State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2015

Name of Facility (as licensed) Paradigm Healthcare Center of South Windsor, LLC		
Address (No. & Street, City, State, Zip Code) 1060 Main Street, South Windsor, CT 06074		
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 8/12/2016	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2349			07-5422

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	20470		

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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Paradigm Healthcare Center of South Windsor, LLC	2349	8/12/2016	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 Paradigm Healthcare Center of South Windsor, LLC [facility name], for the cost report period beginning October 1, 2015 and ending August 12, 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. **{a}**

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.

{a} SUBJECT TO DESK AUDIT REVIEW

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Scott Ziskin (President)			Printed Name (Owner) See page 3	
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
55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Paradigm Healthcare Center of South Windsor, LLC	Period Covered:		From 10/1/2015	To 8/12/2016
Address of Facility 1060 Main Street, South Windsor, CT 06074				
Report Prepared By Marcum LLP	Phone Number 203-781-9600		Date 11/16/2016	

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
860-289-7771	8/12/2016	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Paradigm Healthcare Center of South Windsor, LLC	1060 Main Street, South Windsor, CT 06074

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	2349			07-5422

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
		8/12/2016

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.:
Tracy Newport	1214

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
Paradigm Healthcare Center of South Windsor, LLC	2349	8/12/2016	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
Paradigm Healthcare Development, LLC	130 South Main Street, Thomaston, CT 06787	CT

Name of Partners/Members	Business Address	Title	% Owned
Charles D. Bizilj	130 South Main Street, Thomaston, CT 06787	Chief Medical Office	33.33
Scott L. Ziskin	130 South Main Street, Thomaston, CT 06787	President	33.33
Stephen LeGault	130 South Main Street, Thomaston, CT 06787	CEO	33.34

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Paradigm Healthcare Center of South Winds	2349	8/12/2016	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
N/A		

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
N/A			
Names of Stockholders Owning at Least 10% of Shares			
N/A			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Paradigm Healthcare Center of South Windsor, LL	2349	8/12/2016	3B	37

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

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Paradigm Healthcare Center of South Windsor, LLC	2349	8/12/2016	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	%**				
Paradigm Management, LLC	130 South Main Street, Thomaston, CT 06787	○	⊙		Management of HR, Finance, Clinical, Ops	Pg. 16 / Line m12	191,116	269,315
Paradigm Management, LLC	130 South Main Street, Thomaston, CT 06787	○	⊙		Corp Policy Worker Comp - allocated to eac	Pg. 15 / Line 1a1	203,944	203,944
Paradigm Management, LLC	130 South Main Street, Thomaston, CT 06787	○	⊙		Corp Policy Disability Insurance - billed sep	Pg. 15 / Line 1a2	3,690	3,690
Paradigm Management, LLC	130 South Main Street, Thomaston, CT 06787	○	⊙		Corp Policy Life Insurance - billed separatel	Pg. 15 / Line 1a6	1,630	1,630
Paradigm Management, LLC	130 South Main Street, Thomaston, CT 06787	○	⊙		Corporate Health/Dental Policy-ea entity bil	Pg. 15 / Line 1a5	652,895	652,895
Paradigm Healthcare Development, LLC	130 South Main Street, Thomaston, CT 06787	○	⊙		401k Plan - No employer contribution	N/A		
Paradigm Healthcare Development, LLC	130 South Main Street, Thomaston, CT 06787	○	⊙		Corp Work Capital Interest - allocation basis	Pg. 27 / Line 12D	59,680	59,680
Paradigm Healthcare Development, LLC	130 South Main Street, Thomaston, CT 06787	○	⊙		Liability Insurance (PL/GL)	Pg. 27 / Line 14c3	57,801	57,801
Paradigm Healthcare Development, LLC	130 South Main Street, Thomaston, CT 06787	○	⊙		Property Insurance - allocated to each entity	Pg. 27 / Line 14a	61,759	61,759

* 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

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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (*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.

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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
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
						Total ***	

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

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
** Attach copies of newly acquired leases.
*** Amount should agree to Page 22, Line 6e.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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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 Marcum LLP	555 Long Wharf Drive, New Haven, CT 06511
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Audit, tax preparation, cost report and reimbursement advisory services.	$ 24,870
2		$
3		$
4		$
	Charge for Services Provided	$ 24,870

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

⊙ Yes ○ No — Page 15, Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 State Marshall	N/A
2 State of CT Treasurer	N/A
3 American Arbitration	866-293-4053
4	
5	

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

1 N/A
2 N/A
3 950 Warren Avenue, East Providence, RI
4
5

Services Provided by This Firm (*describe fully*)

1	COP/COE Application (Disallowed)	$ 150
2	COP/COE Application (Disallowed)	$ 800
3	Administrative Fee (Disallowed)	$ 275
4		$
5		$
	Charge for Services Provided	$ 1,225

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

⊙ Yes ○ No — Page 15, Line 1e

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Schedule of Resident Statistics

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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	100	100			100	100			100	100		
B. On last day of THIS report period		N/A			100	100				N/A		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	70	70			70	70			38	38		
B. As of midnight of THIS report period		N/A			38	38				N/A		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,317	1,317			1,268	1,268			49	49		
B. Medicaid (Conn.)	15,695	15,695			14,938	14,938			757	757		
C. Medicaid (other states)												
D. Private Pay	790	790			724	724			66	66		
E. State SSI for RCH												
F. Other (Specify) Managed Care	138	138			127	127			11	11		
G. Total Care Days During Period (3A thru F)	17,940	17,940			17,057	17,057			883	883		
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)**	17,940	17,940			17,057	17,057			883	883		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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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)	
8/12/2016	X			100									Closed

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	N/A	N/A		N/A				
Per Diem Rate								
a. One bed rm.	Various	Various		430.50				
b. Two bed rms.	Various	Various		388.50				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	6,023	6,023		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	750	750		
2. Restorative Treatments				
C. Other	2,909	2,909		
D. ***Total Physical Therapy Treatments***	9,682	9,682		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	337	337		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1	1		
2. Restorative Treatments				
C. Other	169	169		
D. ***Total Speech Therapy Treatments***	507	507		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	5,330	5,330		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	746	746		
2. Restorative Treatments				
C. Other	2,737	2,737		
D. ***Total Occupational Therapy Treatments***	8,813	8,813		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Paradigm Healthcare Center of South Windsor, LLC	2349	8/12/2016	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

Item	Total Cost and Hours					
	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)	122,657	2,177				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	85,862	4,434				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	279,975	17,956				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	108,908	8,156				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	72,871	3,494				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	65,216	4,669				
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	96,005	1,808				
b. RN						
1. Direct Care	335,108	10,493				
2. Administrative**	170,830	4,924				
c. LPN						
1. Direct Care	594,848	20,603				
2. Administrative**						
d. Aides and Attendants	769,302	47,711				
e. Physical Therapists	201,238	5,971				
f. Speech Therapists	5,998	119				
g. Occupational Therapists	107,589	3,094				
h. Recreation Workers	54,221	2,337				
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	42,959	1,566				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	24,437	1,502				
A-13. Total Salary Expenditures	3,138,024	141,015				

* 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**
Medical Records	#VALUE!	1,502				
Total	#VALUE!	1,502	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
	#VALUE!					
Medical Records Contract Services	$ 1,100	44				
Total	#VALUE!	44	$ -	-	$ -	-

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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
Paradigm Healthcare Center of South Windsor, LLC	2349	8/12/2016	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* **										
Tracy Newport	122,657			Non-discrim.	Administrator	2,177	A2	N/A		
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
Paradigm Healthcare Center of South Windsor, LLC	2349	8/12/2016	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	3,000	60				
3. Pharmacist	3,300	60				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	21,078	353				
b. Other						
6. Social Worker	5,145	105				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	35,077	218				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	2,603	43				
b. Other						
10. Occupational Therapist						
a. Resident Care	20,826	347				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	21,880	608				
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	1,100	44				
B-13 Total Fees Paid in Lieu of Salaries	114,009	1,838				

* 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
Paradigm Healthcare Center of South Windsor, LLC	2349	8/12/2016	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
LTC Dental LLP, 174 Scott Road, Prospect, CT 06712	Dentist	○	⊙	
Woodmark Pharmacy of Massachusetts, 69 Hickory Dr., Waltham, MA 02451	Pharmacist, Medical Records	○	⊙	
Omnicare of CT, PO Box 715268, Columbus, OH 43271-5268	Pharmacist	○	⊙	
Synergy Therapy Solutions, 44 Bluff Road, South Glastonbury, CT 06073	PT, OT and ST Resident Care	⊙	○	Wife of Scott Ziskin
National Staffing Solutions, Inc., PO Box 9310, Winterhaven, FL 33883	PT Resident Care	○	⊙	
Social Work Staffing Solutions & Services, Inc., PO Box 1354, Belchertown, MA 01007	Social Worker	○	⊙	
Mohammed Memon, MD, 415 Silas Deane Highway, Suite 210, Wethersfield, CT 06109	Medical Director	○	⊙	
Lisa M Meadows, 11 Fox Hill Drive, Stafford Springs, CT 06076	MDS Consultant	○	⊙	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

* 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
Paradigm Healthcare Center of South Windsor, L	2349	8/12/2016	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	203,944	203,944		
2. Disability Insurance	$	3,690	3,690		
3. Unemployment Insurance	$	83,612	83,612		
4. Social Security (F.I.C.A.)	$	246,428	246,428		
5. Health Insurance	$	652,895	652,895		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	1,630	1,630		
7. Pensions (Non-Discriminatory)	$	56,297	56,297		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	7,943	7,943		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	69,229	69,229		
d. Accounting and Auditing	$	24,870	24,870		
e. Legal (*Services should be fully described on Page 7)*	$	1,225	1,225		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	3,419	3,419		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	(2,117)	(2,117)		
2. Cellular Phones	$				
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	350,475	350,475		
Subtotal	$	1,703,540	1,703,540		

* 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)
	#VALUE!		
Employee Physicials	$ 246		
Union Training Fund	$ 7,697		
Total	#VALUE!	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
	#VALUE!		
Total	#VALUE!	$ -	$ -

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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
Paradigm Healthcare Center of South Windsor, LLC	2349	8/12/2016	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,703,540	1,703,540		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	1,717	1,717		
4. Employee Travel	$	4,587	4,587		
5. Education Expenses Related to Seminars and Conventions	$	200	200		
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*)	$	87	87		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	(1)	(1)		
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	$	1,320	1,320		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	6,255	6,255		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions***	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	72,266	72,266		
12. Administrative Management Services**	$	191,116	191,116		
13. Other (*Specify*)	$	14,325	14,325		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	1,995,412	1,995,412		

* 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)
	#VALUE!		
Total Other Travel and Entertainment	#VALUE!	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional Advertising	#VALUE!		
Total Other Advertising	#VALUE!	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
	#VALUE!		
Dues & Subscriptions	$ 6,255		
Total Dues	#VALUE!	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
	#VALUE!		
Total Contributions	#VALUE!	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
	#VALUE!		
Bank Charges	$ 12,580		
Printing	$ 317		
Nusiness License Fees	$ 634		
Licenses & Permits	$ 794		
Total Other Administrative and General	#VALUE!	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Paradigm Healthcare Center of South Wir	2349	8/12/2016	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 #
Paradigm Management, LLC	191,116	Management of HR, Finance, Clinical, Operations	Pg. 16 / Line M12

*** 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
Paradigm Healthcare Center of South Windsor, LLC	2349	8/12/2016	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	107,662	107,662		
2. Non-Food Supplies	$	7,595	7,595		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	8,296	8,296		
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	123,553	123,553		

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

H.	Is cost of employee meals included in 2E?	○ 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
Paradigm Healthcare Center of South Windsor, LLC	2349	8/12/2016	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. $	6,691	6,691		
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. $				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	6,691	6,691		

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
Paradigm Healthcare Center of South Windsor,	2349	8/12/2016	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.	$	18,997	18,997		
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)		$	18,997	18,997		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Pharmacy		$	48,560	48,560		
b. Medicine Cabinet Drugs		$	26,434	26,434		
c. Medical and Therapeutic Supplies		$				
d. Ambulance/Limousine***		$	6,625	6,625		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	7,822	7,822		
f. X-rays and Related Radiological Procedures***		$	568	568		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	759	759		
i. Recreation		$	23,903	23,903		
j. Other (Specify)**** See Attached Schedule		$	55,593	55,593		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	170,264	170,264		

* 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)
	#VALUE!		
PPD Medical Supplies	$ 22,908		
Diapers/Disposables	$ 7,156		
Tube Feeding	$ 171		
I.V. Therapy	$ 1,750		
Med Equipment Rental - Oxygen	$ 14,945		
Patient Expense	$ 5,847		
Patient Consolidated Billing	$ 1,835		
Physical Therapy Supplies	$ 981		
Total Other Resident Care	#VALUE!	$ -	$ -

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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
Paradigm Healthcare Center of South Windsor, LLC	2349	8/12/2016	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
MDI Achieve, Inc.	Minneapolis, MN	○	⊙	N/A	Software Support	12,224			16	m11
Wescom Solutions Inc.	Minneapolis, MN	○	⊙	N/A	Software Solutions	25,696			16	m11
Joslin Concrete and Snow Lowing, LLC	Bridgeport, CT	○	⊙	N/A	Snow Removal	17,278			22	6f
USA Hauling & Recycling, Inc.	16 Shoham Rd., East Windsor, CT 06088	○	⊙	N/A	Trash Removal	11,935			22	6f
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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
Paradigm Healthcare Center of South Windsor	2349	8/12/2016	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	23,844	23,844		
b. Heat	$	30,854	30,854		
c. Light & Power	$	64,581	64,581		
d. Water	$	11,920	11,920		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	50,252	50,252		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	181,451	181,451		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$				
d. Movable Equipment	$	11,039	11,039		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	11,039	11,039		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	43,760	43,760		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	43,760	43,760		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	90,956	90,956		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	72,349	72,349		
c. Personal property taxes	$	917	917		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	219,021	219,021		

* 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)
	#VALUE!		
Contract Services	$ 16,263		
Pest Control	$ 532		
Groundskeeping/snow removal	$ 17,278		
Trash removal	$ 16,179		
Total Other Repairs and Maintenance	#VALUE!	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Paradigm Healthcare Center of South Windsor, LLC	2349	8/12/2016	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								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	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			Var	Var	53,333		53,333	19,949	S/L	Var	10,887	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			Var	Var	1,516		1,516		S/L	10	152	
D-3. Subtotal												11,039
E. ***Total Depreciation***												11,039

Paradigm Healthcare Center of South Windsor, LLC
8/12/2016

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Land Improvements		$ -		$ -	*
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:					
Total additions for Building Improvements		$ -		$ -	*
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:					
1/20/2016	Snow Blower	$ 690	5	$ 69	
1/31/2016	Software	$ 826	5	$ 83	
Total additions for Movable Equipment		$ 1,516		$ 152	*
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:					
6/23/2016	ACV-Blown Terminal in Control Module	$ 1,480	10	$ 74	
Total additions for Leasehold Improvement		$ 1,480		$ 74	*
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
Paradigm Healthcare Center of South Windsor, LLC	2349	8/12/2016	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	Var	Var	Various	538,452	115,136	S/L	Var	43,686	
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)	Var	Var	5	1,480		S/L	Var	74	
C-4. Subtotal									43,760
D. ***Total Amortization***									43,760

* 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
Paradigm Healthcare Center of South	2349	8/12/2016	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	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	100
6. Square Footage	
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)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part 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
Independence Senior Holdings LLC, 13 Freedom Drive, Lakewood, NJ 08707	Building and all Assets	12/30/11	15 Years	90,956

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
Paradigm Healthcare Center of South	2349	8/12/2016	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				
2. Second Mortgage $				
Name of Lender / Rate				
Address of Lender				
3. Third Mortgage $				
Name of Lender / Rate				
Address of Lender				
4. Fourth Mortgage $				
Name of Lender / Rate				
Address of Lender				
B. CHEFA Loan Information				
1. Original Loan Amount $				
2. Loan Origination Date				
3. Interest Rate %				
4. Term				
5. CHEFA Interest Expense				
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $				

(*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
Paradigm Healthcare Center of Sou	2349	8/12/2016	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				
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*) $	61,759	61,759		
Working Capital $59,680 / Other $2,079				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	61,759	61,759		
14. Insurance				
a. Insurance on Property (buildings only) $	8,803	8,803		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $				
2. Fire and Extended Coverage $				
3. Other (*Specify*) $	57,801	57,801		
Insurance - Non Property				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	66,604	66,604		
15. ***Total All Expenditures (A-13 thru C-14)*** $	6,095,785	6,095,785		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Paradigm Healthcare Center of South Windsor, LLC	2349	8/12/2016	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.	10	A12g	Occupational Therapy	$	107,589	107,589		
4.			Other - See attached Schedule	$				
Page 13 - Professional Fees								
5.			Resident Care Physicians **	$				
6.	13	B10a	Occupational Therapy	$	20,826	20,826		
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.	15	1c	Bad Debts	$	69,229	69,229		
10.	15	1e	Accounting & Legal	$	1,225	1,225		
11.	15	h1	Telephone	$	(2,117)	(2,117)		
12.			Cellular Telephone	$				
13.			Life insurance premiums on the life of Owners, Partners, Operators	$				
14.			Gifts, flowers and coffee shops	$	717	717		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	$				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	$				
17.			Automobile Expense (e.g. personal use)	$				
18.	16	m3	Unallowable Advertising *	$	(1)	(1)		
19.			Income Tax / Corporate Business Tax	$				
20.			Fund Raising / Contributions	$				
21.	16	m12	Unallowable Management Fees	$	49,786	49,786		
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	2,210	2,210		
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)	$	249,464	249,464		

* 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	m13	Bank Charges	$ 782		
16	m13	Nursing License Renewal	$ 634		
16	m13	Non Allowable License Fees	$ 794		
Total Other A&G Adjustments			$ 2,210	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Paradigm Healthcare Center of South Windsor, LLC	2349	8/12/2016	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	249,464	249,464		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $	48,560	48,560		
28.	20	5d	Ambulance/Limousine $	6,625	6,625		
29.	20	5f	X-rays, etc $	568	568		
30.	20	5h	Laboratory $	759	759		
31.			Medical Supplies $				
32.	20	500	Oxygen (non emergency) $	7,822	7,822		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	40,211	40,211		
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.	30	IV8	Vending Machine Revenue $	127	127		
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 $	2,079	2,079		
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)*** $	356,215	356,215		

*** 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

Paradigm Healthcare Center of South Windsor, LLC
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Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Tube Feeding	$ 171		
20	5j	I.V. Therapy	$ 1,750		
20	5j	Med Equipment Rental - Oxygen	$ 14,945		
20	5j	Patient Expense	$ 5,847		
20	5j	Patient Consolidated Billing	$ 1,835		
20	5i	Cable TV Disallowance	$ 15,663		
Total Other Ancillary Costs			$ 40,211	$ -	$ -

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)
Total Other Property Adjustments			$ -	$ -	$ -

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	12d	Interest - Other	$ 2,079		
Total Other Adjustments			$ 2,079	$ -	$ -

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
Paradigm Healthcare Center of South Wir	2349	8/12/2016	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	6,944,460	6,944,460		
b. Medicaid Room and Board Contractual Allowance **	$	(2,646,984)	(2,646,984)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	501,566	501,566		
b. Medicare Room and Board Contractual Allowance **	$	169,937	169,937		
4. a. Private-Pay Residents and Other	$	389,614	389,614		
b. Private-Pay Room and Board Contractual Allowance **	$	(27,242)	(27,242)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	35,156	35,156		
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$	8,853	8,853		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$				
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	314,080	314,080		
b. Physical Therapy - Medicare Contractual Allowance **	$				
c. Physical Therapy - Non-Medicare	$	45,124	45,124		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	46,442	46,442		
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$	2,707	2,707		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	307,467	307,467		
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$	36,196	36,196		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	(338,907)	(338,907)		
b. Other *(Specify)* - Non-Medicare	$	(94,145)	(94,145)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	5,694,324	5,694,324		
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)*	$	79	79		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	61,127	61,127		
V. Total Other Revenue (1 thru 8)	$	61,206	61,206		
VI. Total All Revenue (III +V)	$	5,755,530	5,755,530		

* *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)
		#VALUE!		
30 II 6a	Lab - MA	$ 720		
30 II 6a	Oxygen - MA	$ 865		
30 II 6a	Cont. Allow. - MA	$ (261,484)		
30 II 6a	IV Therapy - M MA	$ 344		
30 II 6a	Cont. Allow. - M MA	$ (344)		
30 II 6a	Contr. Allow. - Medicare B	$ (72,959)		
30 II 6a	Sequester Med B	$ (6,049)		
Total Other Resident Revenue - Medicare		#VALUE!	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
		#VALUE!		
30 II 6b	Lab - MD	$ 14		
30 II 6b	IV Therapy - MD	$ 210		
30 II 6b	Oxygen - MD	$ 6,301		
30 II 6b	Cont. Allow. - MD	$ (70,149)		
30 II 6b	Cont. Allow. - MA	$ (1,265)		
30 II 6b	Oxygen - Hospice	$ 64		
30 II 6b	Cont. Allow. - Hospice	$ (258)		
30 II 6b	Lab - Managed Care	$ 25		
30 II 6b	IV Therapy - Managed Care	$ 1,812		
30 II 6b	Cont. Allow. - Managed Care	$ (30,899)		
Total Other Resident Revenue		#VALUE!	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
			#VALUE!		
30 IV 5	Interest Income		$ 79		
Total Interest Income			#VALUE!	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
		#VALUE!		
30 IV 8	Vending Income	$ 127		
30 IV 8	Medicaid/Medicare Recoupment	$ 61,000		
Total Other Revenue		#VALUE!	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Paradigm Healthcare Center of South W	2349	8/12/2016	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 6,230
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 330,427
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$
a.				
b.				
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 186,532
Due to/from Seller/Receiver		13,310		
Due to/from Paradigm HC Development/Mgmt		241,611		
Due to/from NH, Pros, Torr, Wtby, WH		61,468		
Due to/from Medicaid/Deposits/Donations		(129,857)		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 523,189
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	539,932		$ 381,036
	Accum. Depreciation	158,896	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 163,029
CIP		581		
F/S vs C/R NBV		162,448		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 544,065

* 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
Paradigm Healthcare Center of South W	2349	8/12/2016	32	37

Account				Amount
		Total Brought Forward:	$	1,067,254
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 54,849			
	Accum. Depreciation 30,988	Net	$	23,861
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation	Net	$	
7. Minor Equipment-Not Depreciable			$	
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)			$	23,861
D. Investment and Other Assets				
1. Deferred Deposits			$	
2. Escrow Deposits			$	
3. Organization Expense	*Historical Cost			
	Accum. Depreciation	Net	$	
4. Goodwill (Purchased Only)			$	
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*)			$	(465,725)
Webster Advances	(465,723)			
Rounding	(2)			
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)			$	(465,725)
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$	625,390

* 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
Paradigm Healthcare Center of South Windsor	2349	8/12/2016	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
1.	Trade Accounts Payable				$ 1,458,822
2.	Notes Payable (*itemize*)				$ 176,607
	Note Payable	176,607			
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*)				$ 5,429
5.	Accrued Payroll (*Owners and/or Stockholders only*)				$
6.	Accrued Payroll Taxes Payable				$
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*)				$ 632,002
	Accrued Provider Tax	174,718			
	Union Dues Withholdings	1,074			
	Rent Accrual	490,742			
	Patient Refund	(34,532)			
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 2,272,860

* 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
Paradigm Healthcare Center of South Wind	2349	8/12/2016	34	37

Account	Amount
Total Brought Forward:	2,272,860
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*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 2,272,860

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

Name of Facility	License No.	Report for Year Ended	Page	of
Paradigm Healthcare Center of South	2349	8/12/2016	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	$ (1,359,853)
	6. Gain or Loss for Period 10/1/2015 thru 8/12/2016	$ (287,617)
	7. Total Net Worth	$ (1,647,470)
C.	***Total Reserves and Net Worth***	$ (1,647,470)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 625,390

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Paradigm Healthcare Center of South Wi	2349	8/12/2016	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015			$ (1,359,853)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 5,755,530
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 6,043,147
D.	Net Income or Deficit			$ (287,617)
E.	Balance			$ (1,647,470)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Total Expense per Pg. 27 $6,095,785			
	F/S vs C/R Depreciation (52,637)			
	Rounding (1)			
	Total F/S Expenses $6,043,149			
	2. Other (*itemize*)			
F-3.	Total Additions			$
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***	08/12/16		$ (1,647,470)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Paradigm Healthcare Center of South	2349	8/12/2016	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

Printed Name of Preparer	
Matthew S. Bavolack	
Addres Address	Phone Number
555 Long Wharf Drive, New Haven, CT 06511	203-781-9600

Subject to the attached accountants' consulting report