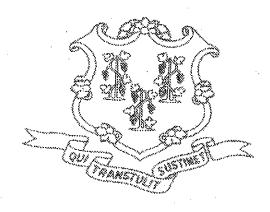
#### **State of Connecticut**



#### Annual Report of Long-Term Care Facility Cost Year 2018

Name of Facility (as li	icensed)						
Farmington Care Cent	ter, LLC						
Address (No. & Stree	t, City, State, Z	ip Code)					
20 Scott Swamp Road	l, Farmington, (	CT 06032					
Type of Facility							
Chronic and Conversing Home			Rest Home with Supervision only (RHNS)		Ø	Other	-
Report for Year Begin 10/1/2017	nning	, , , , , , , , , , , , , , , , , , ,	Report for Year 9/30/2018	Ending			
License Numbers:		CCNH 2149-C	RHNS	,	Other	M	edicare Provider 07-5251
s. r-u- :							
Medicaid Provider N	umbers:	CC 10447	CNH	RH	INS	10	EF-IID
For Department Use	e Only						
Sequence Number Assigned	Signed and Notarized	Date Received	Sequence Nu Assigne		Signed a	nd Notarized	Date Received

#### **General Information**

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2018	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, 2017 and ending September 30, 2018, 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.

			0 0	
Signed (Administrator)		Date	Signed (Owner)	Date
<u> </u>			This A Whigh	2/13/19
Printed Name (Administrator)			Printed Name (Owner)	
John Zazzaro		į.	Chris Wright	
Subscribed and Sworn	State of	Date	Signed (Notary Public)	Comp. Expires
to before me: property in the property of the	1	_ / /		otary Public-Connecticu
Banda Walsh	1 67	2/13/19	Quendy Valor	My Com/mission Explies
Address of Notary Public		1 1 1	L. Sarak	rebludiy ZŸ, ZÜZÜ
341 RELIGION !	+ Ma	apposter	OT OGAGA	

(Notary Seal)

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

CSP-1 Rev.9/2002

#### **General Information**

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2018	1	37

#### Administrator's/Owner's Certification

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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)	aco	Date 2-11-19	Signed (Owner)	Date
Printed Name (Administrator)			Printed Name (Owner)	
John Zazzaro			Chris Wright	SANDRA M. HOLLIS
Subscribed and Sworn	State of	Date	Signed (Notary Public)	MY COMMISSION EXPIRES APR. 30, 2019
to before me:		02-11-07	bolewiter	
Address of Notary Public			9	
341 BIRDELL	SNEET	MANCE	tester, at a	2.040

(Notary Seal)

#### **Table of Contents**

Gene	ral Information - Administrator's/Owner's Certification	1
Gene	ral Information and Questionnaire - Data Required for Real Wage Adjustment	1A
Gene	ral Information and Questionnaire - Type of Facility - Organization Structure	2 3
Gene	ral Information and Questionnaire - Partners/Members	
Gene	ral Information and Questionnaire - Corporate Owners	3A
Gene	ral Information and Questionnaire - Individual Proprietorship	3B
Gene	ral Information and Questionnaire - Related Parties	4
Gene	ral Information and Questionnaire - Basis for Allocation of Costs	5
Gene	ral Information and Questionnaire - Leases	6
Gene	ral Information and Questionnaire - Accounting Basis	7
	dule of Resident Statistics	8
Sche	dule of Resident Statistics (Cont'd)	9
A.	Report of Expenditures - Salaries & Wages	10
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant	
	Administrators and Other Relatives	11
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant	
	Administrators and Other Relatives (Cont'd)	12
B.	Report of Expenditures - Professional Fees	13
	Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee	
	for Service Basis	14
C.	Expenditures Other than Salaries - Administrative and General	15
C.	Expenditures Other than Salaries (Cont'd) - Administrative and General	16
	Schedule C-1 - Management Services	17
C.	Expenditures Other than Salaries (Cont'd) - Dietary	18
C.	Expenditures Other than Salaries (Cont'd) - Laundry	19
C.	Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
	Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C.	Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
	Depreciation Schedule	23
	Amortization Schedule	24
C.	Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C.	Expenditures Other than Salaries (Cont'd) - Interest	26
C.	Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D.	Adjustments to Statement of Expenditures	28
D.	Adjustments to Statement of Expenditures (Cont'd)	29
F.	Statement of Revenue	30
G.	Balance Sheet	31
G.	Balance Sheet (Cont'd)	32
G.	Balance Sheet (Cont'd)	33
G.	Balance Sheet (Cont'd)	34
G.	Balance Sheet (Cont'd) - Reserves and Net Worth	35
H.	Changes in Total Net Worth	36
Ī.	Preparer's/Reviewer's Certification	37

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

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjust	m	ent		Page 1A	of 37
Name of Facility		Period Cov	ered:	From	То
Farmington Care Center, LLC				10/1/2017	9/30/2018
Address of Facility					
20 Scott Swamp Road, Farmington, CT 06032		D1 37	1	Th. /	
Report Prepared By		Phone Nun		Date	
iCare Management, LLC		860-570-2	140	2/15/2019	
Item		Total	CCNH	RHNS	Other
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	\$			<u> </u>	
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	one No. of Fac	ility	Report for Ye	ear Ended	Page	of	
	860	)-677-7707		9/30/2018		2	37	
Name of Facility (as shown on license)		1 '		Street, City, St				
Farmington Care Center, LLC			amp	Road, Farmin	gton, CT (		+ 1	λī
CCNH License Numbers: 2149-C	l	RHNS		Other		Medicare P 07-5251	rovider	NO.
License Numbers: 2149-C Type of Facility (Check appropriate box(es))			<u> </u>			101-2421		
	Da	st Home with	Anroi	ng				
☐ Chronic and Convalescent Nursing Home only (CCNH)		pervision only		- 1/1	Other			
Type of Ownership (Check appropriate box)								
O Proprietorship O LLC O Partnership	) C	Profit Corp.	0	Non-Profit Co	rp. O	Government	O T	rust
			Date	e Opened	Date Clo	sed		
If this facility opened or closed during report year prov	/ide:							
Has there been any change in ownership								
or operation during this report year?	C	Yes	<u> </u>	No	If "Yes,"	explain fully	7.	
Administrator				T XT T	T			
Name of Administrator				Nursing I Administr		001734		
John Zazzaro				License		001/37		
Other Operators/Owners who are assistant administration	tors (ful	l or part time)	of th			-		
Name		<u> </u>		License	No.:			

#### General Information and Questionnaire Partners/Members

Name of Facility		License No. 2149-C	Report for Y 9/30/2018	Year Ended	Page of 3 37
Farmington Care Center, LLC		<u></u> 2147-C	7/30/2018	State(c) and	or Town(s) in
Legal Name of Part	nership/LLC	Business A	Address		Registered
Farmington Care Center, LLC		20 Scott Swamp Farmington, CT	Road,	СТ	
Name of Partners/Members	Business A	ddress		Title	% Owned
Executive Advisors, LLC	341 Bidwell St. Manch	nester, CT 06040	Member		47.5
Apex Advisors LLC	341 Bidwell St. Manch	nester, CT 06040	Member		47.5
Christopher Wright	341 Bidwell St. Manch	nester, CT 06040	Member		5
		**************************************			

## **General Information and Questionnaire Corporate Owners**

Name of Facility	License No.	Report for Year	Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2018		3A	37
If this facility is owned or operated as a corpo	ration, provide th	ne following inform	nation:		
Legal Name of Corporation		ess Address	State(s) in W	hich Incorpo	rated
	i I				
			1	No. Sha	ares
Name of Directors, Officers	Busin	ess Address	Title	Held by	
					***
Names of Stockholders Owning at Least 10%					
of Shares					
	_				

CSP-3B Rev. 10/2005

#### General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2018	3B	37
If this facility is owned or operated as an individu	ıal proprietorship,	provide the following inform	nation:	
Ow	vner(s) of Facility			
	•			
			<del>,</del>	
			***	
			******	

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

Related Parties\*

Business	Name of Facility Farmington Care Center, LLC	ar, tLC	License No. 2149	e No. 2149-C	9. /g	Report for Year Ended 9/3/2018		Page 4	of 37
Patients		Annual and Annual Annua							
Publishiness			Also	Provides	,		Indicate Where		Att of the Att
1978   1978	Name of Related	Business	Goods/Se Relat	rvices to	uoN s	Description of Goods/Services	in Annual Report	Cost	Related
Fig. 232 Bitwell St. Mainchesler   Shared Employees   Cash   Ca	Individual or Company	Address	Xes	-#	, o,	Provided	rage # / Line #	рацодах	140
Page 12   Continue St. Hartford, CT   Shared Employees   19 3   CR7	Bidwell Care Center, LLC	333 Bidwell St. Manchester, CT 06040			S	hared Employees	1	(281)	281
This field of St. East Windsor,   Shared Employees   19 3   3,448	Cheisea Place Care	25 Lorraine St. Hartford, CT 05105			S	hared Employees	1	(287)	287
17.1 Main St. East Windsof,   Shared Employees   16 M     20 Soott Swamp Rd.   Bank Fees   16 M     20 Soott Swamp Rd.   Bank Fees   16 M     20 Soott Swamp Rd.   Shared Employees   19 3     20 Soott Swamp Rd.   Shared Employees   19 3     30 Soott Swamp Rd.   Shared Employees   19 3     31 Stared Employees   19 3     31 Stared Employees   1,703     32 Stay St. Meriden, CT Octoba   Shared Employees   1,703     34 Stay St. Meriden, CT Octoba   Shared Employees   1,703     34 Stay Budwell St. Manchester,   Shared Employees   1,703     44 Def Ave. Bloomfield,   Shared Employees   1,703     54 Stared Employees   1,705002   1,705004     55 Stared Employees   1,705004   1,705004   1,705004     55 Stared Employees   1,705004   1,705004   1,705004     55 Stared Employees   1,705004	Chestnut Point Care	171 Main St. East Windsor,			,	aundry Services			,
Familiagion C 10 00022	Chestnut Point Care	171 Main St. East Windsor,			50	hared Employees	1	3,448	(3,448)
Family Sect Swamp Rd.   Shared Employees   19   3	Farmington Care	20 Scott Swamp Rd. Farmington, CT 06032				sank Fees	l		1
Windsey Croposed: Hill Rd. East         Laundry Services         19         3           96 Prospect Hill Rd. East         Shared Employees         -         16,419         (6,419)           96 Prospect Hill Rd. East         Shared Employees         -         -         16,419         (7           161 Hillside Ave. Harfford, Cr. Oe 6006         Shared Employees         -         -         14,093         (7           161 Hillside Ave. Harfford, Cr. Oe 6007         Shared Employees         -         -         14,093         (7           170 Mest Street, Rocky Hill, Cr. Oe 6007         Shared Employees         -         -         34,180         (7           170 Mosts Street, Rocky Hill, Cr. Oe 6007         Shared Employees         -         -         36,775         (7           163 Silas Deane Hwy, Rocky Hill, Cr. Oe 6007         Shared Employees         -         -         36,775         (7           170 Most Street, Rocky Hill, Cr. Oe 6007         Shared Employees         -         -         36,775         (7           170 Most Street, Rocky Hill, Cr. Oe 6007         Cr. Oe 6008         Cr. Oe 6008         -         -         36,775         (7           170 Most Street, Rocky Hill, Cr. Oe 6007         Cr. Oe 6008         Cr. Oe 6008         -         -         36,775 </td <td>Farmington Care</td> <td>20 Scott Swamp Rd. Farmington, CT 06032</td> <td></td> <td></td> <td>s</td> <td>hared Employees</td> <td>1</td> <td>1</td> <td>1</td>	Farmington Care	20 Scott Swamp Rd. Farmington, CT 06032			s	hared Employees	1	1	1
Care   99 Prospect Hill Rd. East   Shared Employees   1,703     Springs   Do450   Shared Employees   1,703     Springs   Do450   Shared Employees   1,703     Springs   Do450   Shared Employees   1,703     Shared Employees   1,703   Shared Employees   1,703     Shared Employees   1,705002   1,4093   (284)     Care   CT 06002   CT 06002   Shared Employees   1,705002     Shared Employees   1,705002   Shared Employees   1,705002     Shared Employees   1,705002   Shared Employees   1,705002     Shared Employees   1,705002   1,4150   (284)     Shared Employees   1,705002   1,4150   (77000000000000000000000000000000000	Kettle Brook Care	96 Prospect Hill Rd. East Windsor, CT 06088				aundry Services			1
Packings   15 Nov St. Meriden, CT   Shared Employees   1,703	Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088			S	hared Employees	1	16,419	(16,419)
1570   1570	Meriden Care Center,	y St							
14,093   1	LLC (Silver Springs)	06450	••••		S	hared Employees		1,703	(1,703)
349 Bidwell St. Manchester,   Shared Employees   CT 06040     140 Park Ave. Bloomfield,   Shared Employees   CT 06002     150 Park Ave. Bloomfield,   Shared Employees   CT 06002     1638 Silas Deane Hwy,   Shared Employees   CT 06007     1638 Silas Deane Hwy,   Shared Employees   CT 06004     1638 Silas Deane Hwy,   Shared Employees   CT 06004     1641 St. Manchester,   Building Lease & Rent   22,22,27, 10,9,14     1641 St. Manchester,   Shared Es not part of mgmt agmt   CT 06040     1642 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1643 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1644 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1644 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1644 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1644 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1644 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1644 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1644 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1644 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1644 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1644 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1644 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1644 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1644 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1644 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1644 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1644 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1644 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1644 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1644 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 06040     1644 Silas Deane Hwy,   Shared Es not part of mgmt agmt   CT 060	Trinity Hill Care Center, LLC	151 Hillside Ave. Hartford, CT 06106			<u> </u>	shared Employees	-	14,093	(14,093)
140 Park Ave. Bloomfield,   Shared Employees   24,180     CT 06007     R38 Silas Deane Hwy,   Shared Employees   36,775     R38 Silas Deane Hwy,   Shared Employees   36,775     T7 Main St. East Windsor,   OT/PT/ST   13 5,8,10   796,372   (7 0608     T7 Main St. Manchester,   Building Lease & Rent   22,22,27 10,9,14     CT 06040   Shared EEs not part of might agmt   16,15 M,E   13,441     CT 06040   Shared EEs not part of might agmt   16,15 M,E   114,438     CT 06040   Management Services, Indirect   20 5j   105,323     CT 06040   Management Services, Indirect   20 5j   104,328     CT 06040   Shared EEs not part of might agmt   16 M12   331,358     CT 06040   Shared Ees not part of might agmt   16 M12   331,358     CT 06040   Shared Ees not part of might agmt   16 M12   331,358     CT 06040   Shared Ees not part of might agmt   16 M12   331,358     CT 06040   Shared Ees not part of might agmt   16 M12   331,358     CT 06040   Shared Ees not part of might agmt   16 M12   331,358     CT 06040   Shared Ees not part of might agmt   16 M12   331,358     CT 06040   Shared Ees not part of might agmt   16 M12   331,358     CT 06040   Shared Ees not part of might agmt   16 M12   331,358     CT 06040   Shared Ees not part of might agmt   16 M12   331,358     CT 06040   Shared Ees not part of might agmt   16 M12   331,358     CT 06040   Shared Ees not part of might agmt   16 M12   331,358     CT 06040   Shared Ees not part of might agmt   16 M12   331,358     CT 06040   Shared Ees not part of might agmt   16 M12   16	Westside Care Center, LLC	349 Bidwell St. Manchester, CT 06040			<i>S</i>	ilared Employees	,	(284)	284
1838 Silas Deane Hwy,   Shared Employees   -     36,775     1838 Silas Deane Hwy,   Shared Employees   -	Wintonbury Care Center, LLC	140 Park Ave. Bloomfield, CT 06002			- 01	hared Employees		24,180	(24,180)
1838 Silas Deane Hwy,   Shared Employees       1838 Silas Deane Hwy,   Rocky Hill, CT 06067     171 Main St. East Windsor,   OT/PT/ST   13 5,8,10   796,372   (	Secure Care Center	60 West Street, Rocky Hill, CT 06067			03	shared Employees	1	36,775	(36,775)
171 Main St. East Windsor,   171 Main St. Manchester,   171 Manchester,   171 Manchester,   172 Manchester,   172 Management Services, Direct   173 Management Services, Direct   170 Management Services, Indirect   170 Management Services, Indirect   170 Management Services, Indirect   170 Management Services, Administrative   16 Miz   31,358   170 Management Services, Administrative   16 Miz   13,438   170 Management Services, Administrative   170 Miz	Touchpoints at Homecare I.LC	1838 Silas Deane Hwy, Rocky Hill, CT 06067			33	shared Employees		·	
341 Bidwell St. Manchester,   Building Lease & Rent   22,22,7 10,9,14       341 Bidwell St. Manchester,   Postage & Legal   16,15 M,E   13,441       341 Bidwell St. Manchester,   Shared EEs not part of mgnt agmt     170,477   (	Touchpoints therapy	171 Main St. East Windsor, CT 06088				)T/PT/ST		796,372	(796,372)
1, 341 Bidwell St. Manchester, CT 06040       Postage & Legal       16,15 M,E       13,441         CT 06040       341 Bidwell St. Manchester, CT 06040       Shared EEs not part of mgmt agmt agmt agmt agmt administrative and management Services, Direct and management Services, Indirect and management Services, Indirect and management Services, Administrative and management Services and management Services.	Bidwell Realty, LLC	341 Bidwell St. Manchester, CT 06040			144	suilding Lease & Rent		et e	4
341 Bidwell St. Manchester,   Shared EEs not part of mant agmt   20 5j   105,323 (CT 06040   Management Services, Direct   20 5j   14,438   14,438   Management Services, Administrative   16 M12   331,358   (CT 06040   Management Services, Administrative   16 M12   M12   M13,438   (CT 06040   M12   M13,438   (CT 06040   M12   M13,438   (CT 06040   M13,438   M13,438   M13,438   (CT 06040   M13,438   M13,438   (CT 06040   M13,438   M13,438   (CT 06040   M13,438   M13,438   M13,438   (CT 06040   M13,438   M13,438   (CT 06040   M13,438   M13,438   (CT 06040   M13,438   M13,438   M13,438   (CT 06040   M13,438   M13,438   M13,438   M13,438   M13,	iCare Management,	341 Bidwell St. Manchester, CT 06040				ostage & Legal		13,441	(13,441)
Management Services, Direct   20 5j   105,323   C	iCare Health	341 Bidwell St. Manchester, CT 06040			0,	Shared EEs not part of mgmt agmt		170,477	(170,477)
Management Services, Indirect   20 5j   14,438					-	Management Services, Direct	ΙI	105,323	(105,323)
Management Services, Administrative   16 M12   331,358	1	)			r.	Management Services, Indirect	li	14,438	(14,438)
		,				Management Services, Administrative	16	331,358	(331,358)
	-	*		1	+	ere en distribution de la constantina della cons			-
						- Indian			,
	*								
				-			*		
						111100111			The state of the s
	All 9 Care Centers,					hare Common 401k Pension and Inst	rance plans, courier.	legal and various o	ther services

\* 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			
Farmington Care Center, LLC	2149 <b>-</b> C		9/30/2018	5 37			
If the facility is licensed as CDH and/or RCH or	provides A	IDS or TBI	services with special Medica	aid rates, costs			
must be allocated to CCNH and RHNS as follow							
Item			Method of Allocation	on			
Dietary		Number of	meals served to residents				
Laundry			pounds processed				
Housekeeping			square feet serviced				
			hours of routine care provid				
Nursing			classification, i.e., Director (c				
		_	Nurses, Licensed Practical 1	Nurses, Aides and			
		Attendants					
Direct Resident Care Consultants			hours of resident care provi	ded by EACH			
			(See listing page 13)				
Maintenance and operation of plant		Square fee					
Property costs (depreciation)		Square fee					
Employee health and welfare		Gross sala					
Management services		1 2 2 2	te cost center involved				
All other General Administrative expenses			irect and Allocated Costs				
The preparer of this report must answer the foll	owing quest	ions applica	able to the cost information p	rovided.			
1. In the preparation of this Report, were all	• Yes	O No	If "No," explain fully why	such allocation was			
costs allocated as required?	O 103	<u> </u>	not made.				
2. Explain the allocation of related company ex	penses and	attach copy	of appropriate supporting da	ıta.			
3. Did the Facility appropriately allocate and se	elf-disallow	direct and i	ndirect costs to non-nursing	nome cost centers?			
(e.g., Assisted Living, Home Health, Outpat	ient Services	s, Adult Da	y Care Services, etc.)				
	O Yes	O No	If "No," explain fully why not made.	such allocation was			

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		a) -
Farmington Care Center, LLC			2149-C	9/30/2018			6 37
	Related * to	d * to					
	Owners,	ers,				Amnaal	
	Officers	cers		Date of	Term of	Amount	Amount
Name and Address of Lessor	Yes	οN	Description of Items Leased	Lease**	Lease	of Lease	Claimed
Accelerated Care Plus Corp.	0	0	Omnistim Electrotherapy and Omnisound Therapeutic Ultrasound Equipment	05/18/10		22,726	22,726
MS-100,	0	0	Time Clocks and Payroll Punch Equip	06/01/10	60 months & automatic	8,817	8,817
Canon Financial Services, 14904 Collection Center Drive, Chicago, IT 60693	0	0	Copier	03/02/12	60 Months	2,955	2,955
GE Capital C/O Ricoh USA, P.O.Box 41564, Divisional Physics 19101	0	0	Copier	03/04/14	48 Months	3,707	3,707
Mail Finance/Neopost New England, 25881 Newtwork Place Chicago. II. 60673	0	0	Postage Meter Rental		Monthly	1,374	1,374
	0	0					
	0	0					de la
	0	0					
	0	0					
	0	0					
Is a Mileage I of Book Maintained for All Leased Vehicles?	eased Ve	hicles,	O Yes		o No	Total ***	39,580

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	}	Page	of
Farmington Care Center, LLC	2149-C	9/30/2018		7	37
The records of this facility for the p	period covered by this r	eport were maintained on the following basis:			
	Modified Cash				
Is the accounting basis for this		7040 T B T			
L	Yes	If "No," explain.			
previous period? O	No	The second secon			
				· · · · · · · · · · · · · · · · · · ·	
Independent Accounting Firm					
Name of Accounting Firm		Address (No. & Street, City, State, Zip		0.61.00	
<ol> <li>O'Connor, Davies LLP</li> </ol>		100 Great Meadow Road, Ste 401,	Wethersheld, CT	06109	
<sup>2</sup> 2 3					
3		ļ.			
4					
Services Provided by This Firm (d	lescribe fully)		<b>VIII.</b>		
1 Taxes, financial statements, accounting	ng support		\$	9,74	9
2			\$		
3			\$		
4			\$		
			Charge for	Services	Provided
			\$	9,74	9
Are These Charges Reflected in the Expen	diture Portion of This Repor	1? If Yes, Specify Expense Classification and Line No.			
⊙ Yes O No	15D				
Legal Services Information					
Name of Legal Firm or Independe	nt Attorney		Telephone	Number	
I iCare Health Management, Ll			860-570-21	40	
2 Starble and Harris			860-678-77	175	
3 Durant Nichols / Robinson &	Cole, LLP		860-275-82	200	
4 Various others (American Ar	bitration, Various Arb	itration, Murtha Cullina,Jackson Lewis))			
5 Starble and Harris, iCare Hea	lth Management LLC		860-678-77	775 & 86	50-570-2140
Address (No. & Street, City, State	e, Zip Code )				
1 341 Bidwell Street, Manches	ster CT				
2 32 Main Street, Avon, CT					
3 280 Trumbull St, Hartford, C	T				
4					
5 32 Main Street, Avon, CT &		fanchester CT			
Services Provided by This Firm (a					
l Lease and contract issues, general le			\$	10,29	
2 Lease and contract issues, general le		oe .	\$		
3 Employment law, arbitrations, contr	ract negotiations	The state of the s	\$		55
4 Employment Arbitrations, healthcar	e law		\$	2,91	
5 Conservatorships & Collections			\$ C	2,40	
			Charge for		
			\$	15,92	26
Are These Charges Reflected in the Experi		rt? If Yes, Specify Expense Classification and Line No.			
• Yes O No	15E				
0 100					

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 9/2002

# Schedule of Resident Statistics

Name of Facility			License No.	No.			Report for	Year Ende	, q		Page	jo
Farmington Care Center, LLC			21	2149-C		-	9/30/2018	9/30/2018			8	37
x xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx						Period 10/	Period 10/1 Thru 6/30	01		Period 7/1 Thru 9/30	Thru 9/3	
-	Total All	Total CCNH	Total RHNS						,			•
	Levels	Level	Level	Total Other	Total	CCNH	RHINS	Other	Total	CCNH	KHINS	Other
1 世		0.7.6			150	051			105	105		
A. On last day of PRE VIOUS report period	OCT	neī			U.S.	ACT.						- WHATTANIA .
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	94	94			94	94			8	8		
B. As of midnight of THIS report period	96	96			90	06			06	06		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,717	4,717			3,517	3,517			1,200	1,200		
B. Medicaid (Conn.)	26,166	26,166			19,737	19,737			6,429	6,429		
C. Medicaid (other states)												
D. Private Pay	1,697	1,697			1,225	1,225			472	472		
E. State SSI for RCH												
F. Other (Specify) Insurance	559	559			343	343			216	216		
G. Total Care Days During Period (3A thru F)	33,139	33,139	].		24,822	24,822			8,317	8,317		
α3 j												
A. Medicaid Bed Reserve Days  D. Other Bod Beneria Date												
- 1 - 2	33 139	33.139			24.822	24,822			8,317	8,317		
- 1	7.556.5	22.462.2										

Schedule of Resident Statistics (Cont'd)

Name of Faci	lity			Licer	ise No.				Report	for Year	Ended		Page	of
Farmington C	-	ter, LLC			49 <b>-</b> C				-	9/30/201			9	37
			in the certified b		pacity du	ring t	he repo	rt yea	r?	0	Yes	<b>⊙</b> :	No	
If "YES'	, provid	e the fol	lowing informat	ion:										
		Place of	Change		Ch	ange	in Bed	S		Ca	pacity After	r Change		
Date of	CCNH	RHNS	Other		Lost			Gaine	1					
Change								l					r>	C1
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Other	Reason fo	r Change
													**	
	<u> </u>							-						
	·	<u>!</u>		L			<u></u>							
	•	-	in certified bed	_		the r	eport y	ear (as	report	ed in iten	1 4 above) j	provide the num	iber of	
RESID	ENT DA	YS for	90 days followir	ig the	change.								···	
													0.4	
			Change in R	eside	nt Days					CC	NH	RHNS	Otl	ier
1 st chan										ļ				
2nd cha									<del></del>					
3rd char 4th char										<u> </u>				<u> </u>
6. Number	of Resi	dents an	d Rates on Septe	ember	30 of Co	st Ye	ar							
O. Italibei	OI ICCDI	abilito all	Medicare	Ī	Medi					S	elf-Pay		Other Stat	e Assisted
						l		1						
	Item		CCNH		CCNH	R	HNS	C	CNH	RI	INS	Other	R.C.H.	ICF-MR
No. of F		S	12		70		~~~~	7111011000	8	3				******************************
Per Die														
a. One			525.00	<u> </u>	237.00			<b> </b>	451.00	1				
b. Two				<u> </u>				╫						
c. Thre		e		1										
bed	rms.		<u> </u>	<u> </u>		<u> </u>		<u> </u>		-				
7 Total N	umber o	f Physic	al Therapy Treat	ment	S					TC	TAL	CCNH	RHNS	Other
		are - Par									8,103	8,103		
			lusive of Part B	)										
			e Treatments				'				405	405		
		storative	Treatments						··		1,346	1,346		
	Other	Dhamiaa	1 Thougan Tuggt	****							12,657 22,511	12,657 22,511		
			<i>l Therapy Treat</i> 1 Therapy Treatr					-			22,311	22,511		
1		are - Par	• •	пенка						200200000000000000000000000000000000000	122	122	***************************************	\$150910001000000000000000000000000000000
			clusive of Part B	)										
			ce Treatments	,						***************************************	22	22		
	2. Re	storative	Treatments								49	49	ļ	
	. Other										589	589		
			Therapy Treatn								782	782		
			ational Therapy	Treat	ments						2.714	2.714		
A	. Medic	are - Pa	rt B clusive of Part B	`							3,714	3,714		
"			ce Treatments	,							398	398		***************************************
			Treatments							1	820	820	<u>                                     </u>	
	Other										11,868	11,868		
			tional Therapy	Treat	ments		****				16,800	16,800	1	

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

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Report of Ex	<b>`</b>	- Salam			-	
Name of Facility	License No.		Report for Year	Ended	Page	of
Farmington Care Center, LLC	2149-C		9/30/2018		10	37
Are time records maintained by all individuals receiving con	npensation?	•	Yes	0	No	
			Total Cost a	nd Hours		
					Other	
Item **	CCNH	Hours	RHNS	Hours	Other	Hours
A. Salaries and Wages* 1. Operators/Owners (Complete also Sec. I						
of Schedule A1)				(00000000000000000000000000000000000000		
2. Administrator(s) (Complete also Sec. III						
of Schedule A1)	135,745	2,086				
3. Assistant Administrator (Complete also Sec. IV						
of Schedule A1)		***************************************				
<ol> <li>Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)</li> </ol>	144,381	6,888				
5. Dietary Service	144,381	0,000				
a. Head Dietitian	000100001000000000000000000000000000000					
b. Food Service Supervisor	53,123					
c. Dietary Workers	337,844	18,456				
Housekeeping Service     a. Head Housekeeper						300000000000000000000000000000000000000
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	22 222	1,825				<u> </u>
b. Other Maintenance Workers  8. Laundry Service	33,333	1,823				
a. Supervisor				800,00000000000000000000000000000000000		******************************
b. Other Laundry Workers						
9. Barber and Beautician Services			1			
10. Protective Services						
Accounting Services     A. Head Accountant			1			T
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	194,756	4,356	5			
b. RN	440.515	10,56				
Direct Care     Administrative**	440,515 132,279					<del> </del>
c. LPN	,					
1. Direct Care	988,806	33,25			<u> </u>	
2. Administrative**	1 224 740	70,203	2	<u> </u>		
d. Aides and Attendants e. Physical Therapists	1,234,749	70,20	71			
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	128,625	6,69	1			<u> </u>
i. Physicians  1. Medical Director			1			1
2. Utilization Review						
3. Resident Care***				***************************************		
4. Other (Specify)				1		
j. Dentists				1		_
k. Pharmacists						
1. Podiatrists						
m. Social Workers/Case Management	59,006	5 2,73	0			
n. Marketing o. Other (Specify)				1		
See Attached Schedule	42,518	3 2,24	2			
A-13, Total Salary Expenditures	3,925,680					

<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	RE	INS	Oth	er
Position	\$	Hours	\$	Hours	\$	Hours
UNIT SECRETARIES SALARIES	\$ 18,150	1,050			S -	9 00 00 <del>0</del>
MEDICAL RECORDS SALARIES	\$ 24,368	1,192			\$ -	
CENTRAL SUPPLY SALARIES	\$ -				S -	ā
RESPIRATORY THERAPY SALARIES	\$ .	898 (80 (88 ft) <b>-</b> 09 (8			\$ -	
		200 (0) had in a 10 cm				
		2010			e e	
Total	\$ 42,518	2,242	\$ -	5 <u>4.000 (2.000 (2.000</u>	\$ -	F

Schedule of Other Fees (Page 13)

	CC	NH	RI	INS	Oth	er
Service	s	Hours	\$	Hours	\$	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$ 6,687	4			S -	-
ADMISSIONS C/S LABOR	\$ 33,414	733			S -	<u>.</u>
CENTRAL SUPPLY CONTRACT SERVICE	\$ 6,655	487			\$ -	•
ADMINISTRATIVE CONTRACT SERVICE LABOR	\$ 160,651	4,082			\$ -	
RESPIRATORY THERAPY CONTRACT SERVICES	\$ 4,284	27			S -	<u>.</u>
PHYSICAL THERAPY C/S MEDICIAD	\$ 34,409	452			\$ -	
SPEECH THERAPY C/S Medicaid	\$ 3,000	34			S -	
OCCUPATIONAL THERAPY C/S MEDICIAD	\$ 26,383	315			\$ -	
Total	\$ 275,484	6,130	\$ -	-	S -	-00

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\*

		7	Teststair	Y Z X WILLIAM Y	A SOSISIMILI A SAME AND AND A SOSION AND AND AND AND AND AND AND AND AND AN	Donord for	Voor Ended		Page	of
Name of Facility				License No.		ror Hoday	Nepolitoi real Ellucu		} }	
Farmington Care Center, LLC				2149-C		9/30/2018			11	37
		Salary Paid	-							
				Fringe Benefits and/or Other		Total	Line Where		Total	•
Name	CCNH	RHINS	Other	Payments (describe fully)	Full Description of Services Rendered	Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours	Compensation Received
Section I - Operators/Owners										
							***		-	
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who										
may be the Administrator or Assistant Administrators who										
are identified on Page 12).										
								***************************************		
					- Annual Control of the Control of t			and the second s		
								ANNAY.		
**************************************	֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	1	$1 \dots 1 \dots \dots$		is a property of the sale of the sale of the sale of	Pennired				

<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\*

						Danget for Voor Drodoe		Раде	-to
Name of Facility (as licensed)				License No.		Report for 1 car Elucu		- - - - -	5
Farmington Care Center, LLC				2149-C		9/30/2018		12	37
		Salary Paid							
		, Campa		Finge Benefits		I in Where	or or	Total	
				and of Other Payments	Full Description of	S	<u> </u>	Hours	Compensation
Name	CCNH	REINS	Other	(describe fully)	Services Rendered	Worked Fage 10	Other Employment	worked	Necelved
Section III - Administrators***									
				same as					
				employees less					
John Zazzaro	135,745			union funds	Administrator	2,086 A2			
				same as					
				employees less					
				union funds	Administrator	A2			
		The state of the s		same as					
				employees less		-			
				union funds	Administrator	A2			
Section IV - Assistant Administrators									
C. C									
The state of the s									
				***************************************					
	1 1	t 22 - 1 - 1 - 1	1.11 in Commonts	on in morningad I I ac	it is additional shorts it mornings and its additional shorts if remitted	mired			

\*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

Name of Facility  B. Report of Expansion 1.1	License No.		Report for Y		Page	of
Farmington Care Center, LLC	2149		9/30/2018	our analogue	13	37
Turmington cure center, 220			Total Cost a	and Hours		
-						
Item	CCNH	Hours	RHNS	Hours	Other	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	28,822	638				
2. Dentist						
3. Pharmacist	16,360	491				
4. Podiatrist	310000140004440004486 <del>0</del> 1800780			**********************		*****
5. Physical Therapy						
a. Resident Care	399,478	5,243				
b. Other						
6. Social Worker	17,846	344				00.011
7. Recreation Worker	18,237	35+Cable				35+Cable
8. Physicians	• 6 000	000				
a. Medical Director (entire facility)	36,000	277				
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)					<u> </u>	
Staff Development Committee     (Once annually)					1	
e. Other (Specify)						
Physician Care Contract Services	19,643	119				500000000000000000000000000000000000000
9. Speech Therapist	17,5 (5	***				
a. Resident Care	28,342	367			380000000000000000000000000000000000000	
b. Other						
10. Occupational Therapist						
a. Resident Care	305,105	4,004				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	99,485	1,381				
2. Administrative***	55,501	1,172				
b. LPN						
1. Direct Care	10,963	261				
2. Administrative***						
c. Aides	9,649	524				
d. Other						
12. Other (Specify)						
See Attached Schedule	275,484	6,130				
B-13 Total Fees Paid in Lieu of Salaries	1,320,915	20,956				

<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 Farmington Care Center, LLC	License No. 2149-C		Report for \\ 9/30/2018	Year Ended	Page 14	of 37	
Name & Address of Individual	Full Explanation of Service	Operator	to Owners, rs, Officers	Expla		Relationship	
	NI O II'	Yes	No				
Omnicare/ Pharm Scripts	Pharmacy Consulting	0	0				
Tocuhpoints Therapy	Therapy	0	0	Common Own	ership		
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver Springs, Westside Care Centers, iCare Health and iCAre Management, SecureCare Options, Home Care	Shared Employees	•	0	Common Own	ership		
Healthdrive Physician Services	Audiology, Dental and Podiatry	0	0				
Ready Nurse, Nurse Network	Nursing pool (RN, LPN,CNA)	0	0				
Dr Bodanski	Medical Director	0	0				
		0	0				
		0	0				
		0	•				
		0	0				
		0	•				
		0	•				
		0	•				
		0	0				
		0	0				
		0	0				
		0	0				
		0	0				
		0	0			-	
		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

Name of Facility License No.		$\neg$	Report for Ye	ar Ended	Page	of	
Farmington Care Center, LLC 2149-C			9/30/2018		15	37	
			П				
	Item		_	Total	CCNH	RHNS	Other
· ·	ative and General						
	yee Health & Welfare Benefits						
	orkmen's Compensation		\$	148,183	148,183		
	isability Insurance		\$				
	nemployment Insurance		\$			<u></u>	
4. Sc	ocial Security (F.I.C.A.)		\$	345,438	345,438		
	ealth Insurance		\$	699,656	699,656		
6. Li	fe Insurance (employees only)						
(n	ot-owners and not-operators)		\$				
7. Pe	ensions (Non-Discriminatory)		\$	229,631	229,631		
(n	ot-owners and not-operators)						
8. U	niform Allowance		\$				******
9. O	ther (Specify)		\$	28,856	28,856		
Se	ee Attached Schedule						
b. Persoi	nal Retirement Plans, Pensions, and		\$				
Profit	Sharing Plans for Owners and						
Opera	tors (Discriminatory)*						
Î							
c. Bad D	Debts*		\$	149,176	149,176		
d. Accou	ınting and Auditing		\$	9,749	9,749		
e. Legal	(Services should be fully described	on Page 7)	\$	15,926	15,926		
f. Insura	nnce on Lives of Owners and		\$				
Opera	ntors (Specify)*						
	Supplies		\$	19,069	19,069		
	hone and Cellular Phones						
1. To	elephone & Pagers		\$	25,696	25,696		
	ellular Phones		\$	653	653		
i, Appra	aisal (Specify purpose and		\$				
	h copy)*						
j. Corpo	oration Business Taxes (franchise ta	(x )	\$				
<u> </u>	Taxes (Not related to property - Se		_				
	acome*	,	\$	000000000000000000000000000000000000000	aunuterarenteitet in territoria		***************************************
	ther (Specify)	<u> </u>	\$	<del></del>			
	ee Attached Schedule						
	esident Day User Fee		\$	696,582	696,582		A THE REAL PROPERTY OF THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TO THE P
Subtotal			\$		2,368,614		
~ ** ** * * * * **				) <del>} •</del>		tala formerd t	<u> </u>

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

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

Farmington Care Center, LLC 9/30/2018

Attachment Page 15

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

Description	C	CNH	RHNS	Other
UNION TRAINING	\$	28,856		\$ -
	19 (6.00)			
	\$30.500.3			
Total	\$	28,856	\$ -	\$ -

#### **Schedule of Other Taxes**

Description	CCNH	RHNS	Other
INTERNET EXPENSES	\$ -		\$ -
Total	\$ -	\$ -	\$ -

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

Name of Facility License No.			Report for \	ear Ended	Page	of
Farmington Care Center, LLC 2149-C			9/30/2018		16	37
-						
Item			Total	CCNH	RHNS	Other
	s Brought Forwar	·d:	2,368,614	2,368,614	************************	
I. Travel and Entertainment						
Resident Travel and Entertainment		\$				
2. Holiday Parties for Staff		\$	1,068	1,068		
Gifts to Staff and Residents		\$	339	339		
4. Employee Travel		\$	489	489		
<ol><li>Education Expenses Related to Seminars and</li></ol>		\$	2,553	2,553		
6. Automobile Expense (not purchase or depre	ciation)	\$				
7. Other (Specify)		\$	486	486	241024100041000100001000010	
See Attached Schedule						
m. Other Administrative and General Expenses						
Advertising Help Wanted (all such expenses	)	\$	3,955	3,955		
2. Advertising Telephone Directory (all such ex	:penses )***	\$				
3. Advertising Other (Specify)***		\$	15,874	15,874		001000010000000000000000000000000000000
See Attached Schedule						
4. Fund-Raising***		\$				
5. Medical Records		\$				
6. Barber and Beauty Supplies (if this service is		\$			000000000000000000000000000000000000000	
directly and not by contract or fee for service	)***					
7. Postage		\$	4,078	4,078		
* 8. Dues and Membership Fees to Professional		\$	7,165	7,165	************************	
Associations (Specify)						
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other Non-A	Allowable Org.***	\$				
9. Subscriptions		\$				
10. Contributions***		\$	1,674	1,674		
See Attached Schedule						
11. Services Provided by Contract (Specify and	Complete	\$	141,695	141,695		
Schedule C-2, Page 21 for each firm or indi	vidual)					
12. Administrative Management Services**		\$	331,358	331,358		
13. Other (Specify)	***************************************	\$	21,022	21,022		
See Attached Schedule						
C-14 Total Administrative & General Expenditures		\$	2,900,370	2,900,370		

<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

Description	CCNH	RHNS	Other
MEALS	\$ 486.		\$ -
Total Other Trayel and Entertainment	\$ 486	\$ -	\$ -

#### Schedule of Other Advertising

Description	CCNH	RHNS	Other
COMMUNICATIONS SPECIAL EVENTS	\$ 15,874		\$
Total Other Advertising	\$ 15,874	\$ -	\$

#### Schedule of Dues

Description	CCNH	RHNS	Other
ALTCFM			
CAHCF Dues	\$ 7,005		\$
OTHER DUES	\$ . 160		\$ -
			4.59-4.37-433-433
Total Ducs	\$ 7,165	\$	\$ .

#### Schedule of Contributions

Description	CCNH	RHNS	Other
CONTRIBUTIONS	\$ 1,674		\$
	(*************************************		
Total Contributions	\$ 1,674	\$	\$ -

#### Schedule of Other Administrative and General

Description	CCNH	RHNS	Other
SOCIAL SERVICE SUPPLIES	\$		\$ .
SOC SVC MINOR EQUIPMENT	\$		\$ -
ADMINISTRATIVE MINOR EQUIPMENT	\$ 1,774		\$
EMPLOYEE RELATIONS	\$ 3,912		\$ .
EMPLOYEE RELATIONS-OTHER	\$ 125		\$
PERMITS & LICENSES	\$ 980	34.40.004.0	\$ -
VOLUNTEER EXPENSE	\$		\$
BANK PEES	\$ 11,547		\$ .
CMS REVISIT USER FEES	\$ -		\$
PENALTIES	\$		\$ -
LATE FEES	\$ (422)		\$ -
INTERNET EXPENSES	\$ 3,107		\$
Rounding		Parjaden Prins	\$ -
			100000000000000000000000000000000000000
			1605100000
Total Other Administrative and General	\$ 21,022	\$	· \$

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

Name of Facility	License No. 2149-C	Report for Year Ended 9/30/2018	Page of 17   37
Name & Address of Individual or	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Company Supplying Service iCare Management, LLC/iCare Health Management, LLC	331,358	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	105,323	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	14,438	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)

	Note on rage 5)										
1					Report for Yo	ear Ended	Page	of			
Farmington Care Center, LLC			2149-C		9/30/2018		18	37			
								_			
	Item			Total	CCNH	RHNS	C	Other			
2.	Dietary										
	a. In-House Preparation & Service										
	1. Raw Food		\$	193,730	193,730						
	2. Non-Food Supplies		\$		13,748						
	3. Other (Specify)		\$	13,892	13,892	***************************************					
	DIETARY SUPPLEMENTS										
	b. Purchased Services (by contract other		\$	906	906						
	than through Management Services)										
	(Complete Schedule C-2 att. Page 21)										
	c. Other (Specify)		. \$	2,266	2,266						
	DIETARY MINOR EQUIPMENT										
2D.	Total Dietary Expenditures (2a + b + c + d)		\$	224,543	224,543						
2F.	Dietary Questionnaire			Total	CCNH	RHNS	(	Other			
G.	Resident Meals: Total no. of meals served per	day	:*	272	272						
H.	Is cost of employee meals included in 2E?	0	Yes	•	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	t Report	? (Page/Line I	tem)						
	Is cost of meals provided to persons other					If yes, specify					
K.	than employees or residents (i.e., Board	0	Yes	•	No	cost.					
	Members, Guests) included in 2E?										
L.	Is any revenue collected from these people?	0	Yes	•	No	If yes, specify amt.					
M.	Where is the revenue received reported in the 0	Cos	t Report	? (Page/Line I	tem)						
		<del></del>									
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	•	No	If yes, specify amt.					
P.	Where is the revenue received reported in the	Cos	t Repor	t? (Page/Line l	ltem)						
<u> </u>	A		<del></del>								

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

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

Name of Facility Farmington Care Center, LLC		License	No. 2149-C	Report for Y 9/30/2018	ear Ended	Page 19	of   37
1. 91111	ington Care Conta, LDC		1	7,50,2010			1
	Item		Total	CCNH	RHNS	(	Other
1	Laundry  a. In-House Processing*  1. Bed linens, cubicle curtains, draperies, gowns and other resident care items	Lbs.					
	washed, ironed, and/or processed.***	2 11110. 0					
	Employee items including uniforms, gowns, etc. washed, ironed and/or	Lbs.					
	processed.***	Amt. \$	}				
	3. Personal clothing of residents	Lbs.					
	washed, ironed, and/or processed.***	Amt. \$	3				
	4. Repair and/or purchase of linens.***	Lbs.					
	b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	Amt. S		257,653			
	c. Other (Specify)  LAUNDRY MINOR EQUIPMENT		8	0.57 / 50			
3D.	Total Laundry Expenditures (3a + b + c)		257,653	257,653	<u> </u>		
3F. G.	Laundry Questionnaire  Is cost of employee laundry included in 3E?	) 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	e Item)		
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	) Yes	0	No	If yes, specify cost.		W
K.	274 7 54 7 54 7 54 7 54 7 54 7 54 7 54 7	) Yes		No	If yes, specify amt.		
L.	Where is the revenue received reported in the Cos	t Report'	<u> </u>	(Page/Lin	e 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> 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)

Nam	e of Facility	License No.	Repo	ort for Year E	nded	Page	of
Farm	nington Care Center, LLC	2149-C		9/30/2018		20	37
	Τ.			Total	CCNH	RHNS	Other
<u> </u>	Item	la ric i i		Total	CCNII	Kins	One
4.	Housekeeping	Sq. Ft. Serviced					
	a. In-House Care	by Personnel	ets.	10.201	18,201		
	1. Supplies - Cleaning (Mops,	Amt.	\$	18,201	16,201		
	pails, brooms, etc.)						
	b. Purchased Services (by contract other	Sq. Ft. Serviced					1
	than through Management Services)	by Personnel	- da	046.006	246.206	`	
ĺ	(Complete Schedule C-2 att.	Amt.	\$	246,206	246,206		
	Page 21)		ф		68		
	C. Other (Specify)	DA CENTER	\$	68	08		
	HOUSEKEEPING MINOR EQUI		45	064.455	264 475		
4D.	Total Housekeeping Expenditures (4a +	b+c)	\$	264,475	264,475		
5.	Resident Care (Supplies)**						
İ	a. Prescription Drugs***		ф				
	1. Own Pharmacy		\$	200.064	220.264		
	2. Purchased from		\$	229,364	229,364		
	OMNICARE PHARMACY		Φ.	1050	4.070		
	b. Medicine Cabinet Drugs		\$	4,978	4,978		1
	c. Medical and Therapeutic Supplies		\$	68,080	68,080		
	d. Ambulance/Limousine***		\$				
	e. Oxygen		de		4.640		
	For Emergency Use		\$	4,640	4,640		<u>.</u>
<u> </u>	2. Other***		\$		10150		
	f. X-rays and Related Radiological		\$	10,170	10,170		
	Procedures***						
	g. Dental (Not dentists who should be inc	cluded under	\$				
	salaries or fees)						
	h. Laboratory***		\$		24,470		<u> </u>
	i. Recreation		\$				
	j. Direct Management Services*		\$			-	
	k. Indirect Management Services*		\$				
	1. Other (Specify)****		\$	255,610	255,610		1
	See Attached Schedule						
5M	Total Resident Care Expenditures (5a -	5j)	\$	597,312	597,312		

<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	Other
NURSING ADMIN SUPPLIES	\$ 444	\$	-
NURSING MINOR EQUIP	\$ 7,403	\$	
MEDICAL RECORDS SUPPLIES	\$ 310	\$	
MEDICAL RECORDS MINOR EQUIPMENT	\$ -	\$	÷
MANAGEMENT ALLOCATIONS - DIRECT	\$ 105,323	\$	T.
NON-COVERED PPS DR. VISITS	\$ 1,712	\$	(
RESIDENT CARE SUPPLIES	\$ 206	\$	
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 8,127	\$	
PERSONAL CARE SUPPLIES	\$ 1,616	\$	-
INCONTINENCY SUPPLIES	\$ 10,754	\$	
VACCINE RESIDENTS	\$ 12,541	\$	
PATIENT SPECIAL NEEDS	\$ 1,092	\$	
PHYSICAL THERAPY SUPPLIES	\$ -	\$	
PHYSICAL THERAPY EQUIPMENT RENT	\$ -	\$	·
PHYSICAL THERAPY MINOR EQUIPMENT	S -	\$	
OCCUPATIONAL THERAPY SUPPLIES	\$ -	\$	•
OCCUPATIONAL THERAPY EQUIP RENTAL	\$ -	\$	
OCCUPATIONAL THERAPY MINOR EQUIP	\$ -	\$	
SPEECH THERAPY SUPPLIES	\$ -	\$	H
SPEECH THERAPY EQUIPMENT RENT	\$ -	\$	<u>.</u>
SPEECH THERAPY MINOR EQUIPMENT	\$ -	\$	
RENTALS FOR NURSING EQUIPMENT NON BILLABLE	\$ 35,454	\$	
EQUIPMENT RENTAL: AIDS UNIT	\$ -	\$	-
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ 2,155	\$	
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ -	\$	
HI LOW BED RENTAL & MATTRESSES	\$ -	\$	<u> </u>
IV THERAPY SUPPLIES	\$ 24,805	\$	5 7.0 €
IV THERAPY CONTRACT SERVICE	\$ -	\$	
MEDICAL WASTE CONTRACT SERVICE	\$ 1,448	\$	
ACTIVITIES SUPPLIES	\$ 1,820	\$	
ACTIVITIES MINOR EQUIPMENT	\$ -	\$	-
MANAGEMENT ALLOCATION - INDIRECT	\$ 14,438	\$	
ADMISSIONS SUPPLIES	\$ -	\$	. P
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$ 25,961	\$	-
STRIKE COSTS NON REIMBURSABLE	\$ -	S	ian an initation in an initation
Total Other Resident Care	\$ 255,610	\$ - \$	<b>L</b>

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

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

Name of Individual or  Company  S220 Tillman Drive, Health Services Group Health Services Group/Unitex Textile Rental Services Bensalem, PA 19020 Bioserve, Inc. Bioserve, Inc. Brightview Landscaping/Twin Landscaping CWPM American HealthTech			2149-C	9/30/2018				21   37
			THE REAL PROPERTY OF THE PROPE					
Ti I	Related ** to Owners, Operators, Officers	Owners, Officers				Total Cost/I	Total Cost/Page Ref.***	.v.
H .								
	, , , , , , , , , , , , , , , , , , ,	Ž	Explanation of	Full Explanation of	LUL	RHNS	Other	Pg Line
	S		A CATCACACACACACACACACACACACACACACACACAC					
	0	0	VENDOR	Housekeeping Services	246,206			20 4b
	0	•	VENDOR	Laundry Services	257,653			19 3b
	0	•	VENDOR	Elevator Contract	4,703			22 6F
	0	0	VENDOR	Medical Waste	1,448			22 GF
alth Tech	0	•	VENDOR	Snow Removal/Landscaping	25,107			22 6F
	0	0	VENDOR	Trash removal	30,351			22 6F
	0	•	VENDOR	Software Maintenance Contract	18,443			16 M11
P.O. Box 9001006, Automatic Data Processing Louisville, KY 40290		0	VENDOR	Payroll Services	35,733		, in the second	16 M11
National Datacare Corp	0	•	VENDOR	Resident Trust Software	2,396			16 M11
Prime Care Technologuy services	0	0	VENDOR	Computer Consulting Services	35,229			16 M11
Priotiry Express	0	0	VENDOR	Courier Services	2,541			16 M11
Point Right Inc	0	0	VENDOR	Nursing Software	4,680		LLLANCE STORY	16 M11
Aron Security Inc	0	0	VENDOR	Security Contract Services			***************************************	22 6F
	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.

<sup>\*\*\*</sup> 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 Ye	ear Ended		Page	of
Farmington Care Center, LLC	2149-C	9/30/2018			22	37
Item		Total	CCNH	RHNS	0	ther
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	44,353	44,353			
b. Heat	\$	25,221	25,221			
c. Light & Power	\$	63,651	63,651			
d. Water	\$	30,408	30,408			
e. Equipment Lease (Provide detail on po	age 6) \$	39,580	39,580			
f. Other (itemize)	\$	97,976	97,976			
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a -	· 6f) \$	301,189	301,189			
7. Depreciation (complete schedule page 23	*)					
a. Land Improvements	\$					
b. Building & Building Improvements	\$	232	232			
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$	59,093	59,093			
*7e. Total Depreciation Costs (7a+b+c+d	) \$	59,325	59,325			
8. Amortization (Complete att. Schedule Pag	ge 24*)					
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$	85,330	85,330			
d. Other (Specify)	\$				<u> </u>	
*8e. Total Amortization Costs (8a+b+c+c	(i) \$	85,330	85,330			
9. Rental payments on leased real property le	ess					
real estate taxes included in item 10b	\$	246,552	246,552			
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	62,891	62,891			
c. Personal property taxes	\$	6,332	6,332			
11. Total Property Expenses (7e + 8e + 9 +	10) \$	460,429	460,429			

<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	Other
PLANT SUPPLIES	\$ 12,703		\$ -
PLANT CONTRACT SERVICE LABOR	\$ -		\$ -
ELEVATOR CONTRACT SERVICE	\$ 4,703		\$ -
FIRE/SPRINKLER CONTRACT SERVICE	\$ 3,098		\$ -
LANDSCAPING CONTRACT SERVICE	\$ 8,663		\$ -
SNOW REMOVAL CONTRACT SERVICE	\$ 16,444		\$ -
TRASH REMOVAL CONTRACT SERVICE	\$ 30,351		\$ -
HVAC CONTRACT SERVICE	\$ -		\$ -
SECURITY CONTRACT SERVICE	\$ -		\$ -
PLANT CONTRACT SERVICE OTHER	\$ 11,053		\$ -
PLANT MINOR EQUIPMENT	\$ 9,461		\$ -
RENT AUTO	\$ -		\$ -
RENT EQUIPMENT	\$ 1,500		\$ -
RENT OTHER	\$ -		\$ -
Total Other Repairs and Maintenance	\$ 97,976	\$ -	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-23 Rev. 10/2006

Depreciation Schedule

		-						***************************************			
Participation   Participatio	Name of Facility		···········	License No.	(		Report for Year E.	nded		Page 73	oI 27
Property Item	Farmington Care Center, LLC			7149	ار		3/30/2016			67	
Property   Idea   Idea   Property   Idea   Ide				Historical			Accumulated				
Land Improvements				Cost	Less		Depreciation to	Method of			
Land Improvements   Property Item				Exclusive of	Salvage	Cost to Be	Beginning of	Computing		Depreciation	
1. Acquired prior to this corporate and a substitute and bulging in provement and bulging in proving in	Property Item			Land	Value	Depreciated	Year's Operations	Depreciation		for This Year	Totals
1. Acquired further block proble (stream) schools of such schools)  2. Disposals (stream schools)  2. Disposals (stream schools)  2. Disposals (stream schools)  2. Disposals (stream schools)  3. Disposals (stream schools)  4. Acquired during this report period (stream schools)  5. Disposals (stream schools)  5. Disposals (stream schools)  6. Disposals (stream schools)  8. Acquired during this report period (stream schools)  8. Acquired stream schools  9. Acquired stream schools  9. Acquired stream schools  1. Liei	Land Improvements										
2. Disposals (garden backedile)  Benditive and Boulding this report period (streeh schedule)  Benditive and Boulding this report period (article schedule)  1. Acquired during this report period (article schedule)  3. Acquired during this report period (article schedule)  4. Acquired during this report period (article schedule)  5. Acquired during this report period (article schedule)  5. Acquired during this report period (article schedule)  6. Cost to Be Beginning of Computing Useful Depreciation  6. Cost to Be Beginning of Computing Useful Depreciation  7. Acquired during this report period  8. Acquired during this report period  9. Disposals (stated schedule)  1. Disposals (stated schedule)  1. Disposals (stated schedule)  1. Disposals (stated schedule)  2. Acquired during this report period  6. Acquired during this report period  6. Acquired during this report period  8. Acquired during this report period  8. Acquired during this report period  9. Acquired during this report period  1. Disposals (stated schedule)  1. Acquired during this report period  2. Acquired during this report period  3. Acquired during this report period  4. Acquired during this report period  5. Acquired during this report period  6. Acquired during this report period  9. Acquired during this report period  1. Acquired this report period  1. Acquired this report period  1. Acquired this report period  1	1. Acquired prior to this report period										
Subtract during this report period (attach schedule)	2. Disposals (attach schedule)										
Subtrotal	3. Acquired during this report period (attack	h schedule)									
Building and Building Improvements   1,161	A-4. Subtotal										
1,161   1,16	B. Building and Building Improvements										
2. Disposals (strach schedule)   Subtoral forms that is report period   Subtoral forms that is report period   Subtoral forms that is report period (attach schedule)   Subtoral forms that is report to the schedule forms	1. Acquired prior to this report period			1,161		1,161	193			232	
3. Acquired furning this report period (attach schedule)     1. Acquired furning this report period (attach schedule)     2. Disposals (attach schedule)     3. Acquired furning this report period (attach schedule)     4. Acquired furning this report period (attach schedule)     5. Acquired furning this report period (attach schedule)     5. Acquired furning this report period (attach schedule)     6. Acquired furning this report period (attach schedule)     8. Acquired furning this report period (attach schedule)     9. Acquired furning this report period     1. Acquired furning this report period     1. Acquired furning this report period     1. Acquired furning this report period     2. Acquired furning this report period     3. Acquired furning this report period     4. Acquired furning this report period     5. Acquired furning this report period     6. Acquired furning this report period     6. Acquired furning this report period     7. Acquired furning this report period     8. Acquired furning this report period     9. Acquired furning this report period     1.009,441   1.	1										
Non-Morable Equipment		h schedule)									
Non-Morable Equipment   Cost   Less   Cost to Be   Cost	S										232
1. Acquired prior to this report period (stated) schedule)  2. Disposals (attach schedule)  3. Acquired during this report period (stated) schedule)  Subtotal  Movable Equipment  1. Movable Equipment  2. Movable Equipment  3. Acquired during this report period (stated) schedule)  2. Acquired during this report period (stated) schedule)  3. Acquired during this report period (stated) schedule)  4. Accumulated A											
2. Disposals (attach schedule)           Subtotal           Subtotal           Subtotal           Subtotal           Subtotal           Subtotal           Acquisition           Depreciation to logbook           Vss No Movable Equipment           To Movable Equipment           Accumulated											
Subtotal	2. Disposals (attach schedule)										
Subtoral  Subtoral  Is a mileage  Inaintained? Acquired lating this report period  Accumulated  Beginning of Conpt to Be Beginning of Compting  Brokusive of Salvage Cost to Be Beginning of Compting  And year of each vehicle)  Cost  Land O Yalue  Depreciation  Accumulated  Accum	3. Acquired during this report period (attacl	th schedule)									
1 s a mileage											
Movable Equipment   Yes   No   Month   Yes   Less   Depreciation to   Method of   Salvage   Cost to Be   Beginning of   Computing   Useful   Depreciation   Life   for This Year   Total Depreciation   Life   Method of   Computing   Useful   Depreciation   Life   for This Year   Total Depreciation   Life   Method of   Depreciation   Life   for This Year   Total Depreciation   Life   Method of   Depreciation   Life   for This Year   Total Depreciation   Life   Method of   Depreciation   Life   Method   Depreciation   Life   Depreciation   Li	. —	Is a mileage	Tota of	Historical			Accumulated				,,
Movable Equipment         Yes         No         Month         Yes         Land         Value         Depreciation         Life         for This Year         Total Depreciation           1. Movable Equipment and year of each vehicle)         4. Van Repair Hillside Automotive Cerx         1.009,441         1,009,441         838,330         1,009,441         838,330         1,009,441         1,009,441         838,330         2,533           2. Movable Equipment a Acquired during this report period b. Cattach schedule)         25,549         1,009,441         838,330         1,009,441         838,330         2,533           3. Subtotal         3. Subtotal         4.         2,549         2,549         2,549         2,549         2,533			Acquisition	Cost	Less		Depreciation to	Method of			
Movable Equipment         Movable Equipment         According to this report period (attach schedule)         According		Š		Exclusive of Land	Salvage Value	Cost to Be Depreciated	Beginning of Year's Operations	Computing Depreciation	Useful Life	Depreciation for This Year	Totals
1. Motor Vehicles (Specify name, model and year of each vehicle)       a. Van Repair: Hillside Automotive Cerx       b. Van Repair: Hillside Automotive Cerx       c. c. d.         b. Van Repair: Hillside Automotive Cerx       c. d.       d. d.         c. d. d.       d. d.       l.,009,441       l.,009,441       s6,560         b. Disposals (attach schedule)       c. Acquired during this report period (attach schedule)	Movable Equipment										
and year of each vehicle)       a. Van Repair: Hillside Automotive Cet x       b.       c.	1. Motor Vehicles (Specify name, model									******	
a. Van Repair: Hillside Automotive Cel x         a. Van Repair: Hillside Automotive Cel x         b.         c.         c.         c.         d.         c.         d.         c.         d.	and year of each vehicle)									*****	
b. c. d. 2. Movable Equipment a. Acquired prior to this report period b. Disposals (attach schedule) c. Acquired during this report period c. Acquired during this report period a. Acquired during this report period c. Acquired during this report period attach schedule) c. Acquired during this report period c. Acquired during this report period attach schedule) Subtotal Total Depreciation	a. Van Repair: Hillside Automotive Cer	×									
c. Acquired prior to this report period b. Disposals (attach schedule) c. Acquired during this report period (attach schedule) c. Acquired during this report period (attach schedule) Subtotal Subtotal Total Depreciation	b.										
d. Movable Equipment       1,009,441       1,009,441       838,330       56,560         a. Acquired prior to this report period       b. Disposals (attach schedule)       c. Acquired during this report period       25,649       2,533         c. Acquired during this report period (attach schedule)       25,649       2,533         Subtotal       Total Depreciation	C.										
2. Movable Equipment       a. Acquired prior to this report period       1,009,441       1,009,441       838,330       56,560         a. Acquired prior to this report period       b. Disposals (attach schedule)       c. Acquired during this report period       25,649       25,549       2,533         Subtotal       Total Depreciation       Total Depreciation       2,533       2,533											
a. Acquired prior to this report period b. Disposals (attach schedule) c. Acquired during this report period (attach schedule) Subtotal  Total Depreciation	Σ					.,,	000000			075 75	
b. Disposals (attach schedule)         c. Acquired during this report period (attach schedule)         25,649         2,533           Subtotal         Total Depreciation         Total Depreciation	a. Acquired prior to this report period			1,009,441		1,009,441	056,350			70,700	
c. Acquired during this report period (attach schedule)         25,649         2,533           Subtotal         Total Depreciation	b. Disposals (attach schedule)										
(attach schedule)         25,649         2,533           Subtotal         Total Depreciation         2,534	c. Acquired during this report period										
Subtotal Total Depreciation	(attach schedule)			25,649						2,533	200.00
Total Depreciation	D-3. Subtotal									<del>- (</del>	59,093
	E. Total Depreciation										59,325

Useful

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

Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
3.000 (000 000 000 000 000 000				
Cotal additions for	Land Improvements	S -		\$
Deletions:				
				1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Total deletions for	Land Improvements	\$ -		\$ -

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

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

scheame of Buna	ing Improvements Acquired during this report period		Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
		198 (1984 (Ve 1964)) 198 (1984 (Ve 1964))		
Cotal additions fo	or Building Improvements	\$		\$ -
Deletions;				
			Such Such	
	TO JEH T	\$		\$ -
Total deletions fo	or Building Improvements	\$ -		\$

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

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

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
		18:100-88:100-08		
Total additions for	Non-Movable Equipment	\$		\$ -
Deletions:				
C 55				
Total deletions for	Non-Moyable Equipment	\$ -		s -
Tordi deterrony in	parternations of the compartment of the contract of the contra		_ ( · · · · · · · · · · · · · · · · · ·	

<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

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:	Description of Item	Cost	Litt	Depresation
2/3/2018	Beds: Medline	\$ 10,466	60	\$ 1,221
3/29/2018	Furniture: Direct Supply & Medline	\$ 4,703	120	
8/21/2018	Bed & Mattress Medline	\$ 3,788	60	\$ 63
9/19/2018	Electric Lift; Direct Supply	\$ 4,086	120	84:3000 (0.00)
7/31/2017	Laptops & Printer: Prime Care	\$ 2,607	36	\$ 1,014
Total additions fo	r Movable Equipment	\$ 25,649		\$ 2,533
Deletions:				
16, 17, 37, 60, 76, 460				
Total deletions for	r Movable Equipment	\$		\$ -

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

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

Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
				60 60 606 (84 086 8
			ama davab wa 65 mashi Produktako da kamata da	
Total additions for Leasehold I	mprovement	\$ -		\$ -
Deletions:				
Total deletions for Leasehold I	mprovement	3		\$ -

Useful

<sup>\*\*</sup>Ties to Page 23, Line D2b

<sup>\*</sup>Ties to Page 24, Line C3

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

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

# Amortization Schedule\*

N £ 17		I icense No		Report for Year Ended	r Ended		Page	fo
Farmington Care Center, LLC		2149-C		9/30/2018			24	37
				Accumulated				
	Date of			Amort. to				
	Acquisition			Beginning of	Basis for			
		Length of	Cost to Be	Year's	Computing	Rate   Ar	Amortization	
Item	Month Year	A	Amortized	Operations	Amortization**	% for	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			( ) ( )	
1. Acquired prior to this report period			1,388,547	808,968			85,530	
2. Disposals (attach schedule)								
3. Acquired during this report period								
(attach schedule)								000
C-4. Subtotal							·	85,530
D. Total Amortization								85,550
* Ctraight in mathod mist be used								

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.B. Life of mortgage; ORC. Remaining Life of Lease; OR

D. Actual Life if owned by Related Party.

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

,	License No.	Report for Year En	ded		Page	of
Farmington Care Center, LLC	2149-C	9/30/2018			25	37
11. Property Questionnaire						
Part A						
Is the property either owned by the	Facility	V	•	No	If "Yes," comple	te Part B.
or leased from a Related Party?*		) Yes	0	110	If "No," complet	e Part C.
*If any owner or operator of this facil	•					
business association to any person or related party transaction.	organization from whom	buildings are leased, then i	t is considered a			
Description		Total				
Date Land Purchased		12/01/03				
Date Structure Completed						
3. If <b>NOT</b> Original Owner, Date	of Purchase	12/01/03				
4. Date of Initial Licensure		12/01/03	]			
<ol><li>Total Licensed Bed Capacity</li></ol>		105				
6. Square Footage						
7. Acquisition Cost						
a. Land			-			
b. Building	ut on	lat Martanas	and Martanas	3rd Mortanas	4th Mort	rage
Part B - Owner and Related Part 1 Financing	rues	1st Mortgage	2nd Mortgage	ord Mortgage	4ui iviori	zago
a. Type of Financing (e.g., fix	xed_variable)				T	
b. Date Mortgage Obtained	ico, ranacio					
c. Interest Rate for the Cost	Year					
d. Term of Mortgage (numbe						
e. Amount of Principal Borro	owed					
f. Principal balance outstand	ing as of					
Complete if Mortgage was I						
During Current Cost Ye			1			
g. Type of Financing (e.g., fin	xed, variable)					
h. Date of Refinancing						
i. New Interest Rate j. Term of Mortgage (number	or of years)					
k. Amount of Principal Borro						
Principal Outstanding on 1						
Part C - Arms-Length Lease		Improvements Onl	Y			
Name and Address of Lesson		roperty Leased		Term of Lease	Annual Amou	nt of Lease
Summit Farmington, LLC		Swamp Rd,	08/09/17	15 years with	2	297,000
	Farmingt	on, CT				
				year extension	1	
				1		
					[	
			**			
				1		

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

Name of Facility	License No.		Report for Yea	r Ended		Page	of
Farmington Care Center, LLC	2149-C		9/30/2018			26	37
ltem			Total	CCNH	RHNS	C	ther
12. Interest A. Building, Land Improveme Equipment 1. First Mortgage	ent & Non-Movable	\$					
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	l _						
1. Original Loan Amount		\$					
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Exper	ise						
12 B7. Total Building Interest Expe	nse (A1 - A4 + B5)	\$					
			10	C. 1	forward to r		

(Carry Subtotals forward to next page)

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

Name of Facility	License No.		Report for Ye	ear Ended		Page of
Farmington Care Center, LLC	2149-C		9/30/2018		<del></del>	27   37
Ite	n		Total	CCNH	RHNS	Other
	Subtotals Bro	ught Forward:				
12. C. Movable Equipment						
Automotive Equipment	<del></del>	\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)		\$	, , , , , , , , , , , , , , , , , , , ,		2004 400 1 4 2 2 3 4 3	
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equip Expense (C1 + 2)	ment Interest	\$				
12. D. Other Interest Expense (A	Specify)	\$	15,490	15,490		
INTEREST						
13. Total All Interest Expense (1	12B7 + 12C3 + 12D	) \$	15,490	15,490		
14. Insurance						
a. Insurance on Property (b	uildings only)	\$		6,787		
b. Insurance on Automobile		\$				
c. Insurance other than Proj						
1. Umbrella (Blanket Co				36,819		
2. Fire and Extended Co	verage	\$				
3. Other (Specify)		Ş	4,161	4,161		
Other insurance, crim	e					
14d. Total Insurance Expenditur	es(14a+b+c)	9	47,767	47,767		
15. Total All Expenditures (A-1				10,315,823		···

## D. Adjustments to Statement of Expenditures

	e of Fa		Center, LLC	Lic		Report for Year 9/30/2018	ar Ended	Page 28	of   37
· CLL XI	l			1	Total				
[tom	Page	Line			Amount of				
	No.		Item Description		Decrease	CCNH	RHNS		)ther
			es and Wages		Decrease	00111			
	10-L		Outpatient Service Costs	\$				*************	
1.	ļ		Salaries not related to Resident Care	<u>Ψ</u> \$					
2. 3,				<u>Ψ</u>					
4.			Occupational Therapy Other - See attached Schedule	\$					
	72	D C		Φ					
	2 13 ~ 1		sional Fees Resident Care Physicians **	\$					
5.				- \$					
6.	<u> </u>	ļ	Occupational Therapy	\$					
7.			Other - See attached Schedule	4					
		£ 16 -	Administrative and General	φ					
8.		ļ	Discriminatory Benefits	<u>\$</u> \$		149,176			
9.			Bad Debts		· · · · · · · · · · · · · · · · · · ·	149,170			
10.		ļ	Accounting	\$					
10a.	·	<u></u>	Legal	\$					
11.	<u> </u>	ļ	Telephone	\$					
12.	·		Cellular Telephone	\$					
13.			Life insurance premiums on the life	4					
			of Owners, Partners, Operators	\$				1	
14			Gifts, flowers and coffee shops	\$	i				
15			Education expenditures to colleges or						
			universities for tuition and related costs					<b> </b>	
			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	1					
17			Automobile Expense (e.g. personal use)	4				<u> </u>	
18			Unallowable Advertising *	9		15,874			
19			Income Tax / Corporate Business Tax	9					
20			Fund Raising / Contributions	9	3			ļ	
21			Unallowable Management Fees	9	S				
22			Barber and Beauty		8				
23			Other - See attached Schedule		105,186	105,186		<u> </u>	
Pag	e 18 -	Dieta	ry Expenditures						
24	-	T	Meals to employees, guests and others						
			who are not residents	(	S				
Pag	e 19 -	Laun	dry Expenditures						
25		T	Laundry services to employees, guests						
			and others who are not residents	:	\$				
Pao	re 20 -	Hous	ekeeping Expenditures						
26		24.000	Housekeeping services to employees, guests						
20	<u>'</u>		and others who are not residents		\$				
			Subtotal (Items 1 - 20		\$ 270,236	270,236			

<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	Line Ref	Description	CCNH	RHNS	Other
		195 or 19			
Total Othe	r Salaries	Adjustment	\$ -	\$ -	\$ -

## Schedule of Fees Adjustments

Page Ref	Line Ref Description	CCNH	RHNS	Other
Total Othe	r Fees Adjustments	\$ -	\$ -	\$ -

#### Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
16a		PENALTIES	\$ -		\$ -
16a		LATE FEES	\$ (422)		\$ -
16a		PRIOR PERIOD EXPENSES			
		rounding	\$ -		
		Provider User Fee for Medicare days	\$ 105,608		\$ -
Total Othe	r A&G Ac	ljustments	\$ 105,186	\$ -	\$ -

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

r			D. Adjustments to Statemer					r	
Name		-		Lic	ense No.	Report for Y	ear Ended	Page	of
Farmi	ngton	Care	Center, LLC		2149-C	9/30/2018		29	37
I		Ī			Total				
Item	Page	Line			Amount of				
No.	No.	No.	Item Description		Decrease	CCNH	RHNS		Other
			Subtotals Brought Forward	\$	270,236	270,236			
Page	20 - R	Resider	nt Care Supplies***				or hand the state of the second		
27.			Prescription Drugs	\$					
28.			Ambulance/Limousine	\$					
29.			X-rays, etc	\$	10,170	10,170			
30.			Laboratory	\$	24,470	24,470			
31.			Medical Supplies	\$				<u></u>	
32.			Oxygen (non emergency)	\$				<u> </u>	
33.			Occupational Therapy	\$					
34.			Other - See Attached Schedule	\$	2,878	2,878			
Page	22 - A		enance and Property						
35,			Excess Movable Equipment Depreciation						
			See Attached Schedule	\$					
36.			Depreciation on Unallowable						
			Motor Vehicles	\$					
37.			Unallowable Property and Real						
			Estate Taxes	\$				<u> </u>	
38,			Rental of Building Space or Rooms	\$					
39.			Other - See Attached Schedule	\$					
Page	27 - 1	nsura	nce						
40.			Mortgage Insurance	\$					
41.			Property Insurance	\$					
Othe.	r - Mi	scella	neous				Control of the second s		
42.			Other - Indirect	\$					
43.			Interest Income on Account Rec.	\$					
44.			Other - Miscellaneous Administrative	\$					
45.			Management Fees Direct	\$					
46.			Management Fees Indirect	\$				ļ	
47.			Other - Direct	\$	5 5	5			
Not I	For Pi	rofit P	Providers Only						
48.			Building/Non Movable Eq. Depreciation						
			Unallowable Building Interest -						
			See Attached Schedule	\$					
49.	Total	l Amo	unt of Decrease (Items 1 - 48)	9	307,759	307,759			

<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	Other
.20	5J		1,712.03		
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	389		
13	B9A	ST- Resident Care (for outpatent therapy - see schedule)	389		
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)	389		
					000000000000000000000000000000000000000
Total Othe	r Ancillar	y Costs	\$ 2,878	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Exce	ss Movabl	e Equipment Depreciation	\$ -	S -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref Description	CCNH	RHNS	Other
1.5-21.00				
Total Othe	er Property Adjustments	\$ .	s -	\$

Page Ref	Line Ref	Description	CCNH	RHNS	Other
20	4A1	Houskeeping Supplies (for Outpatient Therapy - see schedule)	\$ 0		
20	4B	Housekeeping purchased services (for Outpatient Therapy see schedule)	\$ 3		
22	6B	Heat (for outpatient Therapy see schedule)	\$ 0		
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		
500 1000 0000 000					
Total Othe	r Adjustm	ents	\$ 5	\$ -	\$ -

## Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Other
0.0000000000000000000000000000000000000					
C 400 00 00 00 00 00 00 00 00 00 00 00 00					
Total Unal	lowable B	uilding Interest	\$ -	\$ -	\$ -

CSP-30 Rev.10/2005

## F. Statement of Revenue

Name of Facility	License No.		Report for Y	ear Ended		Page	of
Farmington Care Center, LLC	2149-C		9/30/2018			30	37
	Item		Total	CCNH	RHNS	C	Other
I. Resident Room, Board & Routin	e Care Revenue						
1. a. Medicaid Residents (CT on	ly)	\$	6,231,766	6,231,766			
<ul> <li>b. Medicaid Room and Board</li> </ul>	Contractual Allowance **	\$					
2. a. Medicaid (All other states)		\$					
<ul> <li>b. Other States Room and Boa</li> </ul>	rd Contractual Allowance **	\$					
3. a. Medicare Residents (all inc	lusive)	\$	2,326,809	2,326,809			
b. Medicare Room and Board	Contractual Allowance **	\$					
4. a. Private-Pay Residents and (	Other	\$	878,366	878,366			
b. Private-Pay Room and Boar	d Contractual Allowance **	\$					
II. Other Resident Revenue							
a. Prescription Drugs - Medic	are	\$	189,376	189,376			
b. Prescription Drugs - Medic	· · · · · · · · · · · · · · · · · · ·	\$	(189,376)	(189,376)			
c. Prescription Drugs - Non-N		\$	36,063	36,063			
	fedicare Contractual Allowance **	\$	(36,063)	(36,063)			
2. a. Medical Supplies - Medica		\$	2,413	2,413			
b. Medical Supplies - Medica		\$	(2,413)	(2,413)			
c. Medical Supplies - Non-Medical Supplies -		\$	1,908	1,908			
	edicare Contractual Allowance **	\$	(1,908)	(1,908)			
3. a. Physical Therapy - Medicar		\$	611,304	611,304			
b. Physical Therapy - Medicar		\$	(423,719)	(423,719)			
c. Physical Therapy - Non-Me		\$	109,262	109,262			
	edicare Contractual Allowance **	\$	(109,262)	(109,262)			
4. a. Speech Therapy - Medicare		\$	59,322	59,322			
b. Speech Therapy - Medicare	Man	\$	(47,922)	(47,922)			
c. Speech Therapy - Non-Med		\$	8,790	8,790			
	licare Contractual Allowance **	\$		(8,790)			
5. a. Occupational Therapy - M		\$		513,792			
	edicare Contractual Allowance **	\$		(411,973)			
c. Occupational Therapy - No		\$		90,201			
	on-Medicare Contractual Allowance **	\$					
6. a. Other (Specify) - Medicare	1 10 11 11 11 11 11 11 11 11 11 11 11 11	\$		32,398			
b. Other (Specify) - Non-Med		\$		79,368			
III. Total Resident Revenue (Section		\$		9,871,128			
IV. Other Revenue*			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,			
Meals sold to guests, employer	ong fr others	\$				95513555155	340000000000000000000000000000000000000
2. Rental of rooms to non-reside		\$					
	itto	<u>\$</u>			<u> </u>		
<ul><li>3. Telephone</li><li>4. Rental of Television and Cab</li></ul>	la Sarvinag	\$			1		
5. Interest Income (Specify)	IC DCI v10c9	\$		40	-	-	
6. Private Duty Nurses' Fees		\$		1	1		
7. Barber, Coffee, Beauty and G	ift chance	<u> </u>	<del>                                     </del>		1	1	
	iii ottoba	<u>\$</u>		19,504		-	
8. Other (Specify)		9				<b>†</b>	
V. Total Other Revenue (1 thru 8)				19,544		-	
VI. Total All Revenue (III +V)			9,890,672	9,890,672			

<sup>\*</sup> 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.

#### Schodule of Other Resident Revenue - Medicare

#### Related Exp

Page Ref	Description	CCNH	RHNS	Other
		\$ 30,434		1984,000
	Lab Medicare: CA	\$ (30,434)		yearene
0.030.00	Oxygen Medicare	\$ 258		
	Oxygen Medicare CA	\$ (258)		
	Equipment-sental	\$ 9,523	salagana ayasii	
	Equipment rental CA	\$ (9,523)	00)000000000	
0.0000	Pog Therapy	\$		3500 00000
	Pen Therapy CA	\$		
	Therapy Beds Medicare	\$		2.4919-001B
v18943	Therapy Beds Medicare CA	\$	erangeriesier M	300000000
90% A	Radiology Medicare	\$ 9,352		A0406000
1000	Radiology Medicare CA	\$ (9,352)		
	IV Therapy	\$ 31,915	steriči negodije.	printing w.)
11245	IV.Therapy CA	\$ (31,945)	289999798	0.7900
198000	Medical Transportation	\$	\$1.2884.53	
30.00	Medical Transportation CA	\$	36263733	A 40 TO
	Glucuse testing	Ş		27(0.75/0)
	Glucose lesting CA	\$		200
n galia	Oulpatient dierspy Medicare	\$ 32,398		(30.00) (0.00)
				4.376.514
ofal Oil	nor Resident Revenue - Medicure	\$ 32,398	\$	\$

Schedule of Other Non-Medicare Resident Revenue

#### Related Exp

ge Ref	Description	CCNH	RHNS	Other
	Lab	3,121.79	gwenerwa)	75,000,00
	Lab CA	(3,121.79)		400,000,000
100	Öxygen	\$ 358	angereret.	\$
	Oxygen CA	\$ (358)		\$ -
30.3	Equipment cental	\$ 7,450	100000000000000000000000000000000000000	33000000
de la se	Equipment rental CA	\$ (7,450)		240 C. Care.
	Pen Therapy	\$		100000000000000000000000000000000000000
	Pen Therapy CA	\$	Name (1988)	100000000000000000000000000000000000000
	Therapy Beds	\$ .		20000000
	Therapy Beds CA	S -	t người sử khi thiết	
	Radiology	\$ 819		140 H (110
	Radiology CA	\$ (819)		350,100,700
	Medical Transportation	\$		\$2000 C
	Medical Transportation CA	\$	9800 W-0.000\$	(0.000.8)
20100	Glucose Testing	\$		10.000
	Glucose Testing CA	\$	40,400,000	0.0000000
	IV Borapy	\$ 8,760	10091050000	\$
2000	IV therapy CA	\$ (8,760)	1000001966066	s
20,000	Riu shoi revenue	\$ 120		A (2000)
	Outpatient therapy	\$ (9,195)		2000000
	prior period revenus	\$ 76,192		1000000
Q (1866)	Ophur B	\$ 23,719.	8,1,5,600,4,600%	20000
1900	Ophton B CA	\$ (11,469)		100000
Y	rounding	S 0		5991094.6
		39 88 09 64	de redificiol(SE	10.000
tul Oth	er Resident Revenue	\$ 79,368	\$	\$

#### Interest Income

#### Account

Page Ref Account	Baiance	CCNH	RHNS	Other
INTEREST INCOME	31 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	\$ 40	8050 1855 PERF	100.00000000000000000000000000000000000
	348083094,***		RADIOPHI	
	N. N. S. S. S. L. C.	18.85.65.00		
				41,200 0000Y
Total-Interest Income		\$ 40	\$	\$

#### Schodule of Other Revenue

Pusa Raf	Description	CCNH	RHNS	Other
	MEALS	\$	000000000000000000000000000000000000000	
1010 / 1000	THLEVISION INCOME	\$ 289		
	CONCESSIONS / VENDING INCOME	\$	1,0,7 (4,0,4,0)	Sala as
	RESIDENT LATE FEE REVENUE	\$	1150 m8,038.00	et action and a
000000000	RESIDENT ATTORNEY FEE REVENUE	\$	4.55 0881 F88	Augustie
	TELEPHONE INCOME	\$	120000000	(24.5).45 (24).
	OTHER INCOME	\$ -	11/21/25/19/2014	100000000000000000000000000000000000000
	OPTUM DIVIDENDS REVENUE	\$ 19,221	0.000	\$10,050,050,0
			1998 4883 693648	2000000
(38199)			35,000	4.,
10.7600			V40000000	
			060140136-666	0.000
rotal Oth	er Revegue	\$ 19,504	\$	1 \$

## **G.** Balance Sheet

Name of	Facility	License No.	, -	t for Year	Ended	Page		of
Farmingt	on Care Center, LLC	2149-C	9/30/2	2018		31		37
		Account				Ai	mount	
Assets								
A. Cui	rrent Assets							
1.	Cash (on hand and in banks)	)				\$	•	1,538)
2.	Resident Accounts Receivable	e (Less Allowance f	for Bad D	ebts)		\$	2,08	0,557
3.	Other Accounts Receivable (	Excluding Owners of	or Related	Parties)		\$		
4	Inventories					\$		
5.	Prepaid Expenses					\$	73	9,578
	a. Prepaid Insurance			706,064				
	b. Prepaid Property Taxes			27,216				
	c. Prepaid Expenses Other			6,298				
	d. See Schedule							
6.	Interest Receivable					\$		
7.	Medicare Final Settlement Re	eceivable				\$		
8.	Other Current Assets (itemize	z)				\$	(1,05	7,016)
	Due From (to) Related Parties			(108,448)				
	Other Owners reserves			(948,568)		1		
	See Schedule							
A-9, To	tal Current Assets (Lines A1	thru 8)				\$	1,56	1,581
<del></del>	ted Assets	, , , , , , , , , , , , , , , , , , ,						
1.	Land					\$		
2.	Land Improvements	*Historical Cost				\$		
	•	Accum. Deprecia	tion		Net			
3.	Buildings	*Historical Cost		1,161		\$		735
	2	Accum, Deprecia	tion	426	- Net			
4.	Leasehold Improvements	*Historical Cost		1,388,547		\$	40	6,408
	1	Accum, Deprecia	tion	982,139	Net			
5.	Non-Movable Equipment	*Historical Cost				\$		
	1 1	Accum, Deprecia	tion		- Net			
6.	Movable Equipment	*Historical Cost		1,035,090		\$	13	7,667
	1 1	Accum, Deprecia	tion	897,423	- Net			
7.	Motor Vehicles	*Historical Cost				\$		
		Accum, Deprecia	tion		- Net			
8.	Minor Equipment-Not Depr					\$		
9.	Other Fixed Assets (itemize)	)				\$		2,207
	Construction in Progress			2,207		_		
	See Schedule						w	
B-10.	Total Fixed Assets (Lines E	31 thru 9)				\$	54	17,017

<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
Farm	ingt	on Care Center, LLC	2149-C	9/30/2018	32	37
			Account			nount
				Total Brought Forward:	\$	2,108,598
C.	Lea	asehold or like property record	ded for Equity Purposes	S.		
	1.	Land			\$	
	2.	Land Improvements	*Historical Cost			
			Accum. Depreciation	n Net	\$	
	3.	Buildings	*Historical Cost			
			Accum. Depreciation	n Net	\$	
	4.	Non-Movable Equipment	*Historical Cost			
			Accum. Depreciation	n Net	\$	
	5.	Movable Equipment	*Historical Cost			
			Accum. Depreciatio	n Net	\$	
	6.	Motor Vehicles	*Historical Cost			
			Accum. Depreciatio	n Net	\$	
	7.	Minor Equipment-Not Depr	eciable		\$	
C-8		tal Leasehold or Like Prope			\$	
D.	Inv	vestment and Other Assets				
	1.	Deferred Deposits			\$	
	2.	Escrow Deposits			\$	174,340
	3.	Organization Expense	*Historical Cost			
			Accum. Depreciation	n Net	\$	
	4.	Goodwill (Purchased Only)			\$	
	5.	Investments Related to Resi	dent Care (itemize)		\$	30,062
		Patient Trust Funds		27,507		
		Long Term Deposit - prin	mecare	2,555		
	6.	Loans to Owners or Related	Parties (itemize)		\$	
		Name and Address	Amount	Loan Date		
	7.	Other Assets (itemize)			\$	000000000000000000000000000000000000000
		, , ,				
		See Schedule				
		otal Investments and Other A		)	\$	204,403
		otal All Assets (Lines A9 + B		•	\$	2,313,001

<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 Fac	ility		License No.	Report for Year E	inded	Page	of
Farmington (	Care (	Center, LLC	2149-C	9/30/2018		33	37
			Account			Am	ount
Liabilities							
A.	Cu	rrent Liabilities					
	1.	Trade Accounts Payable			\$		358,511
	2.	Notes Payable (itemize)			\$	1 ) :::::::::::::::::::::::::::::::::::	230,674
		Working Capital Line of C	Credit	230,674			
		See Schedule					
	3.	Loans Payable for Equipn	nent (Current portion		9	<u> </u>	
		Name of Lender	Purpose	Amount	Date Due		
1							
1					1		
	4.	Accrued Payroll (Exclusive	ve of Owners and/or	Stockholders only)		\$	258,626
	5.	Accrued Payroll (Owners				\$	
	6,	Accrued Payroll Taxes Pa				\$	
	7.	Medicare Final Settlemen				\$	
	8.	Medicare Current Financi			,	\$	
	9.	Mortgage Payable (Curre				\$	
		). Interest Payable (Exclusive		Related Parties )		\$	
		. Accrued Income Taxes*				\$	1
		2. Other Current Liabilities	(itemize )			\$	2,260,280
		Related Party Payables		8,077			
		Accrued Expenses	(10	0,668)			
		Accrued Resident User Fees	144	4,151			
		Accrued Workers Comp Expense	588	8,720 See Schedule			
A-1:	3. To	otal Current Liabilities (L				\$	3,108,092

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

# G. Balance Sheet (cont'd)

me of Facility License No. Report for Year Ended		Ended	Page		of	
Farmington Care Center, LLC	2149-C	9/30/2018		34	3	7
	Account			Ar	nount	
		Total Broug	ht Forward:		3,108,09	)2
Liabilities (cont'd)						
B. Long-Term Liabilities						
<ol> <li>Loans Payable-Equipment</li> </ol>	(itemize)		\$			00000000
Name of Lender	Purpose	Amount	Date Due			
		1				
Mortgages Payable			9	3		
3. Loans from Owners or Re	lated Parties (itemize	?)	9	5		
Name and Address of Lender	Amount	Loan D	Date			
		Ì				
	İ					
4. Other Long-Term Liabilit	ies (itemize)			\$	27,5	07
Patient Trust Funds	, ,	27,507	' <b>_</b>			
See Schedule						
B-5. Total Long-Term Liabilities	(Lines B1 thru 4)			\$	27,5	
C. Total All Liabilities (Lines A	A-13 + B-5)			\$	3,135,5	99

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

	ne of Facility	License No.	Report for Y	ear Ended	Page	of
Farr	nington Care Center, LLC	2149-C	9/30/2018		35	ount 37
A.	Reserves	Account			All	iount
/A.		13			\$	
	1. Reserve for value of leased				Ψ	
	2. Reserve for depreciation va	lue of leased building	igs and appurter	ances	<b> </b>	
	to be amortized				<u> \$</u>	
	3. Reserve for depreciation va	lue of leased person	al property (Equ	rity)	\$	
	4. Reserve for leasehold real p	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		· · · · · · · · · · · · · · · · · · ·	and the state of t	\$	
	3. Paid-in Surplus			and the second s	\$	
	4. Treasury Stock				\$	
	5. Cumulated Earnings				\$	(422,446)
	6. Gain or Loss for Period	10/1/2	017 thru	9/30/2018	\$	(425,151)
	7. Total Net Worth				\$	(822,598)
C.	Total Reserves and Net Wort	lı			\$	(822,598)
D.	Total Liabilities, Reserves, ar	nd Net Worth			\$	2,313,001

# H. Changes in Total Net Worth

Name of Facility		License No.	Report for Year I	Ended	Page	of
Farmi	ngton Care Center, LLC	2149-C	9/30/2018		36	37
	Account			Amount \$		
						- 200 (55
	Total Revenue (From Statement of Revenue Page 30)				\$	9,890,672
~~~	Total Expenditures (From Statement of Expenditures Page 27)				\$	10,315,823
D.	Net Income or Deficit	or Deficit			\$	(425,151)
E.	Balance				\$	(425,151)
	Additions  1. Additional Capital Contributed  2. Other (itemize)	(itemize )				
	The Lattice				\$	
					Ψ	
G.	Deductions 1. Drawings of Owners/Operators/Partners (Specify)				\$	
	Name and Address ( <i>No., City,</i>		Title	Amount		
		( )			\$	
	2. Other Withdrawings (Specify)					
	Purpose		Amount			
	3. Total Deductions				\$	
H. Balance at End of Period 09/30/18				\$	(425,151)	

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

Name of Facility		License No.	Report for Year Ended	Page of					
Farmir	ngton Care Center, LLC	2149-C	9/30/2018	37 37					
Check appropriate category									
☑	Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)	☑ Other						
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	ture of Preparer	Title	Date Signed						
Printed Name of Preparer									
iCare	Management, LLC								
	s Address	Phone Number	Phone Number						
341 B	idwell Street, Manchester, CT 06040	860-570-2140	860-570-2140						
	al Report Contact	Phone Number	Phone Number						
Annual Report Contact Email Address									