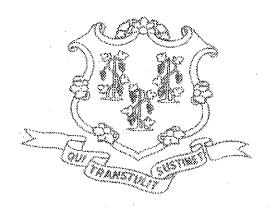
### **State of Connecticut**



### Annual Report of Long-Term Care Facility Cost Year 2017

Name of Facility (as l	icensed)	· · · · · · · · · · · · · · · · · · ·				***************************************		•
Chelsea Place Care C	enter, LLC							
Address (No. & Stree	et, City, State, Z	ip Code)						
25 Lorraine Street, H.	artford, CT 061	05						
Type of Facility								
Chronic and C Nursing Home			Rest Home wit Supervision on (RHNS)	_		NurseFac	-Aids	s
Report for Year Begin	nning		Report for Yea	r Ending				
10/1/2016			9/30/2017					
License Numbers:		CCNH 2220-C	RHNS	Nı	urseFac-Aic	ls	Me	dicare Provider 07-5299
		2220						, c <u>z</u> ,
has realizable for the first of								
Medicaid Provider N	umbers:	C0 9 <b>7</b> 61	CNH	RI	INS		IC	F-IID
For Department Use	e Only							
Sequence Number	Signed and	Date	Sequence N	lumber	Signed	ınd Notari	zad	Date Received
Assigned	Notarized	Received	Assign	ed	Signed	ma notan	Zeu	Date Received

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### **General Information**

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Chelsea Place Care Center, LLC	2220-C	9/30/2017	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 Chelsea Place Care Center, LLC [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, 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) Judy Konow			Printed Name (Owner) Chris Wright	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires
Address of Notary Public				/ /

(Notary Seal)

### State of Connecticut **Department of Social Services**

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	tm	ent		Page	of
				1A	37
Name of Facility		Period Cov	ered:	From	То
Chelsea Place Care Center, LLC				10/1/2016	9/30/2017
Address of Facility					
25 Lorraine Street, Hartford, CT 06105				1	
Report Prepared By		Phone Nun		Date	
iCare Management, LLC		860-570-2	L40	2/15/2017	
Item		Total	CCNH	RHNS	NurseFac- Aids
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.

### General Information and Questionnaire Type of Facility - Organization Structure

	_							
		Pho	ne No. of Fac	ility	Report for Ye	ar Ended	Page	of
		860	-233-8241		9/30/2017		2	37
Name of Facility (as shown on license)			Address (No	o. & S	Street, City, Sto	ite, Zip)	·	
Chelsea Place Care Center, LLC			25 Lorraine	Stree	et, Hartford, CT	06105		
CCN	ΙΗ		RHNS	]	NurseFac-Aids		Medicare I	Provider No.
License Numbers: 2220-C				AID	S		07-5299	
Type of Facility (Check appropriate box(es))								
Chronic and Convalescent	1 4		t Home with I		~ Iv/t	NurseFac	-Aids	
Nursing Home only (CCNH)		Sup	ervision only	(RHI	NS)			
Type of Ownership (Check appropriate box)								
O Proprietorship • LLC O Partnersh	nip	0	Profit Corp.	0	Non-Profit Cor	р. О	Government	O Trust
				Date	e Opened	Date Clo	sed	
If this facility opened or closed during report year pro	ovide:							
							,	
Has there been any change in ownership								
or operation during this report year?		0	Yes	<u> </u>	No	If "Yes,"	explain full	у,
A 3								
Administrator  Name of Administrator					Nursing H	ama l		
					Administrat		1735	
Judy Konow					License 1		1733	
Other Operators/Owners who are assistant administr	atore (	/fi:11	or part time)	of thi		10		
Name	ators	(IUII	or part time,	OI tab	License 1	No ·		
ranc					Diodigo 1			
								<del> · .,,</del>

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### General Information and Questionnaire Partners/Members

Name of Facility Chelsea Place Care Center, LL	.C	License No. 2220-C	Report for Y 9/30/2017	ear Ended	Page of 3 37
Legal Name of Part Chelsea Place Care Center, LL	mership/LLC	Business 25 Lorraine Str CT 06105	Address		or Town(s) in Legistered
		C1 06103			<del></del>
Name of Partners/Members	Business A	ddress	,	Title	% Owned
V. Robert Salazar	2500 18th Street, Suite CO 80211	200, Denver,	Member		31.3
David Sebbag	245 South Benton Stre Lakewood, CO 80226	et, Suite 100,	Member		21.4
Ari Krausz	245 South Benton Stre Lakewood, CO 80226	et, Suite 100,	Member		21.3
Solomon Melamed	245 South Benton Stre Lakewood, CO 80226	et, Suite 100,	Member		1
Christopher Wright	341 Bidwell Street, Ma 06040	anchester, Ct	Member		5
Premier First Investors	245 S. Benton Street, I 80226	Lakewood, CO	Member		10
Global World Investors	245 S. Benton Street, I 80226	Lakewood, CO	Member		10
		- 11			

### General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year	r Ended	Page of
Chelsea Place Care Center, LLC	2220-C	9/30/2017	***************************************	3A 37
If this facility is owned or operated as a corpo	ration, provide th	ne following inforn	nation:	
Legal Name of Corporation		ness Address		nich Incorporated
				MH. 1914 00000
Name of Directors, Officers	Busir	ness Address	Title	No. Shares Held by Each
	:			
Names of Stockholders Owning at Least 10% of Shares				

### General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Chelsea Place Care Center, LLC	2220-C	9/30/2017	3B	37
If this facility is owned or operated as an individu		provide the following informa	ation.	
Ow	ner(s) of Facility			
	VI I I I I I I I I I I I I I I I I I I		A STATE OF THE STA	
			AVANA	·
		A. A	Semile See	
			CARREST CONTRACTOR CON	***************************************
			DESCRIPTION OF THE PROPERTY OF	<del></del>
				No control of the con
			<del></del>	<del></del>
			<del></del>	<del> </del>

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

Related Parties\*

Chelsea Place Care Center, LLC	enter, LLC	2220-C	Ų	9/3/2017		4	3/
		-			Indicate When		
Name of Related	Business	-{\$1 & 82 H	vades ses to Non- arties	Description of Goods/Services	Costs are Included in Annual Report	Cost	Actual Cost to the Related Party
Bidwell Care Center,	ıω	T SS TAG		nonioni	rage # / Luic #	TO TO CONT	S. I.
ПС	CT 06040			Shared Employees		1	1
Chelsea Place Care Center, LLC	25 Lorraine St. Hartford, CT 06105			Shared Employees	r	ı	•
Chestnut Point Care	171 Main St. East Windsor, CT 06088			Laundry Services	19 3		•
Chestnut Point Care Center, LLC	171 Main St. East Windsor, CT 06088			Shared Employees	1	1	-
Farmington Care Center 11 C	20 Scott Swamp Rd. Farminaton, CT 06032			Bank Fees	M 91	ı	,
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032			Shared Employees		7,429	(7,429)
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088			Laundry Services	19 3		•
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088			Shared Employees	,	1,503	(1,503)
Meriden Care Center, LLC (Silver Springs)	33 Roy St. Meriden, CT 06450			Chared Fundanese		3 638	(3 938)
Trinity Hill Care	151 Hillside Ave. Hartford, CT 06406		ļ	Shared Employees	,	21.704	(21,704)
Westside Care	15 8			Shared Employees	,		
Wintonbury Care Center, LLC	140 Park Ave. Bloomfield, CT 06002			Shared Employees		5,922	(5,922)
Secure Care Center	60 West Street, Rocky Hill, CT 06067			Shared Employees		15,540	(15,540)
Touchpoints at Homecare LLC	1838 Silas Deane Hwy, Rocky Hill. CT 06067			Shared Employees	1		•
Touchpoints therapy	171 Main St. East Windsor, CT 06088			OT/PT/ST	13 5,8,10	425,369	(425,369)
Bidwell Realty, LLC	I~ 0			Building Lease & Rent	22,22,27 10,9,14	2,090,268	(2,090,268)
iCare Management, LLC	341 Bidwell St. Manchester, CT 06040			Postage & Legal	16, 15 M.E	27,306	(27,306)
iCare Health	341 Bidwell St. Manchester,			Shared EEs not part of memt aemt	1	188.199	(188.199)
-	2		<u>.</u>	Management Services, Direct	20 5j	265,594	(265,594)
1				Management Services, Indirect	20 5j	35,965	(35,965)
3				Management Services, Administrative	s 16 M12	616,050	(616,050
-	•			-	-		1
	1		_	1 1	1		
							,
				1	-		
( )							
All Care Centers, memt		_					

<sup>\*</sup> Use additional sheets if necessary.

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

### General Information and Questionnaire Basis for Allocation of Costs

Name of Facility	License No	•	Report for Year Ended	Page of
Chelsea Place Care Center, LLC	2220-C		9/30/2017	5 37
If the facility is licensed as CDH and/or RCH or	r provides A	IDS or TBI	services with special Medica	id rates, costs
must be allocated to CCNH and RHNS as follow	ws:			
Item			Method of Allocation	n
Dietary		Number of	meals served to residents	
Laundry		Number of	pounds processed	
Housekeeping		Number of	square feet serviced	
		Number of	hours of routine care provide	d by EACH
Nursing		employee c	lassification, i.e., Director (or	: Charge Nurse),
		Registered	Nurses, Licensed Practical N	urses, Aides and
		Attendants		
Direct Resident Care Consultants		Number of	hours of resident care provid	ed by EACH
		specialist (	See listing page 13)	
Maintenance and operation of plant		Square feet		
Property costs (depreciation)		Square feet	-	
Employee health and welfare	Marie 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Gross salaı		
Management services			e cost center involved	
All other General Administrative expenses		Total of Di	rect and Allocated Costs	
The preparer of this report must answer the foll-	owing questi	ons applica	ble to the cost information pro	ovided.
1. In the preparation of this Report, were all	O 1/		If "No," explain fully why st	ich allocation was
costs allocated as required?	• Yes	O No	not made.	
2. Explain the allocation of related company ex	penses and a	ttach copy	of appropriate supporting dat	a.
	<u> </u>			
3. Did the Facility appropriately allocate and so	elf-disallow o	direct and in	direct costs to non-nursing ho	ome cost centers?
(e.g., Assisted Living, Home Health, Outpati				
(-,8.,,			If "No," explain fully why su	uch allocation was
	Yes	O No	not made.	ion anocation was
			not maue.	

Annual Report of Long-Term Care Facility State of Connecticut CSP-6 Rev. 9/2002

### General Information and Questionnaire Leases (Excluding Real Property)

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

should not be included in these amounts.							
Name of Facility			License No.	Report for Year Ended	ear Ended		Page of
Chelsea Place Care Center, LLC			2220-C	9/30/2017			6 37
	Related * to	d * to					
	Owners,	ers,					· - •
	Operators,	itors,				Annual	
	Officers	cers		Date of	Term of	Amount	Amount
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	of Lease	Claimed
Accelerated Care Plus Corp. 48.50 Jonle Street Suite A-1 Reno.	0	0	Omnistim Electrotherapy and Omnisound Therapeutic Ultrasound Equipment	02/18/10	l yr with automatic	15,972	15,972
MS-100,	0	0	Time Clocks and Payroll Punch Equip	06/01/10	60 Months	9,258	9,258
GE Capital C/O Ricoh USA, P.O.Box 41564, Philadelphai. PA 19101	0	0	Copier	03/05/14	48 months	10,252	10,252
Pitney Bowes P.O. Box 856460	0	0	Postage Machine	07/29/13	1 yr with automatic	969	969
CIT Technology Financial Servies, PO Box 93000, Chicago, IL 60673	0	0	Copier	08/29/14		6,686	6,129
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
Is a Mileage I og Book Maintained for All Leased Vehicles?	eased Ve	hicles ?	O Yes	0	O No	Total ***	42,308

Is a Mileage Log Book Maintained for All Leased Vehicles?

<sup>\*</sup> Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

<sup>\*\*</sup> Attach copies of newly acquired leases.

<sup>\*\*\*</sup> Amount should agree to Page 22, Line 6e.

### General Information and Questionnaire Accounting Basis

Name of Facility	License No.	Report for Year Ended		· .	of
Chelsea Place Care Center, LLC	2220-C	9/30/2017		7	37
The records of this facility for the	period covered by this rep	oort were maintained on the following basis:			
	Modified Cash				
Is the accounting basis for this					
	Yes	If "No," explain.			
previous period? O	No				
Independent Accounting Firm					
Name of Accounting Firm		Address (No. & Street, City, State, Zip Co	,	0.6100	
1 O'Connor, Davies LLP		100 Great Meadow Road, Ste 401, W	ethersheld, CT	06109	
3					
Services Provided by This Firm (d	lescribe fully)				
1 Taxes, financial statements, accounting	ng support	W-000 - V-000	\$	4,303	
2			\$	·	
3			\$		-
4			\$		
		A A A A A A A A A A A A A A A A A A A	Charge for	Services Provid	ded
			\$	4,303	
Are These Charges Reflected in the Expen-	diture Portion of This Report?	If Yes, Specify Expense Classification and Line No.		1,500	
O Yes O No	15D	·· ····			
Legal Services Information					
Name of Legal Firm or Independen	nt Attorney		Telephone	Number	
1 iCare Health Management, LI	LC		860-570-21	140	
2 Starble and Harris			860-678-77	775	
3 Durant Nichols / Robinson &			860-275-82	200	
		ation, Murtha Cullina, Jackson Lewis))			
5 Starble and Harris, iCare Heal			<u>   860-678-71</u>	775 & 860-570	-2140
Address (No. & Street, City, State					
<ol> <li>341 Bidwell Street, Manchest</li> <li>32 Main Street, Avon, CT</li> </ol>	ter C1				
2 32 Main Street, Avon, CT 3 280 Trumbull St, Hartford, C	Т				
4	1				
5 32 Main Street, Avon, CT &	341 Bidwell Street, Man	chester CT			
Services Provided by This Firm (d					
1 Lease and contract issues, general leg	gal advice, Labor Law		\$	25,112	
2 Lease and contract issues, general leg	gal advice, union funds advice		\$	4,756	
3 Employment law, arbitrations, contra	act negotiations		\$	3,349	
4 Employment Arbitrations, healthcare	: law		\$	6,935	
5 Conservatorships			\$	586	
			Charge for	Services Provid	ded
			\$	40,738	
Are These Charges Reflected in the Expen	diture Portion of This Report?	If Yes, Specify Expense Classification and Line No.			
• Yes O No	15E				
0 100	<del>ye</del>				

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### **Schedule of Resident Statistics**

Name of Facility			License N					or Year Ende	d		Page	of
Chelsea Place Care Center, LLC			22	20-C			9/30/201	7			8	37
1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1						Period 10/	/1 Thru 6/	/30		Period 7/	l Thru 9/3	30
	Total All	Total CCNH	Total RHNS	Total NurseFac-				NurseFac-				NurseFac-
	Levels	Level	Level	Aids	Total	CCNH	RHNS	Aids	Total	CCNH	RHNS	Aids
1. Certified Bed Capacity									22.4	02.4		
A. On last day of PREVIOUS report period	234	234			234	234			234	234		<del></del>
B. On last day of THIS report period	234	234			234	234			234	234		ļ
Number of Residents     A. As of midnight of PREVIOUS report period	223	223			223	223			231	231		
B. As of midnight of THIS report period	229	229			231	231			229	229		
Total Number of Days Care Provided During Period												
A. Medicare	2,156	2,156			1,513	1,513			643	643		
B. Medicaid (Conn.)	80,724	80,724			60,467	60,467			20,257	20,257		
C. Medicaid (other states)												
D. Private Pay	304	304			304	304						,
E. State SSI for RCH												
F. Other (Specify) Insurance	9	9			9	9						
G. Total Care Days During Period (3A thru F)	83,193	83,193			62,293	62,293			20,900	20,900		
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)	83,193	83,193			62,293	62,293			20,900	20,900		

Schedule of Resident Statistics (Cont'd)

Name of Facil	lity		300	Licer	ise No.				Report	for Year	Ended		Page	of
Chelsea Place	Care C	enter, L	LC	22	220-C					9/30/201	7		9	37
		~	in the certified b		pacity du	ring t	he repo	rt yea	r?	0	Yes	0	No	
II YES				ion.	Ch	0000	in Bed			Car	pacity Afte	r Change		····
D . C			f Change NurseFac-Aids			ange			1	Ca	pacity Atte	i Change		
Date of	CCNH	KHNS	Nurser ac-Aios		Lost			Jaine	1			NurseFac-		
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Aids	Reason fo	r Change
	(1)	(2)	(3)	(1)	(2)	(3)	(+)	(2)	(3)	001111	Idate	11145	TCGGOIT I	1 0111111111111111111111111111111111111
												1 - 1002 - COLO DELENGO CAMBO CAMBO CAMBO		
5 If there is	voa anst	ohongo	in certified bed o	vanaoi	ty durina	the r	enort w	-ar (as	report	ed in item	4 above)	provide the num	nher of	
	-	_	nn centined bed t 90 days followin			tite i	срот у	Jai (ai	эторого	ca m non	1 4 400,40)	provide the nan	1001 01	
RESIDE	MU DA	19 101	90 days follown	ig the	change.						]			
			Ohanas in D	مرة الأكار	+ Dorra						NH	RHNS	NurseF	ac-Aids
1 st chan	œ.		Change in Ro	estaet	it Days						>1VII	KIINS	1,01201	uo i iita
2nd char														
3rd chan														
4th chan												ACCESSION SON		
6. Number	of Resid	lents an	d Rates on Septe	ember			ar							
			Medicare		Medi	caid				Se	elf-Pay		Other Stat	e Assisted
								İ				NurseFac-		
	Item		CCNH	. C	CNH	R.	HNS	C	CNH	RI	INS	Aids	R.C.H.	ICF-MR
No. of R		3	5	********	224	*******		10000000						
Per Dien a. One b														
b. Two			389.00		248.00		<del> </del>							
c. Three			503.00	<u> </u>	210.00	<u> </u>		<b>†</b>						
bed 1		•												
504	LIIIO.			<b>!</b>		<u> </u>								
														NurseFac-
			al Therapy Treat	ments	3					TC	TAL	CCNH	RHNS	Aids
	Medica									300000000000000000000000000000000000000	5,640	5,640		
В.		•	lusive of Part B	)										
			ce Treatments Treatments		<del></del>						2,889	2,889		
C	Other	torative	Treauments								2,410	2,410		
		Physica	l Therapy Treat	ments	<del></del>						10,939	10,939		
			Therapy Treatn											
Α.	Medica	are - Pai	rt B							NATIONAL PROPERTY OF THE	270	270	,	
В.			clusive of Part B	)										
			ce Treatments											
		torative	Treatments								340	340		
	Other	Chaaak	Thougan Tugata	ante						<b></b>	721	721		
			Therapy Treatmational Therapy		mente			•	<del></del> .		721	721		
	. Medic			Heat	Hems					***************************************	4,705	4,705		
			clusive of Part B	)		-					.,,	,		
			ce Treatments	•						444499999999999				s e monocumento menti libilida (1996)
			Treatments								2,232	2,232		
	Other									ļ <u>.</u>	2,229	2,229		
D.	. Total (	Оссира	tional Therapy 1	Treati	nents					<u> </u>	9,166	9,166		

### **Annual Report of Long-Term Care Facility**

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Report of Expenditures - Salaries & Wages

Report of Ex	·	- palain			Ι ъ	
Name of Facility	License No.		Report for Year	Ended	Page	of
Chelsea Piace Care Center, LLC	2220-C		9/30/2017		10	37
Are time records maintained by all individuals receiving con	pensation?	•	Yes	0	No	
	·		Total Cost as	nd Hours		
	*		Total Cost at	Id Hours	1	
					NurseFac-	
Item	CCNH	Hours	RHNS	Hours	Aids	Hours
A. Salaries and Wages*	CCNII	110413	KIIVO	110413	11145	TIOMS
1. Operators/Owners (Complete also Sec. I						
of Schedule A1)	200/1/00020000000000011/00014/0	t40004009t4000100040	p-04-00-100-100-100-100-100-1	100010001000010001000	****************	19000100010010010010
2. Administrator(s) (Complete also Sec. III						
of Schedule A1)	143,750	2,112				
3. Assistant Administrator (Complete also Sec. IV						
of Schedule A1)						
4. Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)	448,450	22,218				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	59,202	2,120				
c. Dietary Workers  6. Housekeeping Service	756,376	40,484				
a. Head Housekeeper						
b. Other Housekeeping Workers	504,164	27,878				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	74,054	2,060	***************************************			
b. Other Maintenance Workers	96,599					
8. Laundry Service						
a, Supervisor						
b. Other Laundry Workers	266,129	15,388			ļ	
9. Barber and Beautician Services						
10. Protective Services 11. Accounting Services			1			
a. Head Accountant						
b. Other Accountants	1					
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	224,188	4,567	c popular de la compressión de la construcción de l			
b. RN	,					
1. Direct Care	760,683	18,455	***************************************	D0000000000000000000000000000000000000	>+rc=0+0+0+0+0+0+0+0+0+0+0+0+0+0+0+0+0+0+0+	-00100001000000000000000000000000000000
2. Administrative**	351,152					
c. LPN						
1. Direct Care	2,225,335	75,476				
2. Administrative**	2.500.041	107 679				
d. Aides and Attendants e. Physical Therapists	3,529,941	196,578	-		·	
f. Speech Therapists	1					
g. Occupational Therapists	+					
h. Recreation Workers	180,053	9,686	<u> </u>			
i. Physicians						
Medical Director						
2. Utilization Review				ļ	1	
3. Resident Care***		************************				
4. Other (Specify)						
j. Dentists	1					
j. Dentists k. Pharmacists			<del>                                     </del>	<del> </del>		
I. Podiatrists	<del>                                     </del>				<u> </u>	<del> </del>
m. Social Workers/Case Management	243,243	9,251	<b></b>			
n. Marketing				<u> </u>	1	
o. Other (Specify)						
See Attached Schedule	91,936	5,105				
A-13. Total Salary Expenditures	9,955,255	445,259	1		<u> </u>	<u>L</u>

<sup>\*</sup> 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.

<sup>\*\*</sup> 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.

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

### Schedule of Other Salaries and Wages (Page 10)

	CC	NH	RH	INS	NurseF	ac-Aids
Position	\$	Hours	\$	Hours	\$	Hours
UNIT SECRETARIES SALARIES	\$ 36,125	1,852			\$ -	
MEDICAL RECORDS SALARIES	\$ 40,035	2,319			\$ -	
CENTRAL SUPPLY SALARIES	\$ 15,776	934			\$ -	
RESPIRATORY THERAPY SALARIES	\$ -				\$ -	
		10 10 10 10 10 10 10 10 10 10 10 10 10 1				
						10000100110101001001001
			<u> </u>			
Total	\$ 91,936	5,105	S -		\$ +	7

### Schedule of Other Fees (Page 13)

	C	CNH	R	HNS	NurseF	ac-Aids
Service	\$	Hours	\$	Hours	\$	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$ 17,350	11			\$ +	-
ADMISSIONS C/S LABOR	\$ 74,32	1,525			\$ -	2.0
CENTRAL SUPPLY CONTRACT SERVICE	\$ 7,030	5 227			\$ -	
ADMINISTRATIVE CONTRACT SERVICE LABOR	\$ 137,330	4,339			\$ -	4
RESPIRATORY THERAPY CONTRACT SERVICES	\$ -				\$ -	4
PHYSICAL THERAPY C/S MEDICIAD	\$ 57,130	750				
SPEECH THERAPY C/S Medicaid	\$ 13,79	) 181				
OCCUPATIONAL THERAPY C/S MEDICIAD	\$ 44,16	7 580				
Total	\$ 351,13	7,613	\$ -		\$ -	

State of Connecticut Annual Report of Long-Term Care Facility CSP-11 Rev. 10/2005 Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties\*

Nome of Positity		7	Assistan	r Amiliansua License Mo	Assistant Auministrators and Outer Netated Latrics	Report for	Neport for Year Finded		Page	Ju
Ivalue of Facility				Livelise 140.		Total Today	I COT TOTACO		) } !	1 1
Chelsea Place Care Center, LLC			.——	2220-C		9/30/2017			11	37
		Salary Paid	d							
:	1	\$	NurseFac-	Fringe Benefits and/or Other Payments	Full Description of	Total Hours	Line Where Claimed on	Name and Address of All	Total Hours	Compensation
Name	CCNH	RHNS	Aids	(describe fully)	Services Rendered	Worked	Page 10	Other Employment**	Worked	Keceived
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).										

<sup>\*</sup> No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

<sup>\*\*</sup> Include all employment worked during the cost year.

State of Connecticut Annual Report of Long-Term Care Facility CSP-12 Rev. 10/2005

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

Assistant Administrators and Other Related Parties\*

		7	ADDAD COLL	M TO CETTE TO THE	ANDRAGUELL LAMINATION WITH CALLED WITH					
Name of Facility (as licensed)				License No.		Report for Year Ended	ar Ended		Page .	Jo
OLOS Conformation				2220 0		0/30/2017			2	37
Chelsea Flace Care Center, LLC				7-0777		9/30/2017			71	
		Salary Paid	d							
				rringe Benefits and/or Other			Line Where		Total	
			NurseFac-	Payments	Full Description of	Total Hours	п	Name and Address of All	Hours	Compensation
Name	CCNH	RHINS	Aids	(describe fully)	Services Rendered	Worked	Page 10	Other Employment**	Worked	Received
Section III - Administrators***										
				same as emnlovees less						
Judy Konow	143,750			union funds	Administrator	2,112 A2	77			
				same as						
				employees less						
				union funds	Administrator	7	A2			
				same as					100	
				employees less						
				union funds	Administrator		A2			
Section IV - Assistant										
Administrators										
									All transfer de la constitución de	

<sup>\*</sup>No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

<sup>\*\*</sup> Include all other employment worked during the cost year.

<sup>\*\*\*</sup> If more than one Administrator is reported, include dates of employment for each.

### Annual Report of Long-Term Care Facility

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

B. Report of Ex		es - Proi				
Name of Facility	License No.		Report for Y	ear Ended	Page	of
Chelsea Place Care Center, LLC	2220	)-C	9/30/2017		13	37
	ļ		Total Cost a	and Hours		
					NurseFac-	
Ttom	CCNH	Hours	RHNS	Hours	Aids	Hours
*B. Direct care consultants paid on a fee	CCNH	Hours	CHILA	110015	Aius	110018
for service basis in lieu of salary						
(For all such services complete Schedule B1)						
1. Dietitian	74,200	1,484				
2. Dentist	74,200	2,101				
3. Pharmacist	32,052	272				
4. Podiatrist	32,002					
5. Physical Therapy						
a. Resident Care	155,227	3,525		140000000000000000000000000000000000000	*****************	101-0000-00-00-00-00-00-00-00-00-00-00-0
b. Other						
6. Social Worker	3,845					
7. Recreation Worker	<u> </u>	35+Cable			eroemere -	
8. Physicians						
a. Medical Director (entire facility)	80,400	418		110001000000000000000000000000000000000	000000000000000000000000000000000000000	promise receives a service servi
b. Utilization Review						
(Title 18 and 19 only) monthly meeting	-4-2-6-2-1-0-2-4-2-2-3-4-2-2-4-2-3-2-3	5				
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee						
(Quarterly meetings) 2. Pharmaceutical Committee						1
(Quarterly meetings)						
3. Staff Development Committee						
(Once annually)			***************************************		***************************************	***************************************
e. Other (Specify)						
Physician Care Contract Services	30,451	92				
9. Speech Therapist	17.070	217				
a. Resident Care	17,278	217				
b. Other						
10. Occupational Therapist	137,701	1,788				
a. Resident Care b. Other	137,701	1,700				
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	6,359			**************************************		
2. Administrative***	26,412	550				
b. LPN	20,112	330				
1. Direct Care		**************************************				***************************************
2. Administrative***		<del></del>				
c. Aides	(3,840)	(124)				
d. Other		1			-	
12. Other (Specify)						
See Attached Schedule	351,133	7,613		* 1 to 4 this a land local property (1974)		111111111111111111111111111111111111111
B-13 Total Fees Paid in Lieu of Salaries	919,906	15,839		300003733		

<sup>\*</sup> 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.

<sup>\*\*</sup> 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.

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

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

Name of Facility		License No.		Report for Y	Year Ended	Page	of	
Chelsea Place Care Center, LLC		2220-C		9/30/2017		14	37	
				to Owners,				
Name & Address of Individual	Full Expla	nation of Service		s, Officers	Expla	nation of R	elationship	
	ba e		Yes	No				
Omnicare	Pharm	acy Consulting	0	0				
Tocuhpoints Therapy		Therapy	0	0	Common Own			
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Shar	ed Employees	0	0	Common Own	ership		
Healthdrive Physician Services	Audiology,	Dental and Podiatry	0	0				
Dr. Paulekas Wayne	Med	lical Director	0	0				
Dr Buccheri Santo	Мес	lical Director	0	0				
Ready Nurse, Nurse Network	Nursing po	ool (RN, LPN,CNA)	0	0				
			0	0				
			0	0				
			0	0				
			0	0				
			0	0				
		- Alexandra	0	0				
			0	0				
			0	0				
			0	0				
			0	0				
			0	0				
			0	0				
		******	0	0				
			0	0				
			0	0				

<sup>\*</sup> Use additional sheets if necessary.

<sup>\*\*</sup> Refer to Page 4 for definition of related.

### C. Expenditures Other Than Salaries - Administrative and General

Total  48,847  835,494 1,683,868  631,863  81,231	CCNH  48,847  835,494 1,683,868  631,863  81,231	RHNS	NurseFac- Aids
48,847 835,494 1,683,868 631,863	48,847 835,494 1,683,868 631,863	RHNS	
48,847 835,494 1,683,868 631,863	48,847 835,494 1,683,868 631,863	RHNS	
48,847 835,494 1,683,868 631,863	48,847 835,494 1,683,868 631,863	RHNS	Aids
835,494 1,683,868 631,863	835,494 1,683,868 631,863		
835,494 1,683,868 631,863	835,494 1,683,868 631,863		
835,494 1,683,868 631,863	835,494 1,683,868 631,863		
631,863	1,683,868		
631,863	1,683,868		
631,863	1,683,868		
631,863	631,863		
81,231	81,231		
81,231	81,231		
81,231	81,231		<i>.</i>
		l	
	``` 		
1,394,267	1,394,267		
4,303	4,303		
40,738	40,738		
21,135	21,135		
18,117	18,117		
1,042	1,042		
* 5-5-4 8 1 A0000000000000000000000000000000000	ereke i jaga njaya nja nya nisonisona sisonia sisonia sisonia sisonia sisonia sisonia sisonia sisonia sisonia s		The state of the s
1,351	1,351		
1,341,924	1,341,924		
6,104,179	6,104,179		
	4,303 40,738 21,135 18,117 1,042 1,351	4,303     4,303       40,738     40,738       21,135     21,135       18,117     18,117       1,042     1,042       1,351     1,351       1,341,924     1,341,924       6,104,179     6,104,179	4,303     4,303       40,738     40,738       21,135     21,135       18,117     18,117       1,042     1,042       1,351     1,351       1,341,924     1,341,924

<sup>\*</sup> Facility should self-disailow the expense on Page 28 of the Cost Report.

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

Chelsea Place Care Center, LLC 9/30/2017

Attachment Page 15

### **Schedule of Other Employee Benefits**

Description	CCNH	RHNS	NurseFac- Aids
UNION TRAINING	\$ 81,231		\$ -
•			
Total	\$ 81,231	\$ -	\$ -

### **Schedule of Other Taxes**

		NurseFac-
CCNH	RHNS	Aids
\$ 1,351		\$ -
\$ 1,351	\$ -	\$ -
	<b>CCNH</b> \$ 1,351 \$ 1,351	

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

Name of Facility	License No.		Report for Y	ear Ended	Page	of
Chelsea Place Care Center, LLC	2220-C		9/30/2017		16	37
						NurseFac-
Item			Total	CCNH	RHNS	Aids
	ıls Brought Forwa	rd:	6,104,179	6,104,179		
1. Travel and Entertainment						
Resident Travel and Entertainment	MANAGAMANANANAN TITAT TI	\$		***************************************		
2. Holiday Parties for Staff		\$	3,033	3,033		
3. Gifts to Staff and Residents		\$	1,486	1,486		
4. Employee Travel		\$	3,141	3,141		
5. Education Expenses Related to Seminars an	nd Conventions	\$	3,789	3,789		
6. Automobile Expense (not purchase or depr	eciation)	\$				
7. Other (Specify)		\$	1,079	1,079		
See Attached Schedule						
m. Other Administrative and General Expenses	ALL CONTROL OF THE STATE OF THE					
1. Advertising Help Wanted (all such expense	s )	\$	8,194	8,194		
2. Advertising Telephone Directory (all such e	expenses )***	\$				
3. Advertising Other (Specify)***		\$	12,313	12,313		
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	ce)***					
7. Postage		\$	6,428	6,428		
* 8. Dues and Membership Fees to Professional		\$	16,082	16,082		
Associations (Specify)						
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other Non-	Allowable Org.***	\$				
9. Subscriptions		\$				
10. Contributions***		\$	250	250		
See Attached Schedule						
11. Services Provided by Contract (Specify and	l Complete	\$	160,477	160,477		
Schedule C-2, Page 21 for each firm or inc	dividual)					
12. Administrative Management Services**		\$	616,050	616,050		
13. Other (Specify)		\$	27,634	27,634		
See Attached Schedule						
C-14 Total Administrative & General Expenditures	3	\$	6,964,135	6,964,135		

<sup>\*</sup> Do not include Subscriptions, which should go in item 9.

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*\*</sup> Facility should self-disallow the expense on Page 28 of the Cost Report.

### Schedule of Other Travel and Entertainment

	CONT	DING	NurseFac-
Description	CCNH	RHNS	Aids
MBALS	\$ 1,079	ynesiset is in needulise	\$
Fotal Other Travel and Entertainment	\$ 1,079	\$ -	\$ .

### Schedule of Other Advertising

			NurseFac-
Description	CCNH	RHNS	Aids
COMMUNICATIONS SPECIAL EVENTS	\$ 12,313		\$
Total Other Advertising	\$ 12,313	\$ -	\$ -

### Schedule of Dues

			NurseFac-
Description	CCNH	RHNS	Aids
ALTCFM			
CAHCF Dues \$	15,922		\$ -
OTHER DUES \$	160		\$ -
		3 8 3 5 5 5 5 5	
Total Dues S	16,082	\$ -	\$ -

### Schedule of Contributions

			NursoFac-
Description	CCNH	RHNS	Aids
CONTRIBUTIONS	\$ 250	and the state of	\$
Total Contributions	\$ 250	S -	\$ -

### Schedule of Other Administrative and General

Description	CCNH	RHNS	NurseFac- Aids
SOCIAL SERVICE SUPPLIES	\$ 250		38 ⊬
SOC SVC MINOR EQUIPMENT	\$		\$ ~
ADMINISTRATIVE MINOR EQUIPMENT	\$ 1,101		\$ -
EMPLOYEE RELATIONS	\$ 8,486		\$ -
EMPLOYEE RELATIONS-OTHER	\$ 51		\$ -
PERMITS & LICENSES	\$ 2,520		\$ -
VOLUNTEER EXPENSE	\$ .		\$ .
BANK FEES	\$ 11,360		\$ -
CMS REVISIT USER FEES	\$		\$ -
PENALTIES	\$ 1,920		\$ -
LATE FEES	\$ 1,946		\$ ÷
Rounding	\$ -		\$ -
Total Other Administrative and General	\$ 27,634	\$ -	\$ -

### Schedule C-1 - Management Services\*

Name of Facility	License No.	Report for Year Ended	Page of
Chelsea Place Care Center, LLC	2220-C	9/30/2017	17   37
Name & Address of Individual or Company Supplying Service iCare Management, LLC/iCare Health Management, LLC	Cost of Management Service 616,050	Full Description of Mgmt. Service Provided  Management of financial statements, A/R, A/P, Payroll,	Indicate Where Costs are Included in Annual Report Page #/Line # Pg 16 M12
		Financial Accounting and Management, Clinical	
iCare Management, LLC/iCare Health Management, LLC	265,594	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	35,965	MANAGEMENT FEES- INDIRECT CARE	Pg 20 j

<sup>\*</sup> In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.

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

<u> </u>	0.5. 211.			rage 5)	D 10 37	T 1 T	T D	r
3	ne of Facility		Licens		Report for Y		Page	of
Che	sea Place Care Center, LLC			2220-C	9/30/2017	<u> </u>	18	37
	Item			Total	CCNH	RHNS	Nurse	Fac-Aids
2.	Dietary							
	a. In-House Preparation & Service							
	1. Raw Food				496,816			
	2. Non-Food Supplies		5	· <del> </del>	59,856			
	3. Other (Specify)		S	46,421	46,421	***************************************		:::::::::::::::::::::::::::::::::::::::
	DIETARY SUPPLEMENTS							
	b. Purchased Services (by contract other		(	1,364	1,364	HOOLEA ONDS TONDOODS DOOL DOOL LOSSIN LICEL	-5000 (1000) Lochool	0.000.000000000000000000000000000000000
	than through Management Services)							
	(Complete Schedule C-2 att. Page 21)							
	c. Management Scrvices**		(					
	d. Other (Specify)			10,369	10,369			to announce on the transcription to be a made
	DIETARY MINOR EQUIPMENT							
2E.	Total Dietary Expenditures $(2a+b+c+d)$		4	614,826	614,826			
2F.	Dietary Questionnaire			Total	CCNH	RHNS	Nurse	Fac-Aids
G.	Resident Meals: Total no. of meals served per	day	*	684	684			
H.	Is cost of employee meals included in 2E?	0	Yes	0	No			
I,	Did you receive revenue from employees?	0	Yes	•	No	If yes, specify amt.		
J.	Where is the revenue received reported in the	Cost	Repor	t? (Page/Line I	tem)			
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	0	Yes	0	No	If yes, specify cost.		
L.	Is any revenue collected from these people?	0	Yes	0	No	If yes, specify amt.		
M.	Where is the revenue received reported in the	Cos	t Repor	t? (Page/Line I	tem)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	0	Yes	•	No	If yes, specify cost.		
О.	Is any revenue collected from employees?	0	Yes	0	No	If yes, specify amt.	•	
Ρ.	Where is the revenue received reported in the	Cos	t Repor	t? (Page/Line I	tem)			

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

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Name of Facility Chelsea Place Care Center, LLC		e No. 2220-C	Report for Y 9/30/2017	ear Ended	Page of 19   37
Cheliford Flace Cutte Collect, 1940				MATERIAL PROPERTY OF THE PROPE	
Item		Total	CCNH	RHNS	NurseFac-Aids
Laundry     a. In-House Processing*     1. Bed linens, cubicle curtains, draperies,	Lbs.				
gowns and other resident care items washed, ironed, and/or processed.***	Amt.	\$ 281	281		
<ol><li>Employee items including uniforms, gowns, etc. washed, ironed and/or</li></ol>	Lbs.				
processed.***	Amt.	\$			
3. Personal clothing of residents	Lbs.				
washed, ironed, and/or processed.***	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)		\$ 63,580	63,580		
c. Management Services**		\$			
d. Other ( <i>Specify</i> )  LAUNDRY MINOR EQUIPMENT		\$ 518			
3E. Total Laundry Expenditures (3a + b + c + d)		\$ 64,379	64,379		
3F. Laundry Questionnaire  G. Is cost of employee laundry included in 3E? C	) Yes	•	No	If yes, specify cost.	
H. Did you receive revenue from employees?	) Yes	0	No	If yes, specify amt,	
I. Where is the revenue received reported in the Cos	t Report	?	(Page/Line	tem)	
Is Cost of laundry provided to persons other	) Yes		No	If yes, specify cost.	
K. Did you receive revenue from these people?	) Yes	0	No	If yes, specify amt.	
L. Where is the revenue received reported in the Cos	t Report	?	(Page/Line	(Item)	

<sup>\*</sup> 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.

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*\*</sup> Pounds of Laundry only required for multi-level facilities.

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

Name of Facility Lice			Repo	ort for Year E	nded	Page	of
Che	Chelsea Place Care Center, LLC 2220-C			9/30/2017	aousta ann an T	20	37
	Item			Total	CCNH	RHNS	NurseFac- Aids
4.	Housekeeping	Sq. Ft. Serviced	i				
] ''	a. In-House Care	by Personnel					
	1. Supplies - Cleaning (Mops, pails, brooms, etc.)	Amt.	\$	47,494	47,494		
	b. Purchased Services (by contract other	Sq. Ft. Serviced					
	than through Management Services)	by Personnel					
	(Complete Schedule C-2 att. Page 21)	Amt.	\$	30,014	30,014		
	c. Management Services*		\$				
	d. Other ( <i>Specify</i> ) HOUSEKEEPING MINOR EQUI	PMENT	\$				
4E.	Total Housekeeping Expenditures (4a +	b + c + d	\$	77,508	77,508		
5.	Resident Care (Supplies)**  a. Prescription Drugs***  1. Own Pharmacy		\$				
	2. Purchased from		\$	75,974	75,974		
	OMNICARE PHARMACY						
	b. Medicine Cabinet Drugs		\$	20,811	20,811		
	c. Medical and Therapeutic Supplies		\$	94,559	94,559		
	d. Ambulance/Limousine***		\$	1,245	1,245		
	e. Oxygen 1. For Emergency Use		\$	7,494	7,494		
	2. Other***		\$				
	f. X-rays and Related Radiological Procedures***		\$	2,097	2,097		
	g. Dental (Not dentists who should be inc salaries or fees)	luded under	\$				
	h. Laboratory***		\$	5,684	5,684		
	i. Recreation		\$				
	j. Other (Specify)****		\$	474,976	474,976		
	See Attached Schedule					ļ	
5K.	Total Resident Care Expenditures (5a - 5	5j)	\$	682,839	682,839		

<sup>\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*</sup> Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

<sup>\*\*\*</sup> Facility should self-disallow the expense on Page 29 of the Cost Report.

<sup>\*\*\*\*</sup> ICFMR's should provide a detailed schedule of all Day Program Costs.

### Schedule of Other Resident Care

Description	CCNH	RHNS	NurseFac-Aids	
NURSING ADMIN SUPPLIES	\$ 727		\$ -	
NURSING MINOR EQUIP	\$ 5,379		\$ -	
MEDICAL RECORDS SUPPLIES	\$ -		\$ -	
MEDICAL RECORDS MINOR EQUIPMENT	\$ -		\$ -	
MANAGEMENT ALLOCATIONS - DIRECT	\$ 265,594		\$ +	
NON-COVERED PPS DR. VISITS	\$ 25		\$ -	
RESIDENT CARE SUPPLIES	\$ 1,179		\$ -	
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 12,687		\$ -	
PERSONAL CARE SUPPLIES	\$ 13,899		\$ -	
INCONTINENCY SUPPLIES	\$ 46,043		\$ -	
VACCINE RESIDENTS	\$ 5,690		\$ -	
PATIENT SPECIAL NEEDS	\$ 19		\$ -	
PHYSICAL THERAPY SUPPLIES	<b>S</b> -		\$ -	
PHYSICAL THERAPY EQUIPMENT RENT	\$ -		\$ -	
PHYSICAL THERAPY MINOR EQUIPMENT	\$		\$ -	
OCCUPATIONAL THERAPY SUPPLIES	\$ -		\$ -	
OCCUPATIONAL THERAPY EQUIP RENTAL	\$ -		\$ -	
OCCUPATIONAL THERAPY MINOR EQUIP	\$ -		S -	
SPEECH THERAPY SUPPLIES	\$ -		\$ -	
SPEECH THERAPY EQUIPMENT RENT	\$ -		\$ -	
SPEECH THERAPY MINOR EQUIPMENT	\$ -		\$ -	
RENTALS FOR NURSING EQUIPMENT NON BILLABLE	\$ 34,078		\$ -	
EQUIPMENT RENTAL: AIDS UNIT	\$ -		\$ -	
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ (5)		\$ -	
PEN THERAPY FOOD NOT BILLABLE TO PART B	- 8		\$ -	
HI LOW BED RENTAL & MATTRESSES	\$ -		\$ -	
IV THERAPY SUPPLIES	\$ 45,463		\$ -	
IV THERAPY CONTRACT SERVICE	\$ -		\$ -	
MEDICAL WASTE CONTRACT SERVICE	\$ 4,043		\$ -	
ACTIVITIES SUPPLIES	\$ 4,190		\$ -	
ACTIVITIES MINOR EQUIPMENT	\$ -		\$ -	
MANAGEMENT ALLOCATION - INDIRECT	\$ 35,965		\$ -	
ADMISSIONS SUPPLIES	\$ -		\$ -	
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$ -		\$ -	
STRIKE COSTS NON REIMBURSABLE	\$ +		\$ +	
rounding	\$ 0			
Total Other Resident Care	\$ 474,976	\$ -	\$ -	

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

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

Name of Facility Chelsea Place Care Center, LLC	27			License No. 2220-C	Report for Year Ended 9/30/2017				Page 21	of 37
		Related ** to Owners, Operators, Officers	to Owners,				Total Cost/	Total Cost/Page Ref.***	v	
Name of Individual or	**************************************	,	2	Explanation of	Full Explanation of	CCNIH	SHIM	NurseFac-	Dg	in in
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	0	0	VENDOR	Housekeeping Services	32,161	2		0	4b
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	0	0	VENDOR	Laundry Services	68,440	***************************************		19	3b
Eagle Elevator	7	0	0	VENDOR	Elevator Contract	11,080			22	6Э
Bioserve, Inc.		0	0	VENDOR	Medical Waste	4,043			22	6F
Brightview Landscaping/Begley Landscaping		0	0	VENDOR	Snow Removal/Landscaping	22,939			22	6F
USA Hauling & Recycling Inc		0	0	VENDOR	Trash removal	51,868			22	6F
American HealthTech		0	0	VENDOR	Software Maintenance Contract	10,680			16	M11
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	0	0	VENDOR	Payroll Services	80,292			16	M11
National Datacare Corp		0	0	VENDOR	Resident Trust Software	6,552			16	M11
Prime Care Technologuy services		0	0	VENDOR	Computer Consulting Services	30,149			16	M11
Priotiry Express		0	0	VENDOR	Courier Services	8,067			16	M11
Point Right Inc		0	0	VENDOR	Nursing Software	4,680			16	ZZ[
		0	0	VENDOR		-				
		0	0	VENDOR						

<sup>\*</sup> List all contracted services over \$10,000. Use additional sheets if necessary.

<sup>\*\*</sup> Refer to Page 4 for definition of related. \*\*\* Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Y	ear Ended		Page	of
Chelsea Place Care Center, LLC	2220-C	9/30/2017			22	37
Item		Total	CCNH	RHNS	Nursel	Fac-Aids
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	52,855	52,855			
b. Heat	\$	70,088	70,088			
c. Light & Power	\$	136,331	136,331			
d. Water	\$	121,186	121,186			
e. Equipment Lease (Provide detail on p	age 6) \$	42,308	42,308			
f. Other (itemize)	\$	135,395	135,395			
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a	- 6f) \$	558,163	558,163			
7. Depreciation (complete schedule page 23	*)					
a. Land Improvements	\$					
b. Building & Building Improvements	\$	34,701	34,701			
c. Non-Movable Equipment	\$	550	550			
d. Movable Equipment	\$	40,585	40,585			
*7e, Total Depreciation Costs (7a+b+c+c	1) \$	75,836	75,836			
8. Amortization (Complete att. Schedule Pa	ge 24*)					
a. Organization Expense	\$					
b. Mortgage Expense	\$					W-01400000000000000000000000000000000000
c. Leasehold Improvements	\$	89,618	89,618			
d. Other (Specify)	\$					
*8e. Total Amortization Costs (8a+b+c+	d) \$	89,618	89,618			
9. Rental payments on leased real property l	ess					
real estate taxes included in item 10b	\$	1,047,313	1,047,313			
10. Property Taxes						
a. Real estate taxes paid by owner	9					
b. Real estate taxes paid by lessor	9	351,624	351,624			
c. Personal property taxes	9	44,693	44,693			
11. Total Property Expenses (7e + 8e + 9 +	10) \$	1,609,084	1,609,084			

<sup>\*</sup> 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	NurseFac-Aids
PLANT SUPPLIES	\$ 10,768		\$ -
PLANT CONTRACT SERVICE LABOR	\$ -		\$ -
ELEVATOR CONTRACT SERVICE	\$ 11,080		\$ -
FIRE/SPRINKLER CONTRACT SERVICE	\$ 7,288		S -
LANDSCAPING CONTRACT SERVICE	\$ 6,953		\$ -
SNOW REMOVAL CONTRACT SERVICE	\$ 16,054		\$ -
TRASH REMOVAL CONTRACT SERVICE	\$ 51,868		\$ -
HVAC CONTRACT SERVICE	\$		\$ -
SECURITY CONTRACT SERVICE	\$ 3,495		\$ -
PLANT CONTRACT SERVICE OTHER	\$ 9,494		\$ -
PLANT MINOR EQUIPMENT	\$ 13,397		\$ -
RENT AUTO	\$ -		\$ -
RENT EQUIPMENT	\$ 4,998		\$ -
RENT OTHER	S -		\$ -
Total Other Repairs and Maintenance	\$ 135,395	\$ -	\$ -

State of Connecticut

### Annual Report of Long-Term Care Facility

CSP-23 Rev. 10/2006

**Depreciation Schedule** 

DI CD III					License No.	ianon Sc	neadic	Report for Year E	nded		Page	of
Name of Facility Chelsea Place Care Center, LLC					2220	· C		9/30/2017	nucu		23	37
Cheisea Place Care Center, LLC							<u> </u>	Accumulated				
					Historical	Υ		Depreciation to	Method of			i
					Cost	Less		1 *	Computing	Useful	Depreciation	
					Exclusive of	Salvage	Cost to Be	Beginning of	Depreciation	Life	for This Year	Totals
Property Item					Land	Value	Depreciated	Year's Operations	Depreciation	Life	Tor this rear	Totals
A. Land Improvements												
Acquired prior to this report period												
Disposals (attach schedule)												l .
Acquired during this report period (atta-	ch sche	edule)										
A-4. Subtotal												
B. Building and Building Improvements								1			24.703	
Acquired prior to this report period					664,817		664,817	62,365			34,701	
Disposals (attach schedule)												
3. Acquired during this report period (atta	ch sche	edule)										24.501
B-4. Subtotal												34,701
C. Non-Movable Equipment												
<ol> <li>Acquired prior to this report period</li> </ol>					43,932		43,932	41,175			550	1
Disposals (attach schedule)												1
3. Acquired during this report period (attach schedule)												
C-4. Subtotal								1				550
	Is a n	iileage										
		book	Da	te of	Historical			Accumulated				
		ained?	1	usition	Cost	Less		Depreciation to	Method of			
					Exclusive of	Salvage	Cost to Be	Beginning of	Computing	Useful	Depreciation	Í
	Yes	No	Month	Year	Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
D. Movable Equipment												
1. Motor Vehicles (Specify name, model												
and year of each vehicle)												
a. Van Repair: Hillside Automotive Ce	1 X	*******		#200700000000	10,600	************************	10,600	10,600				
b.				1								
C.												
đ.												
Movable Equipment				<b>‡</b>								1
a. Acquired prior to this report period				1	649,808		649,808	505,687			38,588	
b. Disposals (attach schedule)										- 0000000000000000000000000000000000000		
c. Acquired during this report period												
(attach schedule)				L	30,954			]	<u> </u>		1,997	
D-3. Subtotal	1											40,585
E. Total Depreciation	400000000000000000000000000000000000000		A	A 8000 80000	844 AN BERGER	#14000000000000000000000000000000000000	040000000000000000000000000000000000000	::::::::::::::::::::::::::::::::::::::	96000000000000000000000000000000000000	400000000000000000000000000000000000000	5 <b>1</b> 56600 6666 6666 6666 6666 6666	75,836

Useful

### Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions;	Description of tent	Cust	T	Боргосказа
				100 131 131 110 133
Total additions for	Land Improvements	\$ -		\$
Deletions:				
				3.00 30 30 38
Total deletions for l	Land Improvements	\$ -		\$ -

<sup>\*</sup>Ties to Page 23, Line A3

### Schedule of Building Improvements Acquired during this report period

			1.16	D
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
				6.00
Total additions for E	Building Improvements	\$ -		\$ -
Deletions:				
				60.000 80.400 80.00
Total deletions for B	milding Improvements	\$ +		· S · · · ·

<sup>\*</sup>Tles to Page 23, Line B3

### Schedule of Non-Movable Equipment Acquired during this report period

	No controller of them	Cust	Useful Life	Depreciation
Acquisition Date Additions:	Description of Item	Cost	Life	Depreciation
Audulons;		7-7-8-2 F-3-1, 1-7-1, 1-7-1, 1-8-3	1 1000-1000-1000-1000-1000-1000-1000-10	\$24.0 A \$30.0 SQ.104.5
			3.000	in the second second
Total additions for Non-Mov	vable Equipment	\$		S -
Deletions:				
		rakan kada majaa <u>ban</u>		
				6.000 (40.000)
Total deletions for Non-Moy	AND DAVIENDANT	\$ -		\$ -

<sup>\*</sup>Ties to Page 23, Line C3

<sup>\*\*</sup>Ties to Page 23, Line A2

<sup>\*\*</sup>Ties to Page 23, Line B2

<sup>\*\*</sup>Ties to Page 23, Line C2

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
12/22/2016	Upgrade Washers: Daniels Equipment	\$ 13,580	120	\$ 1,019
3/13/2017	Thermostatic Actuators: H.D. Supply	\$ 2,777	60	\$ 278
8/23/2017	Beds: Medline	\$ 11,167	60	\$ 186
12/28/2016	Purchase & Install Dish TV: Audio Video Innovations	\$ 3,430	60	\$ 514
Total additions fo	r Movable Equipment	\$ 30,954		\$ 1,997
Deletions:				
Total deletions for	r Movable Equipment	\$		\$ -

<sup>\*</sup>Ties to Page 23, Line D2c

Schedule of Leasehold Improvements Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
11/23/2016	Repair AC: Saucier Mechanical	\$ 2,793	180	\$ 155
1/24/2017	Toilets: H.D Supply (Part 1)	\$ 4,987	120	\$ 332
3/26/2017	SinkHole: Sahar, Shalom: Vinyl Floor	\$ 19,141	120	\$ 957
6/14/2017	Repair AC: Saucier Mechanical	\$ 9,975	180	\$ 166
3/2/2017	Hollow Metal Door: Accurate Comm. Door	\$ 2,537	240	\$ 63
6/7/2017	Toilets: H.D Supply (Part 2)	\$ 2,174	120	\$ 54
4/21/2017	Hollow Metal Door: Accurate Comm. Door	\$ 4,075	240	\$ 85
8/11/2017	Hollow Metal Door; Accurate Comm: Door	\$ 4,253	240	\$ 18
8/23/2017	Repair Entrance (Concrete): Shalom Sahar	\$ 6,700	240	\$ 28
Total additions fo	r Leaschold Improvement	\$ 56,635		\$ 1,859
Deletions:				
Total deletions for	Leaschold Improvement	S -		\$

<sup>&</sup>quot;Ties to Page 24, Line C3

<sup>\*\*&#</sup>x27;Ties to Page 23, Line D2b

<sup>\*\*</sup>Ties to Page 24, Line C2

### **Amortization Schedule\***

Nam	e of Facility			License No.		Report for Yea	r Ended		Page	of
	sea Place Care Center, LLC			2220	)-C	9/30/2017			24	37
						Accumulated				
		Date	e of			Amort. to				
		Acqui	sition			Beginning of	Basis for			
				Length of	Cost to Be	Year's	Computing	Rate	Amortization	
	Item	Month	Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
A.	Organization Expense								The second secon	
	1.									
	2.							<u> </u>		
	3.									
A-4.	Subtotal									
B.	Mortgage Expense									
	1.									
	2.									
	3.									
B-4.	The state of the s									
C.	Leasehold Improvements and Other					0.1.00			07.750	
	1. Acquired prior to this report period				1,344,985	814,937			87,759	
	2. Disposals (attach schedule)									
	3. Acquired during this report period				56.605				1.050	
	(attach schedule)				56,635				1,859	80 618
C-4.		-								89,618
D.	Total Amortization							1		89,618

<sup>\*</sup> Straight-line method must be 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.

<sup>\*\*</sup> Specify which of the following bases were used:

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

Name of Facility	License No.	Report for Year En	ded		Page	of
Chelsea Place Care Center, LLC	2220-C	9/30/2017			25	37
11. Property Questionnaire						
Part A						
Is the property either owned by the	e Facility	O Yes	0	No	If "Yes," comple	te Part B.
or leased from a Related Party?*		O 168	0	INO	If "No," complete	e Part C.
*If any owner or operator of this faci						
business association to any person or	organization from whon	n buildings are leased, then i	t is considered a			
related party transaction. Description		Total				
Date Land Purchased		04/01/1999				
Date Structure Completed		04/01/1999				
3. If <b>NOT</b> Original Owner, Date	of Purchase	04/01/99				
4. Date of Initial Licensure		04/01/99				
5. Total Licensed Bed Capacity		234	İ			
6. Square Footage		66,285				
7. Acquisition Cost						
a. Land						
b. Building		11,495,942				
Part B - Owner and Related Pa	rties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Morte	zage
1. Financing						
a. Type of Financing (e.g., fi	xed, variable)	HUD fixed				1 10 1 10 10 10 10 10 10 10 10 10
b. Date Mortgage Obtained		05/30/13				
c. Interest Rate for the Cost		319.00%				
d. Term of Mortgage (numbe		24				
e. Amount of Principal Borro		6,664,200				
f. Principal balance outstand						
Complete if Mortgage was I						
During Current Cost Ye						
g. Type of Financing (e.g., fi	xed, variable)	sale of real estate				
h. Date of Refinancing		08/09/17				
i. New Interest Rate	<u> </u>					
j. Term of Mortgage (numbe		1				
k. Amount of Principal Borro  1. Principal Outstanding on I						
Part C - Arms-Length Leas		y Improvements Only	17	l	<u></u>	<del></del>
Name and Address of Lesso		<u> </u>		Term of Lange	Annual Amoun	t of Lanca
Summit Hartford, LLC		Property Leased nine Street, Hartford,			\$1,035,000 yr 1	t of Lease
Building Hardord, LEC	CT CT	illie Sueet, Franciscu,	08/09/17	2-5	1 1,033,000 yr 1	
	C1		· · · · · · · · · · · · · · · · · · ·	year extension		<del></del>
				year extension		
			<del> </del>			
			-			
		·			<del></del>	
P		<del></del>				<del></del>

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

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

Item   Total   CCNH   RHNS   NurseFac-Aids		License No.	***************************************	Report for Yea	r Ended		Page	of
12. Interest A. Building, Land Improvement & Non-Movable Equipment 1. First Mortgage \$ Name of Lender  2. Second Mortgage \$ Name of Lender  Address of Lender  Address of Lender  3. Third Mortgage \$ Name of Lender  Rate  Address of Lender  4. Fourth Mortgage \$ Name of Lender  4. Fourth Mortgage \$ Name of Lender  Address of Lender  2. Second Mortgage \$ Name of Lender  Rate  Address of Lender  Address of Lender  4. Fourth Mortgage \$ Name of Lender  Address of Lender  2. Loan Origination Date 3. Interest Rate % 4. Term 5. CHEFA Interest Expense	Chelsea Place Care Center, LLC	2220-C		9/30/2017		Account 1	26	37
A. Building, Land Improvement & Non-Movable Equipment 1. First Mortgage  Name of Lender  Rate  Address of Lender  2. Second Mortgage  Rate  Address of Lender  3. Third Mortgage  S Name of Lender  Rate  Address of Lender  4. Fourth Mortgage  S Name of Lender  Address of Lender  4. Fourth Mortgage  S Name of Lender  Address of Lender  1. Original Loan Amount 2. Loan Origination Date 3. Interest Rate % 4. Term 5. CHEFA Interest Expense	Item			Total	CCNH	RHNS	NurseF	ac-Aids
Rate  Name of Lender  Address of Lender  2. Second Mortgage  Rate  Address of Lender  Address of Lender  Address of Lender  3. Third Mortgage  Rate  Address of Lender  Address of Lender  4. Fourth Mortgage  S Name of Lender  Address of Lender  Address of Lender  1. Original Loan Amount  2. Loan Origination Date  3. Interest Rate %  4. Term  5. CHEFA Interest Expense		ent & Non-Movable						
Name of Lender         Rate           Address of Lender         \$           Name of Lender         Rate           Address of Lender         \$           Name of Lender         Rate           Address of Lender         \$           A. Fourth Mortgage         \$           Name of Lender         Rate           Address of Lender         Rate           Address of Lender         Rate           B. CHEFA Loan Information         \$           1. Original Loan Amount         \$           2. Loan Origination Date         \$           3. Interest Rate %         4. Term           5. CHEFA Interest Expense         \$	Equipment							
Address of Lender  2. Second Mortgage S Name of Lender Rate  Address of Lender  3. Third Mortgage S Name of Lender Rate  Address of Lender  4. Fourth Mortgage S Name of Lender Rate  Address of Lender  1. Original Loan Amount 1. Original Loan Amount 2. Loan Origination Date 3. Interest Rate % 4. Term 5. CHEFA Interest Expense			,					***************************************
2. Second Mortgage S 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  1. Original Loan Amount \$ 2. Loan Origination Date 3. Interest Rate % 4. Term 5. CHEFA Interest Expense			Rate					
Name of Lender  Address of Lender  3. Third Mortgage \$ Name of Lender  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	Address of Lender							
Address of Lender  3. Third Mortgage  Name of Lender  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	2. Second Mortgage		\$					
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	Name of Lender		Rate					
Name of Lender  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	Address of Lender							
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	3. Third Mortgage		\$	***************************************	664 66 166 166 166 166 166 166 166 166 1			
4. Fourth Mortgage \$ Name of Lender  Address of Lender  B. CHEFA Loan Information  1. Original Loan Amount \$ 2. Loan Origination Date  3. Interest Rate %  4. Term  5. CHEFA Interest Expense	Name of Lender		Rate					
Name of Lender  Address of Lender  B. CHEFA Loan Information  1. Original Loan Amount  2. Loan Origination Date  3. Interest Rate %  4. Term  5. CHEFA Interest Expense	Address of Lender							
Address of Lender  B. CHEFA Loan Information  1. Original Loan Amount  2. Loan Origination Date  3. Interest Rate %  4. Term  5. CHEFA Interest Expense	4. Fourth Mortgage		\$					4.4000-1.4000-1.4000-1.4000-1.400-1.4000-1.400
B. CHEFA Loan Information  1. Original Loan Amount \$  2. Loan Origination Date  3. Interest Rate %  4. Term  5. CHEFA Interest Expense	Name of Lender		Rate					
1. Original Loan Amount \$ 2. Loan Origination Date 3. Interest Rate % 4. Term 5. CHEFA Interest Expense	Address of Lender							
2. Loan Origination Date 3. Interest Rate % 4. Term 5. CHEFA Interest Expense	B. CHEFA Loan Information							
3. Interest Rate % 4. Term 5. CHEFA Interest Expense	1. Original Loan Amount		\$					
4. Term 5. CHEFA Interest Expense	2. Loan Origination Date							
5. CHEFA Interest Expense	3. Interest Rate %							
	4. Term							
12 B7. Total Building Interest Expense (A1 - A4 + B5) \$	5. CHEFA Interest Exper	ise				` `		
	12 B7. Total Building Interest Expe.	nse (A1 - A4 + B5)	\$					

(Carry Subtotals forward to next page)

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

1	me of Facility License No. 2220-C						of 37
Choisea i idoc care center, Elle 22			9/30/2017				
Item			Total	CCNH	RHNS	NurseFac-A	ids
	totals Brou	aght Forward:					
12. C. Movable Equipment							
1. Automotive Equipment		\$					
A. Item	Rate	Amount					
Lender			-				
Address of Lender							
2. Other (Specify)		\$	100000000000000000000000000000000000000	.00010000010000000000000000000000000000	059400590040000000000000000000000000000		susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception of the susception o
A. Item	Rate	Amount					
Lender							
Address of Lender							
B. Item	Rate	Amount					
Lender			1				
Address of Lender		1.113					
12. C. 3. Total Movable Equipment Inter Expense (C1 + 2)	rest	9	3				
12. D. Other Interest Expense (Specify) INTEREST		4	56,509	56,509			
13. Total All Interest Expense (12B7 + 12	2C3 + 12D	) \$	56,509	56,509			
14. Insurance a. Insurance on Property (buildings of		9	12,599	12,599			
b. Insurance on Automobiles							
c. Insurance other than Property (as	specified al						
1. Umbrella (Blanket Coverage)		\$		179,908			
2. Fire and Extended Coverage		(					,, <u>,,</u>
3. Other (Specify)		9	5,908	5,908	000000000000000000000000000000000000000	355500000000000000000000000000000000000	\$60\00000
Other insurance, crime							
14d. Total Insurance Expenditures (14a +		(		198,415			
15. Total All Expenditures (A-13 thru C-	14)	(	21,701,018	21,701,018			

## D. Adjustments to Statement of Expenditures

	e of Fa	•	0 . 110	Lic	cense No.		Report for Year Ended		
Chels	sea Pla	ice Ca	re Center, LLC	1	2220-C	9/30/2017		28	37
T.	n	T 3			Total Amount of				
	Page	1 1	Y. The state			COM	DINIC	Manage	مهند م
No.			Item Description		Decrease	CCNH	RHNS	NurseFa	ic-Aius
	10 - 3	Salarie	es and Wages						
1.	-		Outpatient Service Costs	\$					
2.	ļ		Salaries not related to Resident Care	\$					
3.			Occupational Therapy	\$					
4.		ليلا	Other - See attached Schedule	\$				***************************************	*************
	13 - 1	Profes.	sional Fees	-					
5.			Resident Care Physicians **	\$					<del></del>
6.			Occupational Therapy	\$					
7.			Other - See attached Schedule	\$				******************************	7000750000000000
Page	s 15 8	à 16 -	Administrative and General						
8.			Discriminatory Benefits	\$					
9.			Bad Debts	\$	1,394,267	1,394,267			
10.			Accounting & Legal	\$					
11.			Telephone	\$					
12.			Cellular Telephone	\$					
13.			Life insurance premiums on the life						
			of Owners, Partners, Operators	\$					
14,			Gifts, flowers and coffee shops	\$					
15.	-		Education expenditures to colleges or						
			universities for tuition and related costs						
			for owners and employees	\$	estimativas results results and a second	270000000000000000000000000000000000000	100100011111000	annentichereneneneere	sepanticopirmopir
16.	<del> </del>		Travel for purposes of attending						
, ,			conferences or seminars outside the						
			continental U.S. Other out-of-state						
			travel in excess of one representative	\$				***************************************	400000000000000000
17.	<u> </u>	-	Automobile Expense (e.g. personal use)	\$					
18.	<u> </u>	<del> </del>	Unallowable Advertising *	\$		12,313			
19.		-	Income Tax / Corporate Business Tax	-\$		12,010			www.
20.		-	Fund Raising / Contributions	\$					
21.		<u> </u>	Unallowable Management Fees	\$	*******			<u> </u>	
		-	Barber and Beauty	<u>Ψ</u>				AL-MAUTE	
22.		<u> </u>	Other - See attached Schedule	\$		38,127			
23.		D'-4		ф	30,127	36,127			
	_	Dietar T	y Expenditures					<b></b>	
24.			Meals to employees, guests and others	φ.					
		<u></u>	who are not residents	\$					
$\vdash$		Laune	lry Expenditures						
25.	•		Laundry services to employees, guests	_					
	<u></u>		and others who are not residents	\$					***************************************
		House	ekeeping Expenditures		ļ				
26	.		Housekeeping services to employees, guests						
			and others who are not residents	\$					
			Subtotal (Items 1 - 26	) \$	1,444,707	1,444,707			

<sup>\*</sup> All except "Help Wanted".

<sup>(</sup>Carry Subtotal forward to next page)

<sup>\*\*</sup> 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 Li					
	N. 5. 84				
Total Other Sa	alaries A	.djustment	\$ -	\$ -	\$ -

### Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
Total Othe	r Fees Adj	ustments	\$ -	\$ -	\$ -

### Schedule of Other A&G Adjustments

Page Ref Li	ine Ref Description	CCNH	RHNS	NurseFac-Aids
16a	PENALTIES	\$ 1,920		\$ -
16a	LATE FEES	\$ 1,946		\$ -
16a	PRIOR PERIOD EXPENSES			
	rounding	\$ -		
	Provider User Fee for Medicare days	\$ 34,261		\$ -
Total Other A	A&G Adjustments	\$ 38,127 \$		\$ -
Total Other A	A&G Adjustments	\$ 38,127   \$		1.8

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

NI.	C E -	-:1:4.	D. Adjustments to Statemen	License No. Report for Year Ended				Page	~~~~~	of
	e of Fa			LIC	2220-C	9/30/2017	ear Ended	29	ı	37
Cheis	sea Pia	ice Ca	re Center, LLC	7	Total	9/30/2017		27		<u> </u>
т.	ъ	, ,			Amount of					
	Page	1	Itara Description		Decrease	CCNH	RHNS	Nurse	Fac	Aide
No.	No.	No.	Item Description	\$			Krus	Nuist	Tac	-Alus
	20. 7		Subtotals Brought Forward	Þ	1,444,707	1,444,707				
	20 - F	esiae	nt Care Supplies***	\$						
27.			Prescription Drugs	_	1 245	1 245				·····
28.			Ambulance/Limousine	\$	1,245	1,245				
29.			X-rays, etc	\$	2,097	2,097				~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
30.		<del></del>	Laboratory	\$	5,684	5,684				
31.			Medical Supplies	\$						
32.			Oxygen (non emergency)	\$		7				
33.			Occupational Therapy	\$	25	2.5				
34.	<u> </u>		Other - See Attached Schedule	\$	25	25				
	22 - A	<i>Aainte</i>	enance and Property							
<i>35</i> .			Excess Movable Equipment Depreciation	ф		<u> </u>				
			See Attached Schedule	\$						
36.			Depreciation on Unallowable							
			Motor Vehicles	\$						
37.			Unallowable Property and Real					68.8		
		ļ	Estate Taxes	\$						
38.			Rental of Building Space or Rooms	\$						
39.			Other - See Attached Schedule	\$			Name and the second party of the	***************************************	202222310	manamal Zadas
Page	27 - 1	nsura	ince							
40.			Mortgage Insurance	\$						
41.			Property Insurance	\$				************	AUX COM A SE	
Othe	r - Mi	scella	neous					120,200.1		
42.			Research or Experimental Activities	\$	<u>}</u>	ļ., .				
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,		STATESTICAL CONTRACTOR					
	Į		enhancement or promotion of the							
			providers interest	\$						
48.			Interest Income on Accounts Rec	\$						
49.	,		Other (include personnel and other		440945					
			costs unrelated to resident care) - See							
			Attached Schedule	\$						
Not	For P	rofit F	Providers Only		200000000000					
50.	1	Ī	Building/Non Movable Eq. Depreciation							
			Unallowable Building Interest -							
			See Attached Schedule	\$				4 30 30 70 70 70 70 70 70 70 70 70 70 70 70 70		
51	Tota	l Amo	unt of Decrease (Items 1 - 50)	\$		1,453,758		1		

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

### Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac- Aids
20	5J		24.98		- 1
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)			
13	B9A	ST- Resident Care (for outpatent therapy - see schedule)	30.74		
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)			
Total Othe	r Ancillar	y Costs	\$ 25	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac- Aids
Total Exce	ss Movabl	e Equipment Deprectation	\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

Dogo Dof	Line Def. Description	CCNH	RHNS	NurseFac- Aids
Page Ref	Line Ref Description	COM	IGH IO	1
505.000.000.0000 100.000.0000				
Total Othe	r Property Adjustments	\$ -	\$	S -

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac- Aids
		Houskeeping Supplies (for Outpatient Therapy - see schedule)	\$ -		
20		Housekeeping purchased services (for Outpatient Therapy see schedule)	\$ -		
22	6B	Heat (for outpatient Therapy see schedule)	\$ -		
22	6C	Light and Power (for outpatient therapy see schedule)	\$ -		
22	6D	water (for outpatient therapy see schedule)	\$ -		
22	6A	Repair&Maint (for outpatient thorapy see schedule)	\$ -		
Total Othe	r Adjustm	ents	\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref Desci	ription	CCNH	RHNS	NurseFac- Aids
Total Unal	llowable Building	Interest	\$ -	\$ -	\$ -

### F. Statement of Revenue

Name of Facility	License No.		Report for Y	ear Ended		Page		of
Chelsea Place Care Center, LLC	2220-C		9/30/2017	our Entaca		30	1	37
one is a control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of t						· · ·		
	Item		Total	CCNH	RHNS	Nurse	Fac-A	∖ids
L Resident Room, Board & Routir								
1. a. Medicaid Residents (CT on		\$	20,100,808	20,100,808		1670670007000	5544449	\$16500000
b. Medicaid Room and Board		\$	20,100,000	20,100,000				
2. a. Medicaid (All other states)		\$						
b. Other States Room and Boa		\$						
3. a. Medicare Residents (all inc		\$	949,599	949,599				
b. Medicare Room and Board		\$	747,373					
4. a. Private-Pay Residents and		\$	69,994	69,994				
b. Private-Pay Room and Boar		<del>Ψ</del>	02,224	02,224			·	
II. Other Resident Revenue	d Contractual Anowance							
		۵	70 926	70 026				600000
1. a. Prescription Drugs - Medic		\$ \$	72,836	72,836				
b. Prescription Drugs - Medic			(72,836)	(72,836)				
c. Prescription Drugs - Non-A		\$ \$	9,063	9,063				
	Medicare Contractual Allowance **	-	(9,063)	(9,063)				
2. a. Medical Supplies - Medica		\$						
b. Medical Supplies - Medica		\$						
c. Medical Supplies - Non-M		\$	626	626				
<u> </u>	edicare Contractual Allowance **	\$	(626)	(626)				
3. a. Physical Therapy - Medica		\$	247,352	247,352				
b. Physical Therapy - Medica		\$	(85,120)	(85,120)				
c. Physical Therapy - Non-Mo		\$	101,925	101,925				
	edicare Contractual Allowance **	\$	(101,925)	(101,925)				
4. a. Speech Therapy - Medicare		\$	31,769	31,769				
b. Speech Therapy - Medicare		\$	(10,316)	(10,316)				
c. Speech Therapy - Non-Me		\$	28,830	28,830				
1 17	dicare Contractual Allowance **	\$	(28,830)	(28,830)		<u> </u>		
5. a. Occupational Therapy - M		\$	228,969	228,969				
	edicare Contractual Allowance **	\$	(85,712)	(85,712)				
c. Occupational Therapy - N		\$	83,341	83,341	-			
	on-Medicare Contractual Allowance **	\$	(82,380)	(82,380)		-		
6. a. Other (Specify) - Medicare		<u>\$</u>						
b. Other (Specify) - Non-Med		\$	(51,935)					
III. Total Resident Revenue (Secti	on I. thru Section II.)	\$	21,396,370	21,396,370				*********
IV. Other Revenue*								
Meals sold to guests, employer	ees & others	\$						
2. Rental of rooms to non-reside	nts	\$						
3. Telephone		\$						
4. Rental of Television and Cab	e Services	\$						
5. Interest Income (Specify)	4.00	\$	7	7				
6. Private Duty Nurses' Fees		\$						
7. Barber, Coffee, Beauty and G	ift shops	\$						
8. Other (Specify)		\$	2,293	2,293				
V. Total Other Revenue (1 thru 8)		\$	2,301	2,301				
VI. Total All Revenue (III +V)		\$	21,398,670	21,398,670		ļ		
			1 21,550,010	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.1	<del>.</del>		

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

<sup>\*\*</sup> Facility should report all contractual allowances and/or payer discounts.

#### Schedule of Other Resident Revenue - Medicare

#### Related Exp

Page Ref	Description	CCNH	RHNS	NurseFac-Aid
	Lab Medicare	\$ 17,691		
	Lab Medicare CA	\$ (17,691)		
	Oxygen Medicare	\$ 393		
44.643	Oxygen Medicare CA:	\$ (393)		
	Equipment rental	\$ 614		1,00,00,00
	Equipment rental CA	\$ (614)		
	Pen Therapy	\$		
	Pen Therppy CA	\$		Galle, Holger
	Therapy Bods Medicare	\$		
	Therapy Beds Medicare CA	\$		
	Radiology Medicare	\$ 4,227		
	Radiology Medicare CA	\$ (4,227)		199999999
3 5 5 5 6	IV Therapy	\$ 9,903		
	IV Therapy CA	\$ (9,903)	<u> </u>	rhii sii raki
	Medical Transportation	\$		
	Medical Transportation CA	\$		
	Gilticose testing	\$		
\$4.57Y	Gluense testing CA	\$	garra Pasibir	
33088	Outpatient therapy Medicare	\$ .		
Total Oth	er Resident Revenue - Medicare	\$ -	\$	\$

#### Schedule of Other Non-Medicare Resident Revenue

### Related Exp

Page Ref	Description	CCNH	RHNS	NurseFac-Ald
	Lab	611.42		
	Lab; CA	(611.42)		
	Oxygen	\$ 8,754		\$
	Oxyger CA	\$ (8,754)		\$
	Equipment restal	\$ 5,247		
(39) (4) (4)	Equipment regtal CA	\$ (5,247)		
	Pen Therapy	3		
34546	Peri Therapy CA	\$ -		
	Therapy Beds	3 -		
	Therapy Beds CA	<b>S</b>		
PR 1333	Radiology	\$		
i Pinisa	Rudiology CA	S		100000000000000000000000000000000000000
	Medical Transportation	\$		
	Medical Transportation CA	\$		
	Glucose Testing	\$		
20000	Glucose Testing CA	\$		
	TV therapy	\$ 41,433		S
	IV therapy CA	<b>s</b> (41,433)		\$
	If hu shot revenue	\$ 2,699		
	Outpatient therapy:	\$		
	prior period revejue	\$ (54,634)		<u> 18.85H2H3</u>
	rounding	\$		
Total Oth	er Rekident Revenue	\$ (51,935)	\$	S

#### Interest Income

#### Account

15 (15 (15 (15 (15 (15 (15 (15 (15 (15 (	Page Ref Account		Balance	CCNH	RHNS	NurseFac-Alds
	INTEREST INCOME			7		
		Selevium de la como de				
				ra successive seas. Inga		
TOTAL WITCH EST MICOTIE	Application of the property of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of			e increix de local la la		\$ .

#### Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	NurseFuc-Ald
	MEALS	\$ ·		
43.834.5	TELEVISION INCOME	\$		
34 4.3	CONCESSIONS / VENDING INCOME	\$ 1,668		
	RESIDENT LATE PLE REVENUE	\$		
	RESIDENT ATTORNEY FEE REVENUE	\$ 4		
	TELEPHONE INCOME	\$		2012 July 10
	OTHER INCOME	\$ 625		
	OPTUM DIVIDENOS REVENUE	\$		Sec. 34, 340 (8);
		90,000,000,00		SHOWN SHOW
90000				331, 31, 33, 33
-5.4.165				150 150 150 150 150
di lata di				2000
Total Oth	er Revenue	\$ 2,293	\$	\$

### G. Balance Sheet

		Facility	License No.	Report for Year Ended	Page	of
Che	lsea I	Place Care Center, LLC	2220-C	9/30/2017	31	37
		A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANAGEMENT AND A MANA	Account	AND AND AND AND AND AND AND AND AND AND	A	mount
Asse	ets					
A.	Cu	rrent Assets				
	1.	Cash (on hand and in banks		AND THE RESIDENCE OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY	\$	(349,584
		Resident Accounts Receivab			\$	5,481,782
	3.	Other Accounts Receivable (	Excluding Owners or	Related Parties)	\$	
	4	Inventories			\$	58,648
	5.	Prepaid Expenses			\$	1,410,336
		a. Prepaid Insurance		1,307,765		
		b. Prepaid Property Taxes		98,622		
		c. Prepaid Expenses Other		3,949		
		d.				
	6.	Interest Receivable			\$	
	7.	Medicare Final Settlement R	eceivable		\$	
	8.	Other Current Assets (itemiz	e)		\$	(2,719,625
		Due From (to) Related Parties	,	(579,780)		
		Other Owners reserves	0	(2,139,845)		
			N			
Λ_0	To	tal Current Assets (Lines Al	thru 8)		\$	3,881,557
B.		ked Assets	unu oy			
IJ.		Land			\$	
		Land Improvements	*Historical Cost		\$	
	۷.	Laid improvements	Accum. Depreciati	on Net		
	2	Buildings	*Historical Cost	664,817	\$	567,75
	3.	Dunumgs	Accum, Depreciati		T T	507,70
	1	Leasehold Improvements	*Historical Cost	1,401,619	\$	497,063
	4.	Leasenoid improvements	Accum, Depreciati		T T	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	5	Non-Movable Equipment	*Historical Cost	43,932	\$	2,20
	Э,	Non-Movable Equipment	Accum. Depreciati		Ψ,	_,_∨
		Marshla Tarrinment	*Historical Cost	680,763	\$	134,49
	6.	Movable Equipment			Ψ	154,47
		37 1 3	Accum. Depreciati *Historical Cost	10,600	\$	
	7.	Motor Vehicles			Φ	
			Accum, Depreciati	on 10,600 Net	d)	
		Minor Equipment-Not Depr	eciable		\$	
	8.	Willion Equipment Not Dept				
	8. 9.	Other Fixed Assets (itemize	)		\$	
		Other Fixed Assets (itemize	)		\$	
			)		\$	

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

# G. Balance Sheet (cont'd)

Name of Facility		Facility	License No.	Report for Year Ended		Page of
Chels	sea I	Place Care Center, LLC	2220-C	9/30/2017		32   37
			Account		<b></b>	Amount
				Total Brought Forward:	\$	5,083,070
C.	Lea	asehold or like property record	led for Equity Purposes	,		
	l.	Land	Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of the Commence of th		\$	
	2.	Land Improvements	*Historical Cost	**************************************		
			Accum. Depreciation	Net	\$	WYC.
	3.	Buildings	*Historical Cost	AMAZONIA		
			Accum. Depreciation	Net	\$	
	4.	Non-Movable Equipment	*Historical Cost			
			Accum, Depreciation	n Net	\$	
	5.	Movable Equipment	*Historical Cost		i	
			Accum. Depreciation	Net Net	\$	
	6.	Motor Vehicles	*Historical Cost			
			Accum, Depreciation	n Net	\$	
	7.	Minor Equipment-Not Depre	eciable		\$	
C-8	To	tal Leasehold or Like Proper	ties (C1 thru 7)		\$	
D.	Inv	vestment and Other Assets	***************************************			
	1.	Deferred Deposits			\$	
	2.	Escrow Deposits			\$	411,151
	3.	Organization Expense	*Historical Cost			
		_	Accum. Depreciation	n Net	\$	
	4.	Goodwill (Purchased Only)			\$	
	5.	Investments Related to Resid	lent Care (itemize)	<del></del>	\$	79,857
		Patient Trust Funds		77,302		
		Long Term Deposit - prin	necare	2,555		
	6.	Loans to Owners or Related			\$	
		Name and Address	Amount	Loan Date		
	7.	Other Assets (itemize)			\$	nagarnaconacci (2000) (2000) (2000) (2000) (2000) (2000) (2000) (2000) (2000) (2000) (2000) (2000) (2000) (2000)
D-8.	To	otal Investments and Other A	ssets (Lines D1 thru 7)		\$	491,008
<b>D-</b> 9.	To	otal All Assets (Lines A9 + B	10 + C8 + D8		\$	5,574,078

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

## G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year I	Inded	Page	of	
Chelsea Place Care Center, LLC		2220-C	9/30/2017		33	37	
			Account	***************************************		Am	ount
Liabilities							
A.	Cu	rrent Liabilities					
wasnon a	1.	Trade Accounts Payable		WALL THE ADMINISTRATION OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE	\$		1,548,067
	2.	Notes Payable (itemize)			\$		1,234,232
		Working Capital Line of C	redit	1,234,232	2		
1			Oromonia				
		- Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Continues - Cont					
	3,	Loans Payable for Equipm			15 5 8		
		Name of Lender	Purpose	Amount	Date Due		
	4,	Accrued Payroll (Exclusiv	e of Owners and/or S	Stockholders only)	Ç		334,990
	5.	Accrued Payroll (Owners	and/or Stockholders	only)	3		
	6,	Accrued Payroll Taxes Pay	yable		9	}	
	7.	Medicare Final Settlement	Payable		\$		
	8.	Medicare Current Financia	ng Payable		9	3	
	9,	Mortgage Payable (Curren	nt Portion)		(5	8	
	10	. Interest Payable (Exclusiv		elated Parties)	5	5	
	11. Accrued Income Taxes*					5	
	12. Other Current Liabilities (itemize)				5	1,937,255	
Related Party Payables 909,499 Accrued Expenses (30,741)							
			(30,	.741)			
		Accrued Resident User Fees	326,				
		Accrued Workers Comp Expense	731,	.731			
A-13	3. Te	otal Current Liabilities (Li	nes A1 thru 12)		5	5	5,054,544

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

# G. Balance Sheet (cont'd)

Name of Facility			Page	of	
Chelsea Place Care Center, LLC	2220-C	9/30/2017	1000000	34	37
A	Account	M. H.		Am	ount
		Total Broug	ht Forward:		5,054,544
Liabilities (cont'd)					
B. Long-Term Liabilities					
Loans Payable-Equipment (			1 8	3	
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable	<u> </u>		'	\$	
3. Loans from Owners or Rela	ated Parties (itemize	)	5	\$	
Name and Address of Lender	Amount	Loan D	ate		
4. Other Long-Term Liabilitie	\$	77,302			
Patient Trust Funds					
11.11.11.11.11.11.11.11.11.11.11.11.11.					
B-5. Total Long-Term Liabilities (	Lines B1 thru 4)			\$	77,302
C. Total All Liabilities (Lines A-	13 + B-5)			\$	5,131,846

### **Annual Report of Long-Term Care Facility**

CSP-35 Rev. 6/95

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

	ne of Facility	License No.	Report for Y	ear Ended	Page	of
Che	lsea Place Care Center, LLC	2220-C	9/30/2017		35	37
Α	Dagayara	Account			A	mount
Α.	Reserves					
	1. Reserve for value of leased	land			\$	
	2. Reserve for depreciation va	lue of leased building	igs and appurten	ances		
	to be amortized		All the second		\$	
	3. Reserve for depreciation va	lue of leased person	al property (Equ	rity)	\$	
	4. Reserve for leasehold real p	roperties on which	fair rental value	is based	\$	
**************************************	5. Reserve for funds set aside	as donor restricted		Accession of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the	\$	
	6. Total Reserves				\$	
В.	Net Worth					
	1. Owner's Capital				\$	1,000
	2. Capital Stock				\$	
	3. Paid-in Surplus				\$	
	4. Treasury Stock	,			\$	
	5. Cumulated Earnings				\$	743,580
	6. Gain or Loss for Period	10/1/20	016 thru	9/30/2017	\$	(302,348)
	7. Total Net Worth				\$	442,232
C.	Total Reserves and Net Worth	,			\$	442,232
D.	Total Liabilities, Reserves, an	d Net Worth			\$	5,574,078

# H. Changes in Total Net Worth

Account		e of Facility	License No.	Report for Year I	Ended	Page	of
A.   Balance at End of Prior Period as shown on Report of 09/30/2016   S	Chels	sea Place Care Center, LLC	2220-C	9/30/2017	1 1 0 30 1 2 11 11 11 11 11	36	37
B.   Total Revenue (From Statement of Revenue Page 30)   \$   21,398,6	A						nount
C. Total Expenditures (From Statement of Expenditures Page 27)   \$ 21,701,0     D. Net Income or Deficit   \$ (302,3)     E. Balance   \$ (302,3)     F. Additions   1. Additional Capital Contributed (itemize)				09/30/2016			
D. Net Income or Deficit   \$ (302,3)				INSERTITE III III			21,398,670
E. Balance \$ (302,3)  F. Additions 1. Additional Capital Contributed (itemize)  2. Other (itemize)  F-3. Total Additions G. Deductions 1. Drawings of Owners/Operators/Partners (Specify)  Name and Address (No., City, State, Zip)  Title Amount  2. Other Withdrawings (Specify)  Purpose  Amount  3. Total Deductions  \$			ent of Expenditures I	Page 27)			21,701,018
F. Additions 1. Additional Capital Contributed (itemize)  2. Other (itemize)  F-3. Total Additions G. Deductions 1. Drawings of Owners/Operators/Partners (Specify)  Name and Address (No., City, State, Zip)  Title Amount  2. Other Withdrawings (Specify)  Purpose  Amount  3. Total Deductions  \$				Name of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second seco			(302,348)
1. Additional Capital Contributed (itemize)  2. Other (itemize)  F-3. Total Additions G. Deductions 1. Drawings of Owners/Operators/Partners (Specify)  Name and Address (No., City, State, Zip)  Title Amount  2. Other Withdrawings (Specify)  Purpose  Amount  3. Total Deductions  \$						\$	(302,348)
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	Γ.	1. Additional Capital Contribute	d (itemize )				
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	F-3	Total Additions				\$	
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  \$						•	
Name and Address (No., City, State, Zip)  Title Amount  2. Other Withdrawings (Specify)  Purpose  Amount  3. Total Deductions			rs/Partners (Specify)			\$	
Purpose Amount  3. Total Deductions \$					Amount		
3. Total Deductions \$		2. Other Withdrawings (Specify)				\$	
		Purpose		Amou	ınt		
		3. Total Deductions				\$	
	H.		09/30	)/17		\$	(302,348)

### I. Preparer's/Reviewer's Certification

Name of Facility		License No.	Report for Year Ended	Page o	f
Chelsea Place Care Center, LLC		2220-C	9/30/2017	37 3′	7
Check appropriate category					
Ø	Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☑ NurseFac-Aids		
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.					
Signat	ure of Preparer	Title	Date Signed		
Printed Name of Preparer					
iCare Management, LLC					
Address			Phone Number		
341 Bidwell Street, Manchester, CT 06040			860-570-2140		
					~~~~