			1,409	1,409			312	312		
B. Medicaid (Conn.)	26,583	26,583			19,643	19,643			6,940	6,940		
C. Medicaid (other states)												
D. Private Pay	1,819	1,819			1,268	1,268			551	551		
E. State SSI for RCH												
F. Other (Specify)	9,215	9,215			6,479	6,479			2,736	2,736		
G. Total Care Days During Period (3A thru F)	39,338	39,338			28,799	28,799			10,539	10,539		
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												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	39,338	39,338			28,799	28,799			10,539	10,539		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a Amberv	2332	9/30/2016	9	37

4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ 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						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	7	68		22				
Per Diem Rate								
a. One bed rm.	RUX - $795.27	231.89		424.00				
b. Two bed rms.	PA1 - $199.21	231.89		373.00				
c. Three or more bed rms.	N/A	N/A		N/A				

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	2,110	2,110		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	448	448		
2. Restorative Treatments				
C. Other	6,032	6,032		
D. ***Total Physical Therapy Treatments***	8,590	8,590		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	441	441		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	11	11		
2. Restorative Treatments				
C. Other	626	626		
D. ***Total Speech Therapy Treatments***	1,078	1,078		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,230	2,230		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	627	627		
2. Restorative Treatments				
C. Other	6,928	6,928		
D. ***Total Occupational Therapy Treatments***	9,785	9,785		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a Amberwoods of Farmi	2332	9/30/2016	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ 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)	$ 101,224	2,096				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	$ 308,413	13,569				
5. Dietary Service						
a. Head Dietitian	$ 28,840	683				
b. Food Service Supervisor	$ 62,634	2,456				
c. Dietary Workers	$ 276,358	23,498				
6. Housekeeping Service						
a. Head Housekeeper	$ 42,065	2,214				
b. Other Housekeeping Workers	$ 171,818	17,182				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	$ 52,159	2,268				
b. Other Maintenance Workers	$ 59,532	3,721				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	$ 53	3				
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	$ 195,385	4,530				
b. RN						
1. Direct Care	$ 763,313	21,215				
2. Administrative**	$ 90,918	2,879				
c. LPN						
1. Direct Care	$ 976,039	37,729				
2. Administrative**						
d. Aides and Attendants	$ 1,484,464	108,513				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists	$ 10,274	263				
h. Recreation Workers	$ 192,366	9,948				
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	$ 230,759	7,677				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	$ 5,046,614	260,444				

* 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)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

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

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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 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).										

* 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.

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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
Farmington Rehab Center, LLC d/b/a Amberwoods of Farmington	2332	9/30/2016	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* **										
Tamlyn Campenalli (10/1/15 - 2/7/16)	42,377			Standard Employee Package	Facility Administration	736	A.2			
Martin Julmisse (2/8/16 - 9/30/16)	58,847			Standard Employee Package	Facility Administration	1,360	A.2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a Amberwoods	2332	9/30/2016	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						
2. Dentist	$ 8,005	160				
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	$ 175,499	3,763				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	$ 30,000	300				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	$ 22,986	230				
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	$ 40,757	627				
b. Other						
10. Occupational Therapist						
a. Resident Care	$ 163,715	2,519				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	$ 8,953					
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	$ 449,915	7,599				

* 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.

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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
Farmington Rehab Center, LLC d/b/a Amberwoods of Fa	2332	9/30/2016	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Foremost Rehab of CT	PT, ST, OT	○	⊙	
Preferred Therapy Solutions	PT, ST, OT	○	⊙	
CT Multispecialty Group	Medical Director	○	⊙	
CT Multispecialty Group	Patient Care	○	⊙	
Practitioners Support Services	Patient Care	○	⊙	
John Dempsey Hospital	Patient Care	○	⊙	
Starling Physicians	Patient Care	○	⊙	
University Physicians	Patient Care	○	⊙	
Hartford Healthcare	Patient Care	○	⊙	
GeriDent Solutions, LLC	Dental Care	○	⊙	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a Amberwoo	2332	9/30/2016	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	504,782	504,782		
2. Disability Insurance	$	22,334	22,334		
3. Unemployment Insurance	$	132,337	132,337		
4. Social Security (F.I.C.A.)	$	383,015	383,015		
5. Health Insurance	$	628,125	628,125		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	6,728	6,728		
7. Pensions (Non-Discriminatory)	$	122,794	122,794		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	16,481	16,481		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	41,303	41,303		
e. Legal (*Services should be fully described on Page 7)*	$	89,129	89,129		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	17,761	17,761		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	10,271	10,271		
2. Cellular Phones	$	4,348	4,348		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	777,304	777,304		
Subtotal	$	2,756,712	2,756,712		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Training Fund-Union	$ 16,341		
Other Employee Benefits	$ 140		
-	$ -		
Total	$ 16,481	$ -	$ -

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a Amberwoods o	2332	9/30/2016	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,756,712	2,756,712		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	1,015	1,015		
4. Employee Travel	$	23,290	23,290		
5. Education Expenses Related to Seminars and Conventions	$	3,208	3,208		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$				
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	6,435	6,435		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	5,445	5,445		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	9,200	9,200		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	650	650		
9. Subscriptions	$	1,111	1,111		
10. Contributions***	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	110,532	110,532		
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	45,388	45,388		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,962,986	2,962,986		

* 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)
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Advertising - Promotional	$ 6,435		
-	$ -		
Total Other Advertising	$ 6,435	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCA	$ 9,200		
Total Dues	$ 9,200	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Charges	$ 2,624		
Taxes & Licenses	$ 2,265		
Minor Equipment - Gen & Admn	$ 981		
Probate Court Fees - Conservatorships	$ 873		
Background Checks	$ 75		
Nurse Evaluator	$ 269		
-	$ -		
Disallowed Expenses	$ -		
Resident Items - Lost/Stolen	$ 657		
Late Fee/Finance Charge	$ 17,953		
Prior Year Expense	$ (4,493)		
Miscellaneous Expense	$ 766		
	$ 23,418		
Total Other Administrative and General	$ 45,388	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Farmington Rehab Center, LLC d/b/a Am	2332	9/30/2016	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 #

*** 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.**

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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
Farmington Rehab Center, LLC d/b/a Amberwoods of	2332	9/30/2016	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	269,348	269,348		
2. Non-Food Supplies	$	36,991	36,991		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)_____ Supplements	$	26,246	26,246		
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	332,585	332,585		

		Total	CCNH	RHNS	(Specify)
2F. Dietary Questionnaire					
G. Resident Meals:	Total no. of meals served per day:*	323	323		

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ 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.

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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
Farmington Rehab Center, LLC d/b/a Amberwoods of F	2332	9/30/2016	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. $	3,001	3,001		
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. $	8,019	8,019		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	140,423	140,423		
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	151,443	151,443		

3F.	Laundry Questionnaire			
G.	Is cost of employee laundry included in 3E?	○ Yes	⊙ No	If yes, specify cost.
H.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report?			(Page/Line Item)
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	○ Yes	⊙ No	If yes, specify cost.
K.	Did you receive revenue from these people?	○ Yes	⊙ 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.

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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
Farmington Rehab Center, LLC d/b/a Amberw	2332	9/30/2016	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	28,058	28,058		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	28,058	28,058		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	326,819	326,819		
b. Medicine Cabinet Drugs		$	13,027	13,027		
c. Medical and Therapeutic Supplies		$	102,105	102,105		
d. Ambulance/Limousine***		$	1,460	1,460		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	23,866	23,866		
f. X-rays and Related Radiological Procedures***		$	6,339	6,339		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	22,029	22,029		
i. Recreation		$	11,440	11,440		
j. Other (Specify)**** See Attached Schedule		$	39,411	39,411		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	546,496	546,496		

* 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 Medical & Therapeutic Supplies

Description	CCNH	RHNS	(Specify)
Nursing Supplies - Nursing	$ 99,370		
Supplies - PT	$ 2,716		
Supplies - ST	$ 19		
-	$ -		
-	$ -		
-	$ -		
-	$ -		
Total Other Resident Care	$ 102,105	$ -	$ -

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Incontinent Supplies	$ 39,343		
Medical Equipment Rental	$ 68		
-	$ -		
-	$ -		
-	$ -		
-	$ -		
Total Other Resident Care	$ 39,411	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a Amberwoods of Farmington	2332	9/30/2016	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Iris Carafaro		○	⊙		A/R Billing Services	$ 41,040			16	m.11
Anthony Santino		○	⊙		Computer Services	$ 19,319			16	m.11
Broadway Database		○	⊙		Payroll Processing	$ 16,367			16	m.11
ImageFIRST		○	⊙		Laundry Services	$ 140,423			19	3.b
Complete Waste Removal		○	⊙		Trash Removal	$ 26,632			22	6.f
Jesse`s Lawn Care & Snow Removal LLC		○	⊙		Lawn & Snow Removal	$ 21,761			22	6.f
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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).

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

Name of Facility	License No.	Report for Year Ended	Page of
Farmington Rehab Center, LLC d/b/a Amberv	2332	9/30/2016	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	91,394	91,394		
b. Heat	$	33,724	33,724		
c. Light & Power	$	107,387	107,387		
d. Water	$	62,845	62,845		
e. Equipment Lease (*Provide detail on page 6*)	$	4,122	4,122		
f. Other (*itemize*)	$	101,935	101,935		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	401,407	401,407		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	7,170	7,170		
b. Building & Building Improvements	$	54,440	54,440		
c. Non-Movable Equipment	$	4,804	4,804		
d. Movable Equipment	$	38,567	38,567		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	104,981	104,981		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$				
9. Rental payments on leased real property less real estate taxes included in item 10b	$	617,218	617,218		
10. Property Taxes					
a. Real estate taxes paid by owner	$	148,575	148,575		
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	870,774	870,774		

* 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)
Minor Equipment	$ 5,327		
Waste Disposal	$ 3,453		
Grounds Maintenance	$ -		
Equipment Rental	$ 15,377		
P/S Maintenance	$ 16,286		
Pest Control	$ 1,792		
Cable TV - Reclass from P/S Recreation	$ 6,986		
Internet - Reclass from P/S Recreation	$ 4,321		
Page 21			
CWPM	$ 26,632		
Jesse`s Lawn Care & Snow Removal LLC	$ 21,761		
Total Other Repairs and Maintenance	$ 101,935	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a Amberwoods of Farmington	2332	9/30/2016	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	93,259		93,259	20,066			7,068	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	3,000						102	
A-4. Subtotal								7,170
B. **Building and Building Improvements**								
1. Acquired prior to this report period	684,423		684,423	225,302			52,452	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	22,153		22,153				1,988	
B-4. Subtotal								54,440
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	43,879		43,879	24,035			4,804	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								4,804

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					732,175		732,175	659,770			37,503	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					21,295		21,295				1,064	
D-3. Subtotal												38,567
E. ***Total Depreciation***												104,981

Farmington Rehab Center, LLC d/b/a Amberwoods of Farmington
9/30/2016

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
4/17/2016	Sidewalk Replacement	$ 3,000	15	$ 102	
Total additions for Land Improvements		$ 3,000		$ 102	*
Deletions:					
Total deletions for Land Improvements		$ -		$ -	**

***Ties to Page 23, Line A3**
****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/13/2015	Heat Exchangers	$ 5,956	10	$ 600	
11/16/2015	Daikin Units Rooftop	$ 7,423	10	$ 682	
11/4/2015	Control Unit	$ 2,921	10	$ 264	
12/28/2015	Disposal	$ 2,843	7	$ 340	
4/4/2016	Accurate Commercials Fire Door	$ 3,010	15	$ 102	
Total additions for Building Improvements		$ 22,153		$ 1,988	*
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:					
Total additions for Non-Movable Equipment		$ -		$ -	*
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:					
11/20/2015	Mattresses	$ 2,039	5	$ 374	
5/16/2016	Dishwasher	$ 13,252	10	$ 550	
8/17/2016	Mattresses	2388	5	80	
9/9/2016	Hospital Beds	3616	5	60	
Total additions for Movable Equipment		$ 21,295		$ 1,064	*
Deletions:					
Total deletions for Movable Equipment		$ -		$ -	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Leasehold Improvement		$ -		$ -	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a Amberwoods of Farmi	2332	9/30/2016	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a	2332	9/30/2016	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ⊙ Yes ○ 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	07/07/08
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	130
6. Square Footage	39,341
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	12/30/11			
c. Interest Rate for the Cost Year	3.75%			
d. Term of Mortgage (number of years)	35			
e. Amount of Principal Borrowed	6,341,000			
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 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

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.

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

Name of Facility	License No.	Report for Year Ended	Page of
Farmington Rehab Center, LLC d/b/a	2332	9/30/2016	26 | 37

Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$				
Name of Lender	Rate				
Address of Lender 00					
2. Second Mortgage	$				
Name of Lender	Rate				
Address of Lender 00					
3. Third Mortgage	$				
Name of Lender	Rate				
Address of Lender 00					
4. Fourth Mortgage	$				
Name of Lender	Rate				
Address of Lender 00					
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)	$				

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Farmington Rehab Center, LLC d/	2332	9/30/2016	27 | 37

Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		$				
A. Item	Rate	Amount				
Lender						
Address of Lender 00						
2. Other (*Specify*)		$				
A. Item	Rate	Amount				
Lender						
Address of Lender 00						
B. Item	Rate	Amount				
Lender						
Address of Lender 00						
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)		$	23,072	23,072		
b. Insurance on Automobiles		$	1,178	1,178		
c. Insurance other than Property (as specified above)						
1. Umbrella (*Blanket Coverage*)		$	20,128	20,128		
2. Fire and Extended Coverage		$				
3. Other (*Specify*) Liability Insurance		$	59,885	59,885		
14d. ***Total Insurance Expenditures (14a + b + c)***		$	104,263	104,263		
15. ***Total All Expenditures (A-13 thru C-14)***		$	10,894,541	10,894,541		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Farmington Rehab Center, LLC d/b/a Amberwoods of Farming	2332	9/30/2016	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.	Pg 10	12.g	Occupational Therapy $	10,274	10,274		
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.	Pg 13	8.c	Resident Care Physicians ** $	22,986	22,986		
6.			Occupational Therapy $	163,715	163,715		
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $				
10.			Accounting & Legal $	13,111	13,111		
11.			Telephone $				
12.	Pg 15	1.h.2	Cellular Telephone $	2,908	2,908		
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) $	8,304	8,304		
18.	Pg 16	1.m.3	Unallowable Advertising * $	6,435	6,435		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	38,301	38,301		
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) $	266,034	266,034		

* 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)
Total Other Salaries Adjustment			$ -	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Fees Adjustments			$ -	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m.8.a	Chamber of Commerce	$ -		
16	m.13	-	$ -		
16	m.13	-	$ -		
16	m.13	Resident Items - Lost/Stolen	$ 657		
16	m.13	Late Fee/Finance Charge	$ 17,953		
16	m.13	Prior Year Expense	$ (4,493)		
16	m.13	Miscellaneous Expense	$ 766		
		-	$ 23,418		
Total Other A&G Adjustments			$ 38,301	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Farmington Rehab Center, LLC d/b/a Amberwoods of Farmi	2332	9/30/2016	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	266,034	266,034		
Page 20 - Resident Care Supplies***							
27.	Pg 20	5.a.2	Prescription Drugs $	326,819	326,819		
28.	Pg 20	5.d	Ambulance/Limousine $	1,460	1,460		
29.	Pg 20	5.f	X-rays, etc $	6,339	6,339		
30.	Pg 20	5.h	Laboratory $	22,029	22,029		
31.	Pg 20	5.c	Medical Supplies $	102,086	102,086		
32.	Pg 20	5.e.2	Oxygen (non emergency) $	23,866	23,866		
33.	Pg 20	5.c	Occupational Therapy $	19	19		
34.			Other - See Attached Schedule $				
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 $				
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)***		$	748,652	748,652		

*** 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.

Attachment Page 29

Farmington Rehab Center, LLC d/b/a Amberwoods of Farmington
9/30/2016

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5.c	-	$ -		
20	5.c	-	$ -		
		-	$ -		
Total Other Ancillary Costs			$ -	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	C.9	-	$ -		
22	C.9	-	$ -		
22	C.9	-	$ -		
		-	$ -		
Total Other Property Adjustments			$ -	$ -	$ -

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Adjustments			$ -	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a Am	2332	9/30/2016	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	10,367,633	10,367,633		
b. Medicaid Room and Board Contractual Allowance **	$	(4,203,694)	(4,203,694)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	694,741	694,741		
b. Medicare Room and Board Contractual Allowance **	$	197,543	197,543		
4. a. Private-Pay Residents and Other	$	4,460,015	4,460,015		
b. Private-Pay Room and Board Contractual Allowance **	$	(922,555)	(922,555)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	65,981	65,981		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(65,981)	(65,981)		
c. Prescription Drugs - Non-Medicare	$	233,678	233,678		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(193,348)	(193,348)		
2. a. Medical Supplies - Medicare	$	579	579		
b. Medical Supplies - Medicare Contractual Allowance **	$	(579)	(579)		
c. Medical Supplies - Non-Medicare	$	257	257		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(257)	(257)		
3. a. Physical Therapy - Medicare	$	205,640	205,640		
b. Physical Therapy - Medicare Contractual Allowance **	$	(160,440)	(160,440)		
c. Physical Therapy - Non-Medicare	$	138,414	138,414		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(114,957)	(114,957)		
4. a. Speech Therapy - Medicare	$	46,810	46,810		
b. Speech Therapy - Medicare Contractual Allowance **	$	(15,493)	(15,493)		
c. Speech Therapy - Non-Medicare	$	42,469	42,469		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(33,197)	(33,197)		
5. a. Occupational Therapy - Medicare	$	219,650	219,650		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(141,428)	(141,428)		
c. Occupational Therapy - Non-Medicare	$	166,156	166,156		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(138,582)	(138,582)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	41,466	41,466		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	10,890,521	10,890,521		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	43,170	43,170		
V. Total Other Revenue (1 thru 8)	$	43,170	43,170		
VI. Total All Revenue (III +V)	$	10,933,691	10,933,691		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Laboratory - MCR A	$ 38,527		
	IV Therapy - MCR A	$ 1,546		
	Radiology - MCR A	$ 8,318		
	-	$ -		
	-	$ -		
	Contractual Adj - Ancill - MCR A	$ (48,391)		
	-	$ -		
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Laboratory - INS	$ 590		
	Radiology - INS	$ 729		
	Laboratory - MCD	$ 2,121		
	Radiology - MCD	$ 259		
	IV Therapy - MCD	$ 4,419		
	IV Therapy - MHO	$ 587		
	Laboratory - MML	$ 1,447		
	Radiology - MML	$ 2,701		
	IV Therapy - MML	$ 1,054		
	IV Therapy - INS	$ 794		
	Labortory - VA	$ 39,999		
	-	$ -		
	-	$ -		
	-	$ -		
	Contractual Adj - Ancillaries - MCD	$ (6,799)		
	Contractual Adj - Ancill - INS	$ (1,341)		
	Contractual Adj- Ancill - MML	$ (3,608)		
	Contractual Adj - Ancill - MHO	$ (1,486)		
	Contractual Adj - Ancill - MDP	$ -		
	Contractual Adj -Ancillaries - VA	$ -		
	Contractual Adj - Ancill - HOS	$ -		
	-	$ -		
	-	$ -		
Total Other Resident Revenue		$ 41,466	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Total Interest Income			$ -	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Miscellaneous Income	$ 43,170		
	-	$ -		
	-	$ -		
	Reclass Private potion of Payment over Pending	$ -		
	-	$ -		
Total Other Revenue		$ 43,170	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a A	2332	9/30/2016	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 75,218
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 2,693,582
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 15,000
5. Prepaid Expenses				$ 70,947
a. Prepaid Insurance			70,947	
b.				
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 1,500
Deposits			1,500	
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,856,247
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost		96,259	$ 69,023
	Accum. Depreciation		(27,236) Net	
3. Buildings	*Historical Cost		706,576	$ 426,834
	Accum. Depreciation		(279,742) Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost		43,879	$ 15,040
	Accum. Depreciation		(28,839) Net	
6. Movable Equipment	*Historical Cost		753,470	$ 55,133
	Accum. Depreciation		(698,337) 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)				$ 566,030

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a A	2332	9/30/2016	32	37

Account				Amount
			Total Brought Forward:	$ 3,422,277
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
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			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$ 147,853
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 147,853
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 3,570,130

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a Amberw	2332	9/30/2016	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 1,083,819
	2. Notes Payable (*itemize*)				$ 773
	Medicaid Advances	773			
	3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
	Name of Lender	Purpose	Amount	Date Due	
	4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 261,737
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 25,601
	7. Medicare Final Settlement Payable				$
	8. Medicare Current Financing Payable				$
	9. Mortgage Payable (*Current Portion*)				$
	10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
	11. Accrued Income Taxes*				$
	12. Other Current Liabilities (*itemize*)				$ 306,570
	Resident Trust	40,005	Accrued Expenses		
	Accrued Provider Taxes	240,958			
	Accrued Property Taxes	25,497			
	Employee Deductions - Medical Insu	110			
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 1,678,500

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a Ambe	2332	9/30/2016	34	37

Account	Amount
Total Brought Forward:	1,678,500
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ 220,000

Name and Address of Lender	Amount	Loan Date
Due To Owner - MB	220,000	

4. Other Long-Term Liabilities (*itemize*)		$ 2,192,073
Due To Farmington Realty	1,373,299	
Due To Farmington - Rent	818,774	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 2,412,073
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 4,090,573

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a	2332	9/30/2016	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					$
4. Treasury Stock					$
5. Cumulated Earnings					$ (559,593)
6. Gain or Loss for Period	10/1/2015	thru	9/30/2016		$ 39,150
7. Total Net Worth					$ (520,443)
C. ***Total Reserves and Net Worth***					$ (520,443)
D. ***Total Liabilities, Reserves, and Net Worth***					$ 3,570,130

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a Ar	2332	9/30/2016	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015			$ (365,566)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 10,933,691
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 10,894,541
D.	Net Income or Deficit			$ 39,150
E.	Balance			$ (326,416)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
	Prior Year Adjustments	(194,027)		
F-3.	Total Additions			$ (194,027)
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose	Amount		
	3. Total Deductions			$
H.	***Balance at End of Period***	09/30/16		$ (520,443)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a	2332	9/30/2016	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision 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
Wonneberger & Morgan, LLC		2/13/2017

Printed Name of Preparer

Wonneberger Business Solutions

Addres Address	Phone Number
1781 Highland Avenue, Suite 207, Cheshire, CT 06410	(203) 250-2013