State of Connecticut

Annual Report of Long-Term Care Facility
Cost Year 2017

Name of Facility (as licensed) Farmington Care Center, LLC		
Address (No. & Street, City, State, Zip Code) 20 Scott Swamp Road, Farmington, CT 06032		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☑ NurseFac-Aids
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017	

License Numbers:	CCNH	RHNS	NurseFac-Aids	Medicare Provider
	2149-C		AIDS	07-5251

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	10447		

For Department Use Only

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

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General Information

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Farmington Care Center, LLC	2149-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 Farmington 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) John Zazzaro			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)

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Department of Social Services
55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Farmington Care Center, LLC	Period Covered:		From 10/1/2016	To 9/30/2017
Address of Facility 20 Scott Swamp Road, Farmington, CT 06032				
Report Prepared By iCare Management, LLC	Phone Number 860-570-2140		Date 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.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-677-7707	9/30/2017	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Farmington Care Center, LLC	20 Scott Swamp Road, Farmington, CT 06032

License Numbers:	CCNH	RHNS	NurseFac-Aids	Medicare Provider No.
	2149-C		AIDS	07-5251

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☑ NurseFac-Aids

Type of Ownership (Check appropriate box)

○ Proprietorship ◉ LLC ○ Partnership ○ Profit Corp. ○ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
John Zazzaro	001734

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
Farmington Care Center, LLC	20 Scott Swamp Road, Farmington, CT 06032	CT

Name of Partners/Members	Business Address	Title	% Owned
Executive Advisors, LLC	341 Bidwell St. Manchester, CT 06040	Member	47.5
Apex Advisors, LLC	341 Bidwell St. Manchester, CT 06040	Member	47.5
Christopher Wright	341 Bidwell St. Manchester, CT 06040	Member	5

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	3A	37

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

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

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

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	3B	37

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

Owner(s) of Facility

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Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/3/2017	4	37

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Bidwell Care Center, LLC	333 Bidwell St. Manchester, CT 06040				Shared Employees	- -	(4,230)	4,230
Chelsea Place Care Center, LLC	25 Lorraine St. Hartford, CT 06105				Shared Employees	- -	(7,429)	7,429
Chestnut Point Care Center, LLC	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	- -	(4,385)	4,385
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032				Bank Fees	16 M		-
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032				Shared Employees	- -	-	-
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	- -	(4,295)	4,295
Meriden Care Center, LLC (Silver Springs)	33 Roy St. Meriden, CT 06450				Shared Employees	- -	(3,036)	3,036
Trinity Hill Care Center, LLC	151 Hillside Ave. Hartford, CT 06106				Shared Employees	- -	12,764	(12,764)
Westside Care Center, LLC	349 Bidwell St. Manchester, CT 06040				Shared Employees	- -	(5,145)	5,145
Wintonbury Care Center, LLC	140 Park Ave. Bloomfield, CT 06002				Shared Employees	- -	(1,762)	1,762
Secure Care Center LLC	60 West Street, Rocky Hill, CT 06067				Shared Employees	- -	10,374	(10,374)
Touchpoints at Homecare LLC	1838 Silas Deane Hwy, Rocky Hill, CT 06067				Shared Employees	- -		
Touchpoints therapy	171 Main St. East Windsor, CT 06088				OT/PT/ST	13 5,8,10	826,623	(826,623)
Bidwell Realty, LLC	341 Bidwell St. Manchester, CT 06040				Building Lease & Rent	22,22,27 10,9,14	453,791	(453,791)
iCare Management, LLC	341 Bidwell St. Manchester, CT 06040				Postage & Legal	16, 15 M,E	13,632	(13,632)
iCare Health Management, LLC	341 Bidwell St. Manchester, CT 06040				Shared EEs not part of mgmt agmt	- -	189,239	(189,239)
-	-				Management Services, Direct	20 5j	108,797	(108,797)
-	-				Management Services, Indirect	20 5j	14,733	(14,733)
-	-				Management Services, Administrative	16 M12	334,034	(334,034)
-	-				-	- -		-
-	-				-	- -		-
-	-				-	- -		-
-	-				-	- -		-
-	-				-	- -		
All 9 Care Centers, mgmt co, realty cos					Share Common 401k, Pension and Insurance plans, courier, legal and various other services			

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Accelerated Care Plus Corp. 4850 Joule Street, Suite A-1 Reno,	○	⊙	Omnistim Electrotherapy and Omnisound Therapeutic Ultrasound Equipment	05/18/10	1 yr with automatic	24,078	24,078
ADP, Inc., One ADP Drive MS-100, Augusta, GA 30909	○	⊙	Time Clocks and Payroll Punch Equip	06/01/10	60 Months	8,794	8,794
Canon Financial Services, 14904 Collection Center Drive, Chicago, IL 60693	○	⊙	Copier	03/02/12	60 Months	2,948	2,948
GE Capital C/O Ricoh USA, P.O.Box 41564, Philadelphai, PA 19101	○	⊙	Copier	03/04/14	48 Months	4,311	4,311
Mail Finance/Neopost New England, 25881 Newtwork Place, Chicago, IL 60673	○	⊙	Postage Meter Rental		Monthly	622	622
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ○ No **Total** *** 40,754

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

** Attach copies of newly acquired leases.

*** Amount should agree to Page 22, Line 6e.

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General Information and Questionnaire
Accounting Basis

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 O'Connor, Davies LLP	100 Great Meadow Road, Ste 401, Wethersfield, CT 06109
2	
3	
4	

Services Provided by This Firm (*describe fully*)	
1 Taxes, financial statements, accounting support	$ 4,303
2	$
3	$
4	$
	Charge for Services Provided: $ 4,303

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

⊙ Yes ○ No 15D

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 iCare Health Management, LLC	860-570-2140
2 Starble and Harris	860-678-7775
3 Durant Nichols / Robinson & Cole, LLP	860-275-8200
4 Various others (American Arbitration , Various Arbitration, Murtha Cullina,Jackson Lewis))	
5 Starble and Harris, iCare Health Management LLC	860-678-7775 & 860-570-2140

Address (*No. & Street, City, State, Zip Code*)
1 341 Bidwell Street, Manchester CT
2 32 Main Street, Avon, CT
3 280 Trumbull St, Hartford, CT
4
5 32 Main Street, Avon, CT & 341 Bidwell Street, Manchester CT

Services Provided by This Firm (*describe fully*)	
1 Lease and contract issues, general legal advice, Labor Law	$ 11,279
2 Lease and contract issues, general legal advice, union funds advice	$ 1,229
3 Employment law, arbitrations, contract negotiations	$ 1,863
4 Employment Arbitrations, healthcare law	$
5 Conservatorships	$ (19,052)
	Charge for Services Provided: $ (4,680)

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

⊙ Yes ○ No 15E

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total NurseFac-Aids	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	NurseFac-Aids	Total	CCNH	RHNS	NurseFac-Aids
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	120	120			120	120			105	105		
B. On last day of THIS report period	105	105			105	105			105	105		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	98	98			98	98			89	89		
B. As of midnight of THIS report period	94	94			89	89			94	94		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,723	4,723			3,369	3,369			1,354	1,354		
B. Medicaid (Conn.)	27,078	27,078			20,340	20,340			6,738	6,738		
C. Medicaid (other states)												
D. Private Pay	1,554	1,554			1,192	1,192			362	362		
E. State SSI for RCH												
F. Other (Specify) Insurance	724	724			572	572			152	152		
G. Total Care Days During Period (3A thru F)	34,079	34,079			25,473	25,473			8,606	8,606		
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)**	34,079	34,079			25,473	25,473			8,606	8,606		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ◉ Yes ○ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	NurseFac-Aids	Lost			Gained			CCNH	RHNS	NurseFac-Aids	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5/8/2017	X			15						105			delicensed beds

5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.

Change in Resident Days	CCNH	RHNS	NurseFac-Aids
1st change	8,554		
2nd change			
3rd change			
4th change			

6. Number of Residents and Rates on September 30 of Cost Year

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	NurseFac-Aids	R.C.H.	ICF-MR
No. of Residents	11	77		6				
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.	551.00	240.00		420.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	NurseFac-Aids
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	6,060	6,060		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	2,293	2,293		
C. Other	13,173	13,173		
D. ***Total Physical Therapy Treatments***	21,526	21,526		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	333	333		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	112	112		
C. Other	1,016	1,016		
D. ***Total Speech Therapy Treatments***	1,461	1,461		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	3,352	3,352		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	1,465	1,465		
C. Other	12,334	12,334		
D. ***Total Occupational Therapy Treatments***	17,151	17,151		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	10	37

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

Item	Total Cost and Hours					
	CCNH	Hours	RHNS	HIours	NurseFac-Aids	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	152,718	2,086				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	227,495	10,393				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	52,994	2,086				
c. Dietary Workers	365,531	19,774				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	33,554	1,838				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	-17					
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	198,873	4,452				
b. RN						
1. Direct Care	505,479	12,305				
2. Administrative**	130,664	3,343				
c. LPN						
1. Direct Care	984,178	33,117				
2. Administrative**						
d. Aides and Attendants	1,344,453	76,549				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	146,084	7,970				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	86,697	3,832				
n. Marketing						
o. Other (Specify) See Attached Schedule	44,477	2,456				
A-13. Total Salary Expenditures	4,273,178	180,200				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH $	CCNH Hours	RHNS $	RHNS Hours	NurseFac-Aids $	NurseFac-Aids Hours
UNIT SECRETARIES SALARIES	$ -	-			$ -	-
MEDICAL RECORDS SALARIES	$ 33,402	1,664			$ -	-
CENTRAL SUPPLY SALARIES	$ 11,075	793			$ -	-
RESPIRATORY THERAPY SALARIES	$ -	-			$ -	-
Total	$ 44,477	2,456	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH $	CCNH Hours	RHNS $	RHNS Hours	NurseFac-Aids $	NurseFac-Aids Hours
MEDICAL RECORDS CONTRACT SERVICE	$ 5,872	2			$ -	-
ADMISSIONS C/S LABOR	$ 37,340	712			$ -	-
CENTRAL SUPPLY CONTRACT SERVICE	$ (530)	(115)			$ -	-
ADMINISTRATIVE CONTRACT SERVICE LABOR	$ 141,760	3,606			$ -	-
RESPIRATORY THERAPY CONTRACT SERVICES	$ 5,421	120			$ -	-
PHYSICAL THERAPY C/S MEDICIAD	$ 42,305	572				
SPEECH THERAPY C/S Medicaid	$ 4,817	63				
OCCUPATIONAL THERAPY C/S MEDICIAD	$ 30,378	381				
Total	$ 267,364	5,341	$ -	-	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	NurseFac-Aids							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	NurseFac-Aids							
Section III - Administrators* **										
John Zazzaro	152,718			same as employees less union funds	Administrator	2,086	A2			
				same as employees less union funds	Administrator		A2			
				same as employees less union funds	Administrator		A2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility Farmington Care Center, LLC	License No. 2149-C		Report for Year Ended 9/30/2017		Page 13	of 37
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	NurseFac-Aids	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian	33,480	744				
2. Dentist						
3. Pharmacist	11,275	170				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	377,728	4,957				
b. Other						
6. Social Worker	3,695					
7. Recreation Worker	16,671	35+Cable				
8. Physicians						
a. Medical Director (entire facility)	36,000	328				
b. Utilization Review (Title 18 and 19 only) monthly meeting		5				
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
Physician Care Contract Services	10,927	72				
9. Speech Therapist						
a. Resident Care	54,663	717				
b. Other						
10. Occupational Therapist						
a. Resident Care	316,502	4,157				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	58,827	846				
2. Administrative***	10,990	(6)				
b. LPN						
1. Direct Care	2,457	50				
2. Administrative***						
c. Aides	(81)	199				
d. Other						
12. Other (Specify)						
See Attached Schedule	267,364	5,341				
B-13 Total Fees Paid in Lieu of Salaries	1,200,499	17,579				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Omnicare	Pharmacy Consulting	○	⊙	
Tocuhpoints Therapy	Therapy	⊙	○	Common Ownership
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Shared Employees	⊙	○	Common Ownership
Healthdrive Physician Services	Audiology, Dental and Podiatry	○	⊙	
Dr Bodanski	Medical Director	○	⊙	
		○	⊙	
Ready Nurse, Nurse Network	Nursing pool (RN, LPN,CNA)	○	⊙	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
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		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	15	37

Item		Total	CCNH	RHNS	NurseFac-Aids
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	261,070	261,070		
2. Disability Insurance	$				
3. Unemployment Insurance	$				
4. Social Security (F.I.C.A.)	$	382,837	382,837		
5. Health Insurance	$	705,852	705,852		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	229,028	229,028		
8. Uniform Allowance	$				
9. Other (*Specify*) See Attached Schedule	$	29,340	29,340		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	38,268	38,268		
d. Accounting and Auditing	$	4,303	4,303		
e. Legal (*Services should be fully described on Page 7*)	$	(4,680)	(4,680)		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	23,275	23,275		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	21,098	21,098		
2. Cellular Phones	$	1,319	1,319		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22*)					
1. Income*	$				
2. Other (*Specify*) See Attached Schedule	$	3,148	3,148		
3. Resident Day User Fee	$	718,695	718,695		
Subtotal	$	2,413,551	2,413,551		

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

(Carry Subtotals forward to next page)

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

Farmington Care Center, LLC
9/30/2017

Schedule of Other Employee Benefits

Description	CCNH	RHNS	NurseFac-Aids
UNION TRAINING	$ 29,340		$ -
Total	$ 29,340	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	NurseFac-Aids
INTERNET EXPENSES	$ 3,148		$ -
Total	$ 3,148	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	16	37

Item		Total	CCNH	RHNS	NurseFac-Aids
Subtotals Brought Forward:		2,413,551	2,413,551		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	1,425	1,425		
3. Gifts to Staff and Residents	$	1,008	1,008		
4. Employee Travel	$	1,657	1,657		
5. Education Expenses Related to Seminars and Conventions	$	4,919	4,919		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*) See Attached Schedule	$	433	433		
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	4,271	4,271		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$	26,823	26,823		
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	4,351	4,351		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	8,908	8,908		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions*** See Attached Schedule	$	250	250		
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	135,821	135,821		
12. Administrative Management Services**	$	334,034	334,034		
13. Other (*Specify*) See Attached Schedule	$	22,259	22,259		
C-14 Total Administrative & General Expenditures	$	2,959,710	2,959,710		

* Do not include Subscriptions, which should go in item 9.

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	NurseFac-Alds
MEALS	$ 433		$ -
Total Other Travel and Entertainment	$ 433	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	NurseFac-Alds
COMMUNICATIONS SPECIAL EVENTS	$ 26,823		$ -
Total Other Advertising	$ 26,823	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	NurseFac-Alds
ALTCFM			
CAHCF Dues	$ 8,748		$ -
OTHER DUES	$ 160		$ -
Total Dues	$ 8,908	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	NurseFac-Alds
CONTRIBUTIONS	$ 250		$ -
Total Contributions	$ 250	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	NurseFac-Alds
SOCIAL SERVICE SUPPLIES	$ -		$ -
SOC SVC MINOR EQUIPMENT	$ -		$ -
ADMINISTRATIVE MINOR EQUIPMENT	$ 193		$ -
EMPLOYEE RELATIONS	$ 5,680		$ -
EMPLOYEE RELATIONS-OTHER	$ 41		$ -
PERMITS & LICENSES	$ 2,245		$ -
VOLUNTEER EXPENSE	$ -		$ -
BANK FEES	$ 13,503		$ -
CMS REVISIT USER FEES	$ -		$ -
PENALTIES	$ -		$ -
LATE FEES	$ 596		$ -
Rounding	$ 0		$ -
Total Other Administrative and General	$ 22,259	$ -	$ -

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CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Farmington Care Center, LLC	License No. 2149-C	Report for Year Ended 9/30/2017	Page 17 of 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
iCare Management, LLC/iCare Health Management, LLC	334,034	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	108,797	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	14,733	MANAGEMENT FEES- INDIRECT CARE	Pg 20 j

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

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CSP-18 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page of
Farmington Care Center, LLC	2149-C	9/30/2017	18 | 37

Item		Total	CCNH	RHNS	NurseFac-Aids
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	193,424	193,424		
2. Non-Food Supplies	$	15,486	15,486		
3. Other (*Specify*) DIETARY SUPPLEMENTS	$	19,282	19,282		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	863	863		
c. Management Services**	$				
d. Other (*Specify*) DIETARY MINOR EQUIPMENT	$	1,867	1,867		
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	230,922	230,922		

2F. Dietary Questionnaire		Total	CCNH	RHNS	NurseFac-Aids
G. Resident Meals:	Total no. of meals served per day:*	280	280		

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.
** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Name of Facility	License No.	Report for Year Ended	Page
Farmington Care Center, LLC	2149-C	9/30/2017	19 | 37

Item		Total	CCNH	RHNS	NurseFac-Aids
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	74	74		
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $				
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	261,078	261,078		
c. Management Services**	$				
d. Other (*Specify*) LAUNDRY MINOR EQUIPMENT	$	102	102		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	261,253	261,253		

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

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3E.

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

*** Pounds of Laundry only required for multi-level facilities.

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CSP-20 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	20	37

Item			Total	CCNH	RHNS	NurseFac-Aids
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	20,390	20,390		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	254,703	254,703		
c. Management Services*		$				
d. Other (*Specify*) HOUSEKEEPING MINOR EQUIPMENT		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	275,094	275,094		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from OMNICARE PHARMACY		$	184,441	184,441		
b. Medicine Cabinet Drugs		$	16,840	16,840		
c. Medical and Therapeutic Supplies		$	51,134	51,134		
d. Ambulance/Limousine***		$	9,214	9,214		
e. Oxygen						
1. For Emergency Use		$	3,201	3,201		
2. Other***		$				
f. X-rays and Related Radiological Procedures***		$	6,034	6,034		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***		$	14,933	14,933		
i. Recreation		$				
j. Other (Specify)**** See Attached Schedule		$	263,174	263,174		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	548,972	548,972		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	NurseFac-Aids
NURSING ADMIN SUPPLIES	$ 886		$ -
NURSING MINOR EQUIP	$ 4,671		$ -
MEDICAL RECORDS SUPPLIES	$ 1,035		$ -
MEDICAL RECORDS MINOR EQUIPMENT	$ -		$ -
MANAGEMENT ALLOCATIONS - DIRECT	$ 108,797		$ -
NON-COVERED PPS DR. VISITS	$ 1,242		$ -
RESIDENT CARE SUPPLIES	$ -		$ -
CENTRAL SUPPLY MINOR EQUIPMENT	$ 11,472		$ -
PERSONAL CARE SUPPLIES	$ 7,635		$ -
INCONTINENCY SUPPLIES	$ 30,073		$ -
VACCINE RESIDENTS	$ 4,273		$ -
PATIENT SPECIAL NEEDS	$ 21		$ -
PHYSICAL THERAPY SUPPLIES	$ -		$ -
PHYSICAL THERAPY EQUIPMENT RENT	$ -		$ -
PHYSICAL THERAPY MINOR EQUIPMENT	$ -		$ -
OCCUPATIONAL THERAPY SUPPLIES	$ -		$ -
OCCUPATIONAL THERAPY EQUIP RENTAL	$ -		$ -
OCCUPATIONAL THERAPY MINOR EQUIP	$ -		$ -
SPEECH THERAPY SUPPLIES	$ -		$ -
SPEECH THERAPY EQUIPMENT RENT	$ -		$ -
SPEECH THERAPY MINOR EQUIPMENT	$ -		$ -
RENTALS FOR NURSING EQUIPMENT NON BILLABLE	$ 32,008		$ -
EQUIPMENT RENTAL: AIDS UNIT	$ -		$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	$ 415		$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	$ -		$ -
HI LOW BED RENTAL & MATTRESSES	$ -		$ -
IV THERAPY SUPPLIES	$ 39,622		$ -
IV THERAPY CONTRACT SERVICE	$ -		$ -
MEDICAL WASTE CONTRACT SERVICE	$ 2,643		$ -
ACTIVITIES SUPPLIES	$ 3,647		$ -
ACTIVITIES MINOR EQUIPMENT	$ -		$ -
MANAGEMENT ALLOCATION - INDIRECT	$ 14,733		$ -
ADMISSIONS SUPPLIES	$ -		$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	$ -		$ -
STRIKE COSTS NON REIMBURSABLE	$ -		$ -
Total Other Resident Care	$ 263,174	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	NurseFac-Aids	Pg	Line
Health Services Group		O	O	VENDOR	Housekeeping Services	266,254			20	4b
Kettle Brook Care Center/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	O	O	VENDOR	Laundry Services	261,334			19	3b
Eagle Elevator		O	O	VENDOR	Elevator Contract	4,461			22	6F
Bioserve, Inc.		O	O	VENDOR	Medical Waste	2,643			22	6F
Brightview Landscaping/Twin Landscaping		O	O	VENDOR	Snow Removal/Landscaping	21,481			22	6F
CWPM		O	O	VENDOR	Trash removal	30,043			22	6F
American HealthTech		O	O	VENDOR	Software Maintenance Contract	17,934			16	M11
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	O	O	VENDOR	Payroll Services	36,969			16	M11
National Datacare Corp		O	O	VENDOR	Resident Trust Software	2,205			16	M11
Prime Care Technologuy services		O	O	VENDOR	Computer Consulting Services	33,099			16	M11
Priotiry Express		O	O	VENDOR	Courier Services	4,172			16	M11
Point Right Inc		O	O	VENDOR	Nursing Software	4,680			16	M11
		O	O	VENDOR						
		O	O	VENDOR						

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Farmington Care Center, LLC	2149-C	9/30/2017	22 | 37

Item		Total	CCNH	RHNS	NurseFac-Aids
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	43,800	43,800		
b. Heat	$	26,335	26,335		
c. Light & Power	$	60,209	60,209		
d. Water	$	31,631	31,631		
e. Equipment Lease (*Provide detail on page 6*)	$	40,754	40,754		
f. Other (*itemize*) See Attached Schedule	$	92,415	92,415		
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	295,144	295,144		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	193	193		
c. Non-Movable Equipment	$				
d. Movable Equipment	$	63,569	63,569		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	63,763	63,763		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	110,937	110,937		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	110,937	110,937		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	415,584	415,584		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	50,771	50,771		
c. Personal property taxes	$	6,686	6,686		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	647,740	647,740		

* 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	$ 13,295		$ -
PLANT CONTRACT SERVICE LABOR	$ -		$ -
ELEVATOR CONTRACT SERVICE	$ 4,461		$ -
FIRE/SPRINKLER CONTRACT SERVICE	$ 5,572		$ -
LANDSCAPING CONTRACT SERVICE	$ 8,520		$ -
SNOW REMOVAL CONTRACT SERVICE	$ 12,961		$ -
TRASH REMOVAL CONTRACT SERVICE	$ 30,043		$ -
HVAC CONTRACT SERVICE	$ -		$ -
SECURITY CONTRACT SERVICE	$ -		$ -
PLANT CONTRACT SERVICE OTHER	$ 10,029		$ -
PLANT MINOR EQUIPMENT	$ 6,005		$ -
RENT AUTO	$ -		$ -
RENT EQUIPMENT	$ 1,529		$ -
RENT OTHER	$ -		$ -
Total Other Repairs and Maintenance	$ 92,415	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period							(0)	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	1,161						193	
B-4. Subtotal								193
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. Auto	x											
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					994,711		994,711	774,761			62,957	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					14,729						612	
D-3. Subtotal												63,569
E. ***Total Depreciation***												63,763

Farmington Care Center, LLC
9/30/2017

Schedule of Land Improvements Acquired during this report period

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

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

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
11/11/2016	Smoke Detectors: HD Supply	$ 1,161	60	$ 193	
Total additions for Building Improvements		$ 1,161		$ 193	*
Deletions:					
Total deletions for Building Improvements		$ -		$ -	**

*Ties to Page 23, Line B3
**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Non-Movable Equipment		$ -		$ -	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

*Ties to Page 23, Line C3
**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
2/6/2017	Beds: Medline	$ 3,669	60	$ 428	
8/8/2017	Beds: Medline	$ 11,060	60	$ 184	
Total additions for Movable Equipment		$ 14,729		$ 612	*
Deletions:					
Total deletions for Movable Equipment		$ -		$ -	**

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/12/2016	Electrical Panel: Precision Electrical	$ 6,993	180	$ 427	
Total additions for Leasehold Improvement		$ 6,993		$ 427	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period				1,381,554	785,872			110,509	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				6,993				427	
C-4. Subtotal									110,937
D. ***Total Amortization***									110,937

* Straight-line method must be used.

** Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.
B. Life of mortgage; OR
C. Remaining Life of Lease; OR
D. Actual Life if owned by Related Party.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* O Yes ⊙ No

If "Yes," complete Part B.
If "No," complete Part C.

*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total
1. Date Land Purchased	12/01/03
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	12/01/03
4. Date of Initial Licensure	12/01/03
5. Total Licensed Bed Capacity	105
6. Square Footage	
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed HUD			
b. Date Mortgage Obtained	05/30/13			
c. Interest Rate for the Cost Year	335.00%			
d. Term of Mortgage (number of years)	26			
e. Amount of Principal Borrowed	2,102,000			
f. Principal balance outstanding as of 9/30/2016				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)	08/09/2017			
h. Date of Refinancing	Real Estate Sold - see			
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
Summit Farmington, LLC	20 Scott Swamp Rd, Farmington, CT	08/09/17	15 years with 2-5 year extension	297,000

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

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

Name of Facility	License No.	Report for Year Ended			Page of
Farmington Care Center, LLC	2149-C	9/30/2017			26 | 37

Item	Total	CCNH	RHNS	NurseFac-Aids
12. Interest				
A. Building, Land Improvement & Non-Movable Equipment				
1. First Mortgage $				
Name of Lender / Rate				
Address of Lender				
2. Second Mortgage $				
Name of Lender / Rate				
Address of Lender				
3. Third Mortgage $				
Name of Lender / Rate				
Address of Lender				
4. Fourth Mortgage $				
Name of Lender / Rate				
Address of Lender				
B. CHEFA Loan Information				
1. Original Loan Amount $				
2. Loan Origination Date				
3. Interest Rate %				
4. Term				
5. CHEFA Interest Expense				
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $				

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	27	37

Item	Total	CCNH	RHNS	NurseFac-Aids
Subtotals Brought Forward:				
12. C. Movable Equipment 1. Automotive Equipment $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*) $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
B. Item / Rate / Amount				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $				
12. D. Other Interest Expense (*Specify*) $ INTEREST	7,759	7,759		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	7,759	7,759		
14. Insurance				
a. Insurance on Property (buildings only) $	6,801	6,801		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	38,755	38,755		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $ Other insurance, crime	3,746	3,746		
14d. ***Total Insurance Expenditures (14a + b + c)*** $	49,302	49,302		
15. ***Total All Expenditures (A-13 thru C-14)*** $	10,749,573	10,749,573		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	28	37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	NurseFac-Aids
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $	38,268	38,268		
10.			Accounting & Legal $				
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.			Unallowable Advertising * $	26,823	26,823		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	99,065	99,065		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $				
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	164,157	164,157		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
Total Other Salaries Adjustment			$ -	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
Total Other Fees Adjustments			$ -	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
16a		PENALTIES	$ -		$ -
16a		LATE FEES	$ 596		$ -
16a		PRIOR PERIOD EXPENSES			
		rounding	$ 0		
		Provider User Fee for Medicare days	$ 98,469		$ -
Total Other A&G Adjustments			$ 99,065	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	29	37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	NurseFac-Aids
			Subtotals Brought Forward $	164,157	164,157		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $				
28.			Ambulance/Limousine $	9,214	9,214		
29.			X-rays, etc $	6,034	6,034		
30.			Laboratory $	14,933	14,933		
31.			Medical Supplies $				
32.			Oxygen (non emergency) $				
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	2,727	2,727		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Research or Experimental Activities $				
43.			Radio and Television Revenue $				
44.			Vending Machine Revenue $				
45.			Purchase Discounts and Allowances $				
46.			Duplications of functions or services $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest $				
48.			Interest Income on Accounts Rec $				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $	6	6		
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.			***Total Amount of Decrease (Items 1 - 50)*** $	197,071	197,071		

*** 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.

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Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
20	5J		1,242.47		-
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	495		
13	B9A	ST- Resident Care (for outpatent therapy - see schedule)	495		
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)	495		
Total Other Ancillary Costs			$ 2,727	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
Total Other Property Adjustments			$ -	$ -	$ -

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
20	4A1	Housekeeping Supplies (for Outpatient Therapy - see schedule)	$ 0		
20	4B	Housekeeping purchased services (for Outpatient Therapy see schedule)	$ 4		
22	6B	Heat (for outpatient Therapy see schedule)	$ 1		
22	6C	Light and Power (for outpatient therapy see schedule)	$ 0		
22	6D	water (for outpatient therapy see schedule)	$ 1		
22	6A	Repair&Maint (for outpatient therapy see schedule)	$ 0		
Total Other Adjustments			$ 6	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Farmington Care Center, LLC	2149-C	9/30/2017	30 | 37

Item		Total	CCNH	RHNS	NurseFac-Aids
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	6,518,023	6,518,023		
b. Medicaid Room and Board Contractual Allowance **	$				
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	2,384,413	2,384,413		
b. Medicare Room and Board Contractual Allowance **	$				
4. a. Private-Pay Residents and Other	$	840,896	840,896		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	98,451	98,451		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(98,451)	(98,451)		
c. Prescription Drugs - Non-Medicare	$	28,056	28,056		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(28,056)	(28,056)		
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	558,228	558,228		
b. Physical Therapy - Medicare Contractual Allowance **	$	(415,385)	(415,385)		
c. Physical Therapy - Non-Medicare	$	131,267	131,267		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(131,267)	(131,267)		
4. a. Speech Therapy - Medicare	$	93,579	93,579		
b. Speech Therapy - Medicare Contractual Allowance **	$	(68,728)	(68,728)		
c. Speech Therapy - Non-Medicare	$	12,257	12,257		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(12,257)	(12,257)		
5. a. Occupational Therapy - Medicare	$	515,866	515,866		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(413,684)	(413,684)		
c. Occupational Therapy - Non-Medicare	$	104,286	104,286		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(86,086)	(86,086)		
6. a. Other *(Specify)* - Medicare	$	38,027	38,027		
b. Other *(Specify)* - Non-Medicare	$	93,820	93,820		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	10,163,254	10,163,254		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	1	1		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	33,320	33,320		
*V. **Total Other Revenue*** (1 thru 8)	$	33,321	33,321		
*VI. **Total All Revenue*** (III+V)	$	10,196,575	10,196,575		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	NurseFac-Aids
	Lab Medicare	$ 23,641		
	Lab Medicare CA	$ (23,641)		
	Oxygen Medicare	$ 139		
	Oxygen Medicare CA	$ (139)		
	Equipment rental	$ 4,527		
	Equipment rental CA	$ (4,527)		
	Pen Therapy	$ -		
	Pen Therapy CA	$ -		
	Therapy Beds Medicare	$ -		
	Therapy Beds Medicare CA	$ -		
	Radiology Medicare	$ 4,899		
	Radiology Medicare CA	$ (4,899)		
	IV Therapy	$ 41,455		
	IV Therapy CA	$ (41,455)		
	Medical Transportation	$ -		
	Medical Transportation CA	$ -		
	Glucose testing	$ -		
	Glucose testing CA	$ -		
	Outpatient therapy Medicare	$ 38,027		
Total Other Resident Revenue - Medicare		$ 38,027	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	NurseFac-Aids
	Lab	1,572.85		
	Lab CA	(1,572.85)		
	Oxygen	$ 248		$ -
	Oxygen CA	$ (248)		$ -
	Equipment rental	$ 5,800		
	Equipment rental CA	$ (5,800)		
	Pen Therapy	$ -		
	Pen Therapy CA	$ -		
	Therapy Beds	$ -		
	Therapy Beds CA	$ -		
	Radiology	$ 745		
	Radiology CA	$ (745)		
	Medical Transportation	$ -		
	Medical Transportation CA	$ -		
	Glucose Testing	$ -		
	Glucose Testing CA	$ -		
	IV therapy	$ 6,441		$ -
	IV therapy CA	$ (6,441)		$ -
	Flu shot revenue	$ -		
	Outpatient therapy	$ 9,529		
	prior period revenue	$ 84,291		
	rounding	$ -		
Total Other Resident Revenue		$ 93,820	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	NurseFac-Aids
	INTEREST INCOME		$ 1		
Total Interest Income			$ 1	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	NurseFac-Aids
	MEALS	$ -		
	TELEVISION INCOME	$ 720		
	CONCESSIONS / VENDING INCOME	$ -		
	RESIDENT LATE FEE REVENUE	$ -		
	RESIDENT ATTORNEY FEE REVENUE	$ -		
	TELEPHONE INCOME	$ -		
	OTHER INCOME	$ 500		
	OPTUM DIVIDENDS REVENUE	$ 32,100		
Total Other Revenue		$ 33,320	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ (94,383)
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 2,271,890
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 567,711
a. Prepaid Insurance		528,323		
b. Prepaid Property Taxes		27,080		
c. Prepaid Expenses Other		12,308		
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ (447,425)
Due From (to) Related Parties		(194,949)		
Other Owners reserves		(252,476)		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,297,794
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost	1,161		$ 967
	Accum. Depreciation	193	Net	
4. Leasehold Improvements	*Historical Cost	1,388,547		$ 491,738
	Accum. Depreciation	896,808	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	1,009,441		$ 171,111
	Accum. Depreciation	838,330	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
Construction in Progress				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 663,817

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	32	37

Account				Amount
			Total Brought Forward:	$ 2,961,610
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$ 115,491
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$ 34,687
Patient Trust Funds		32,132		
Long Term Deposit - primecare		2,555		
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 150,178
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 3,111,788

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 280,383
2. Notes Payable (*itemize*)					$ 296,575
Working Capital Line of Credit				296,575	
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)					$ 263,904
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 1,210,059
Related Party Payables				566,044	
Accrued Expenses				(8,677)	
Accrued Resident User Fees				154,791	
Accrued Workers Comp Expense				497,902	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 2,050,921

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	34	37

Account	Amount
Total Brought Forward:	2,050,921
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$ 32,132
Patient Trust Funds 32,132	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 32,132
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 2,083,053

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	35	37

Account		Amount
A. **Reserves**		
1. Reserve for value of leased land		$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized		$
3. Reserve for depreciation value of leased personal property *(Equity)*		$
4. Reserve for leasehold real properties on which fair rental value is based		$
5. Reserve for funds set aside as donor restricted		$
6. Total Reserves		$
B. **Net Worth**		
1. Owner's Capital		$ 25,000
2. Capital Stock		$
3. Paid-in Surplus		$
4. Treasury Stock		$
5. Cumulated Earnings		$ 1,556,733
6. Gain or Loss for Period	10/1/2016 thru 9/30/2017	$ (552,998)
7. Total Net Worth		$ 1,028,735
C. ***Total Reserves and Net Worth***		$ 1,028,735
D. ***Total Liabilities, Reserves, and Net Worth***		$ 3,111,788

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	36	37

Account	Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2016	$
B. Total Revenue (*From Statement of Revenue Page 30*)	$ 10,196,575
C. Total Expenditures (*From Statement of Expenditures Page 27*)	$ 10,749,573
D. Net Income or Deficit	$ (552,998)
E. Balance	$ (552,998)
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		$
H. ***Balance at End of Period***	09/30/17	$ (552,998)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2017	37	37

Check appropriate category

☑ 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.

Signature of Preparer	Title	Date Signed

Printed Name of Preparer	
iCare Management, LLC	
Address	**Phone Number**
341 Bidwell Street, Manchester, CT 06040	860-570-2140