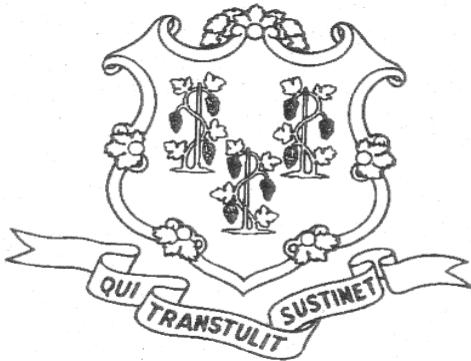


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2022

Name of Facility (as licensed) SecureCare Options, LLC		
Address (No. & Street, City, State, Zip Code) 60 West Street Rocky Hill CT		
Type of Facility		
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> Other
Report for Year Beginning 10/1/2021	Report for Year Ending 9/30/2022	

License Numbers:	CCNH 2389	RHNS	Other	Medicare Provider 07-5442
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Medicaid Provider Numbers:	CCNH 8046363	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022	Page 1	of 37
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Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT 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 SecureCare Options, LLC [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)	Date	Signed (Owner)	Date	
Printed Name (Administrator) Melissa Schmitt		Printed Name (Owner) Chris Wright		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility SecureCare Options, LLC	Period Covered:		From 10/1/2021	To 9/30/2022
Address of Facility 60 West Street Rocky Hill CT				
Report Prepared By Plante Moran, PLLC	Phone Number 248-223-3569	Date 2/15/2023		
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	\$			
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

	Phone No. of Facility 860-529-0880	Report for Year Ended 9/30/2022	Page 2
Name of Facility (as shown on license) SecureCare Options, LLC		Address (No. & Street, City, State, Zip) 60 West Street Rocky Hill CT	
License Numbers: Type of Facility (Check appropriate box(es))	CCNH 2389	RHNS	Other
	<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> Other
Type of Ownership (Check appropriate box)			
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust			
If this facility opened or closed during report year provide:		Date Opened	Date Closed
Has there been any change in ownership or operation during this report year?		<input type="radio"/> Yes <input checked="" type="radio"/> No	If "Yes," explain fully.
Administrator			
Name of Administrator Jessica Dering		Nursing Home Administrator's License No.: 1580	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name Melissa Schmitt		License No.: 2182	

State of Connecticut

Annual Report of Long-Term Care Facility

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**General Information and Questionnaire
Partners/Members**

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022	Page of 3 37
Legal Name of Partnership/LLC		Business Address	State(s) and/or Town(s) in Which Registered
SecureCare Options, LLC		60 West Street Rocky Hill CT	CT
Name of Partners/Members	Business Address	Title	% Owned
Rocky Associates	245 South Benton St STE 100, Lakewood, CO 80226	Member	31.66
UTG Investments, LLC	2500 17th St, STE 201 Denver CO 80211	Member	31.66
LTC Associates, LLC	245 South Benton St STE 100, Lakewood, CO 80226	Member	31.66
Vantage Capital, LLC	c/o iCare, 341 Bidwell St Manchester CT 06040	Member	5.02

General Information and Questionnaire

Corporate Owners

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022	Page 3A	of 37
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If this facility is owned or operated as a corporation, provide the following information:

General Information and Questionnaire

Individual Proprietorship

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022	Page 3B	of 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

General Information and Questionnaire

Related Parties*

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input type="radio"/> Yes <input checked="" type="radio"/> No					If "Yes," provide the Name/Address and complete the information on Page 11 of the report.			
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? <input checked="" type="radio"/> Yes <input type="radio"/> No					If "Yes," provide the following information:			
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Bidwell Care Center, LLC	333 Bidwell St. Manchester, CT 06040	<input type="radio"/>	<input checked="" type="radio"/>		Shared Employees	Pg 13, B11a2; Pg 13, B	(13,801)	13,801
Chelsea Place Care Center, LLC	25 Lorraine St. Hartford, CT 06105	<input type="radio"/>	<input checked="" type="radio"/>		Shared Employees	Pg 13, B11a2; Pg 13, B	(14,082)	14,082
Chestnut Point Care Center, LLC	171 Main St. East Windsor, CT 06088	<input type="radio"/>	<input checked="" type="radio"/>		Shared Employees	Pg 13, B11a2; Pg 13, B	(2,835)	2,835
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Shared Employees	Pg 13, B11a2; Pg 13, B	(9,122)	9,122
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088	<input type="radio"/>	<input checked="" type="radio"/>		Shared Employees	Pg 13, B11a2; Pg 13, B	(14,965)	14,965
Meriden Care Center, LLC (Silver Springs)	33 Roy St. Meriden, CT 06450	<input type="radio"/>	<input checked="" type="radio"/>		Shared Employees	Pg 13, B11a2; Pg 13, B	(17,358)	17,358
Trinity Hill Care Center, LLC	151 Hillside Ave. Hartford, CT 06106	<input type="radio"/>	<input checked="" type="radio"/>		Shared Employees	Pg 13, B11a2; Pg 13, B	44,096	(44,096)
Westside Care Center, LLC	349 Bidwell St. Manchester, CT 06040	<input type="radio"/>	<input checked="" type="radio"/>		Shared Employees	Pg 13, B11a2; Pg 13, B	18,319	18,319
See Additional Schedule Attached		<input type="radio"/>	<input checked="" type="radio"/>					

* 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 SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

1. In the preparation of this Report, were all costs allocated as required?	<input checked="" type="radio"/> Yes <input type="radio"/> No	If "No," explain fully why such allocation was not made.
2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.		
3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)		
<input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.		

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.

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

⊕ No

Total ***

11,949

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

** Attach copies of newly acquired leases.

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

General Information and Questionnaire

Accounting Basis

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

⊕ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1	Taxes, financial statements, accounting support	\$ 11,258
2		\$
3		\$
4		\$
Charge for Services Provided		
		\$ 11,258

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

Yes No 15D

Legal Services Information

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

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

1 341 Bidwell Street, Manchester CT
2 280 Trumbull St, Hartford, CT
3
4
5 341 Bidwell Street, Manchester CT

Services Provided by This Firm (*describe fully*)

1	Lease and contract issues, general legal advice, Labor Law	\$
2	General legal advice, union funds advice, employment law	\$
3	Employment Arbitrations, healthcare law & Conservatorships	\$ 1,954
4		\$
5	Collections	\$

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

THE THERMAGNETOMETER

Schedule of Resident Statistics

Name of Facility SecureCare Options, LLC			License No. 2389				Report for Year Ended 9/30/2022				Page 8		of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total Other	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30					
					Total	CCNH	RHNS	Other	Total	CCNH	RHNS	Other		
1. Certified Bed Capacity					95	95								
A. On last day of PREVIOUS report period	95	95												
B. On last day of THIS report period	95	95								95	95			
2. Number of Residents					80	80			80	80				
A. As of midnight of PREVIOUS report period	80	80												
B. As of midnight of THIS report period	88	88								88	88			
3. Total Number of Days Care Provided During Period					339	339							46	46
A. Medicare	385	385											7,667	7,667
B. Medicaid (Conn.)	29,296	29,296			21,629	21,629								
C. Medicaid (other states)														
D. Private Pay														
E. State SSI for RCH														
F. Other (Specify) Insurance	1,422	1,422			1,054	1,054				368	368			
G. Total Care Days During Period (3A thru F)	31,103	31,103			23,022	23,022				8,081	8,081			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds														
A. Medicaid Bed Reserve Days														
B. Other Bed Reserve Days														
5. Total Resident Days (3G + 4A + 4B)	31,103	31,103			23,022	23,022				8,081	8,081			

Schedule of Resident Statistics (Cont'd)

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? Yes No

If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change	
	CCNH	RHNS	Other	Lost			Gained			CCNH	RHNS	Other		
				(1)	(2)	(3)	(1)	(2)	(3)					

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

1st change	Change in Resident Days			CCNH	RHNS	Other
	CCNH	RHNS	Other	CCNH	RHNS	Other
1st change						
2nd change						
3rd change						
4th change						

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	Other	R.C.H.	ICF-MR
No. of Residents	1	88						
Per Diem Rate								
a. One bed rm.	662.00	456.00						
b. Two bed rms.								
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B	2,639	2,639	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments	2,114	2,114	
2. Restorative Treatments	101	101	
C. Other	2,492	2,492	
D. Total Physical Therapy Treatments	7,346	7,346	

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	408	408	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments	197	197	
2. Restorative Treatments	5	5	
C. Other	423	423	
D. Total Speech Therapy Treatments	1,033	1,033	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	1,385	1,385	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments	1,711	1,711	
2. Restorative Treatments	128	128	
C. Other	1,996	1,996	
D. Total Occupational Therapy Treatments	5,220	5,220	

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
SecureCare Options, LLC	2389	9/30/2022		10	37
Are time records maintained by all individuals receiving compensation?	<input checked="" type="radio"/> Yes <input type="radio"/> No				
Item	CCNH	Hours	RHNS	Hours	Other
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	209,253	2,630			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	32,725	677			
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	184,458	6,656			
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor					
c. Dietary Workers					
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers					
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	81,779	2,000			
b. Other Maintenance Workers	1,665	106			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers					
9. Barber and Beautician Services					
10. Protective Services					
11. Accounting Services					
a. Head Accountant					
b. Other Accountants					
12. Professional Care of Residents					
a. Directors and Assistant Director of Nurses	295,754	4,667			
b. RN					
1. Direct Care	744,258	11,934			
2. Administrative**	490,376	11,299			
c. LPN					
1. Direct Care	1,097,161	30,348			
2. Administrative**	29,828	784			
d. Aides and Attendants	2,075,818	92,575			
e. Physical Therapists					
f. Speech Therapists					
g. Occupational Therapists					
h. Recreation Workers	266,651	9,350			
i. Physicians					
1. Medical Director					
2. Utilization Review					
3. Resident Care***					
4. Other (Specify)					
j. Dentists					
k. Pharmacists					
l. Podiatrists					
m. Social Workers/Case Management	358,130	10,653			
n. Marketing					
o. Other (Specify)					
See Attached Schedule	157,452	6,310			
<i>A-13. Total Salary Expenditures</i>	6,025,308	189,988			

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

** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and

Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

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

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH		RHNS		Other	
	\$	Hours	\$	Hours	\$	Hours
UNIT SECRETARIES SALARIES	\$ 8,874	256			\$ -	-
MEDICAL RECORDS SALARIES	\$ 38,561	1,958			\$ -	-
CENTRAL SUPPLY SALARIES	\$ 65,389	2,086			\$ -	-
RESPIRATORY THERAPY SALARIES	\$ -	-			\$ -	-
PLANT SECURITY SALARIES	\$ 44,627	2,011			\$ -	-
MEDICAL RECORDS SALARIES SPCL	\$ -	-			\$ -	-
Total	\$ 157,452	6,310	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		Other	
	\$	Hours	\$	Hours	\$	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$ -	-			\$ -	-
ADMISSIONS C/S LABOR	\$ 33,715	612			\$ -	-
CENTRAL SUPPLY CONTRACT SERVICE	\$ (72,203)	(1,958)			\$ -	-
ADMINISTRATIVE CONTRACT SERVICE LABOR	\$ 177,346	2,632			\$ -	-
RESPIRATORY THERAPY CONTRACT SERVICES	\$ 236	-			\$ -	-
PHYSICAL THERAPY C/S MEDICIAD	\$ -	-			\$ -	-
SPEECH THERAPY C/S Medicaid	\$ -	-			\$ -	-
OCCUPATIONAL THERAPY C/S MEDICIAD	\$ -	-			\$ -	-
Total	\$ 139,094	1,286	\$ -	-	\$ -	-

State of Connecticut

Annual Report of Long-Term Care Facility

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

Name of Facility SecureCare Options, LLC			License No. 2389		Report for Year Ended 9/30/2022			Page 11	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Other							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)			License No.		Report for Year Ended			Page	of	
SecureCare Options, LLC			2389		9/30/2022			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Other							
Section III - Administrators***										
Jessica Dering	209,253			same as employees less union funds	Administrator	2,630	A2			
				same as employees less union funds	Administrator		A2			
				same as employees less union funds	Administrator		A2			
Section IV - Assistant Administrators										
Melissa Schmitt	32,725			same as employees less union funds	Assistant Administrator	677	A3			

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022		Page 13	of 37
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Other
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)					
1. Dietitian					
2. Dentist					
3. Pharmacist	15,969	160			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	94,853	1,817			
b. Other					
6. Social Worker	(35,635)	(451)			
7. Recreation Worker	22,498	132			
8. Physicians					
a. Medical Director (entire facility)	42,000	152			
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**					
d. Administrative Services facility					
1. Infection Control Committee (Quarterly meetings)					
2. Pharmaceutical Committee (Quarterly meetings)					
3. Staff Development Committee (Once annually)					
e. Other (Specify)					
Physician Care Contract Services	11,093	21			
9. Speech Therapist					
a. Resident Care	34,668	664			
b. Other					
10. Occupational Therapist					
a. Resident Care	69,171	1,325			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	65,800	480			
2. Administrative***	(71,734)	(1,765)			
b. LPN					
1. Direct Care	186,995	2,140			
2. Administrative***					
c. Aides	52,221	1,410			
d. Other					
12. Other (Specify)					
See Attached Schedule	139,094	1,286			
B-13 Total Fees Paid in Lieu of Salaries	626,995	7,372			

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

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

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

Report of Expenditures

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

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022		Page 15	of 37
Item		Total	CCNH	RHNS	Other
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 84,498	84,498			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$				
4. Social Security (F.I.C.A.)	\$ 482,106	482,106			
5. Health Insurance	\$ 901,919	901,919			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 261,881	261,881			
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$ 23,100	23,100			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ (2)	(2)			
d. Accounting and Auditing	\$ 11,258	11,258			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 1,954	1,954			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 46,363	46,363			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 46,833	46,833			
2. Cellular Phones	\$ 2,810	2,810			
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 646,171	646,171			
Subtotal	\$ 2,508,891	2,508,891			

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

(Carry Subtotals forward to next page)

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

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Other
UNION TRAINING	\$ 23,100		\$ -
Total	\$ 23,100	\$ -	\$ -

Schedule of Other Taxes

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

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

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022	Page 16	of 37
Item	Total	CCNH	RHNS	Other
<i>Subtotals Brought Forward:</i>	2,508,891	2,508,891		
I. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$			
3. Gifts to Staff and Residents	\$			
4. Employee Travel	\$	10,152	10,152	
5. Education Expenses Related to Seminars and Conventions	\$	5,220	5,220	
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$			
7. Other (<i>Specify</i>) See Attached Schedule	\$	900	900	
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	15,482	15,482	
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$			
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	5,505	5,505	
4. Fund-Raising***	\$			
5. Medical Records	\$			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$			
7. Postage	\$	4,524	4,524	
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	6,483	6,483	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$	858	858	
10. Contributions*** See Attached Schedule	\$	250	250	
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	149,966	149,966	
12. Administrative Management Services**	\$	354,174	354,174	
13. Other (<i>Specify</i>) See Attached Schedule	\$	34,185	34,185	
<i>C-14 Total Administrative & General Expenditures</i>	\$	3,096,589	3,096,589	

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

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	Other
MEALS	\$ 900		\$ -
Total Other Travel and Entertainment	\$ 900	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	Other
COMMUNICATIONS SPECIAL EVENTS	\$ 5,505		\$ -
Total Other Advertising	\$ 5,505	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	Other
ALTCFM			
CAHCF Dues	\$ 6,483		\$ -
OTHER DUES			
Total Dues	\$ 6,483	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	Other
CONTRIBUTIONS	\$ 250		\$ -
Total Contributions	\$ 250	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	Other
SOCIAL SERVICE SUPPLIES	\$ -		\$ -
SOC SVC MINOR EQUIPMENT	\$ -		\$ -
ADMINISTRATIVE MINOR EQUIPMENT	\$ 8,183		\$ -
EMPLOYEE RELATIONS	\$ 3,266		\$ -
EMPLOYEE RELATIONS-OTHER	\$ 2,030		\$ -
PERMITS & LICENSES	\$ 2,572		\$ -
VOLUNTEER EXPENSE	\$ -		\$ -
BANK FEES	\$ 1,238		\$ -
CMS REVISIT USER FEES	\$ -		\$ -
PENALTIES	\$ 6,747		\$ -
LATE FEES	\$ 639		\$ -
INTERNET EXPENSES	\$ 9,510		\$ -
Rounding	\$ -		
Total Other Administrative and General	\$ 34,185	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
iCare Management, LLC/iCare Health Management, LLC	354,174	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	139,048	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	33,424	MANAGEMENT FEES- INDIRECT CARE	Pg 20 k

* 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)

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022	Page 18	of 37
Item	Total	CCNH	RHNS	Other
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 6,725	6,725		
2. Non-Food Supplies	\$ 2,170	2,170		
3. Other (Specify) _____ DIETARY SUPPLEMENTS	\$ 2,618	2,618		
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 1,364,002	1,364,002		
c. Other (Specify) _____ DIETARY MINOR EQUIPMENT	\$ 11,337	11,337		
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 1,386,853	1,386,853		
2E. Dietary Questionnaire	Total	CCNH	RHNS	Other
F. Resident Meals: Total no. of meals served per day:*	256	256		
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				
H. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.	
K. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
M. Is cost of food (other than meals, e.g., snacks provided to employees included in 2D?) at monthly staff meetings, board meetings)	<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.	
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022		Page 19	of 37
Item	Total	CCNH	RHNS	Other	
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	1,611	1,611		
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. \$				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. \$				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. \$				
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$	280,229	280,229		
c. Other (<i>Specify</i>) LAUNDRY MINOR EQUIPMENT	\$				
3D. Total Laundry Expenditures (3a + b + c)	\$	281,840	281,840		
3E. Laundry Questionnaire					
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
K. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3D.

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

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

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022		Page 20	of 37
Item		Total	CCNH	RHNS	Other
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 15,143	15,143		
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)					
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	Sq. Ft. Serviced by Personnel				
	Amt.	\$ 293,471	293,471		
C. Other (<i>Specify</i>)	\$				
HOUSEKEEPING MINOR EQUIPMENT					
4D. Total Housekeeping Expenditures (4a + b + c)	\$	308,614	308,614		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from PHARMACY	\$	89,547	89,547		
b. Medicine Cabinet Drugs	\$	17,898	17,898		
c. Medical and Therapeutic Supplies	\$	61,075	61,075		
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$	2,840	2,840		
2. Other***	\$				
f. X-rays and Related Radiological Procedures***	\$	6,369	6,369		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	22,287	22,287		
i. Recreation	\$				
j. Direct Management Services*	\$	139,048	139,048		
k. Indirect Management Services*	\$	33,424	33,424		
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	115,836	115,836		
5M. Total Resident Care Expenditures (5a - 5j)	\$	488,325	488,325		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	Other
NURSING ADMIN SUPPLIES	\$ 1,091		\$ -
NURSING MINOR EQUIP	\$ 5,363		\$ -
MEDICAL RECORDS SUPPLIES	\$ 898		\$ -
MEDICAL RECORDS MINOR EQUIPMENT	\$ -		\$ -
NON-COVERED PPS DR. VISITS	\$ 17,836		\$ -
RESIDENT CARE SUPPLIES	\$ -		\$ -
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 6,340		\$ -
PERSONAL CARE SUPPLIES	\$ 13,314		\$ -
INCONTINENCY SUPPLIES	\$ 19,996		\$ -
VACCINE RESIDENTS	\$ 6,024		\$ -
PATIENT SPECIAL NEEDS	\$ 3,583		\$ -
PHYSICAL THERAPY SUPPLIES	\$ -		\$ -
PHYSICAL THERAPY EQUIPMENT RENT	\$ -		\$ -
PHYSICAL THERAPY MINOR EQUIPMENT	\$ -		\$ -
OCCUPATIONAL THERAPY SUPPLIES	\$ -		\$ -
OCCUPATIONAL THERAPY EQUIP RENTAL	\$ -		\$ -
OCCUPATIONAL THERAPY MINOR EQUIP	\$ -		\$ -
SPEECH THERAPY SUPPLIES	\$ -		\$ -
SPEECH THERAPY EQUIPMENT RENT	\$ -		\$ -
SPEECH THERAPY MINOR EQUIPMENT	\$ -		\$ -
RENTALS FOR NURSING EQUIPMENT NON BILLABLE	\$ 10,899		\$ -
EQUIPMENT RENTAL: AIDS UNIT	\$ -		\$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ 155		\$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ 14,593		\$ -
HI LOW BED RENTAL & MATTRESSES	\$ -		\$ -
IV THERAPY SUPPLIES	\$ 2,695		\$ -
IV THERAPY CONTRACT SERVICE	\$ -		\$ -
MEDICAL WASTE CONTRACT SERVICE	\$ 1,053		\$ -
ACTIVITIES SUPPLIES	\$ 7,866		\$ -
ACTIVITIES MINOR EQUIPMENT	\$ 904		\$ -
ADMISSIONS SUPPLIES	\$ -		\$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$ 3,227		\$ -
STRIKE COSTS NON REIMBURSABLE	\$ -		\$ -
COVID NON REIMBURSABLE	\$ -		\$ -
Total Other Resident Care	\$ 115,836	\$ -	\$ -

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

Name of Facility SecureCare Options, LLC				License No. 2389	Report for Year Ended 9/30/2022			Page of 21 37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***			
		Yes	No			CCNH	RHNS	Other	Pg
									Line
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Housekeeping Services	293,471			20 4b
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Laundry Services	280,229			19 3b
Eagle Elevator		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Elevator Contract	622			22 6F
Plummer All Season Landscaping LLC		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Landscaping	15,349			22 6F
Plummer All Season Landscaping LLC		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Snow Removal	11,243			22 6F
All Waste Inc		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Trash removal	27,323			22 6F
Facility Complaince		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Plant Contract Services	66,898			22 6F
American HealthTech	P.O. Box 9001006, Louisville, KY 40290	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Software Maintenance Contract	12,315			16 M11
Automatic Data Processing		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Payroll Services	43,456			16 M11
National Datacare Corp		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Resident Trust Software	4,036			16 M11
Prime Care Technologuy services		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Computer Consulting Services	52,301			16 M11
Priortiry Express		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Courier Services	1,967			16 M11
Us Security Associate		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Security Contract Servie	222,551			22 6F
Health Services Group		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Dieraty/Raw Food	1,364,002			18 a1,b

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

** Refer to Page 4 for definition of related.

*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022			Page 22 37
Item	Total	CCNH	RHNS	Other	
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 29,081	29,081			
b. Heat	\$ 45,751	45,751			
c. Light & Power	\$ 82,271	82,271			
d. Water	\$ 57,568	57,568			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 11,949	11,949			
f. Other (<i>itemize</i>)	\$ 396,277	396,277			
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 622,897	622,897			
7. Depreciation (<i>complete schedule page 23*</i>)					
a. Land Improvements	\$				
b. Building & Building Improvements	\$				
c. Non-Movable Equipment	\$				
d. Movable Equipment	\$ 59,254	59,254			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 59,254	59,254			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)					
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$ 76,646	76,646			
d. Other (<i>Specify</i>)	\$				
*8e. Total Amortization Costs (8a + b + c + d)	\$ 76,646	76,646			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 454,417	454,417			
10. Property Taxes					
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$ 95,774	95,774			
c. Personal property taxes	\$ 13,170	13,170			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 699,260	699,260			

* 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	\$ 16,674		\$ -
PLANT CONTRACT SERVICE LABOR	\$ -		\$ -
ELEVATOR CONTRACT SERVICE	\$ 622		\$ -
FIRE/SPRINKLER CONTRACT SERVICE	\$ 4,220		\$ -
LANDSCAPING CONTRACT SERVICE	\$ 15,349		\$ -
SNOW REMOVAL CONTRACT SERVICE	\$ 11,243		\$ -
TRASH REMOVAL CONTRACT SERVICE	\$ 27,323		\$ -
PLANT (POOL) CONTRACT SERVICES OTHER	\$ 66,898		\$ -
SECURITY CONTRACT SERVICE	\$ 222,551		\$ -
PLANT CONTRACT SERVICE OTHER	\$ 8,001		\$ -
PLANT MINOR EQUIPMENT	\$ 14,303		\$ -
RENT AUTO	\$ -		\$ -
RENT EQUIPMENT	\$ 9,092		\$ -
RENT OTHER	\$ -		\$ -
Total Other Repairs and Maintenance	\$ 396,277	\$ -	\$ -

Depreciation Schedule

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

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

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

Amortization Schedule*

Name of Facility SecureCare Options, LLC			License No. 2389		Report for Year Ended 9/30/2022			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1. Start Up Costs				864,740	864,740				
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period				999,327	527,472			76,475	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				8,596				170	
C-4. Subtotal									76,646
D. Total Amortization									76,646

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022	Page 25	of 37																				
11. Property Questionnaire																								
Part A																								
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.																				
<small>*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.</small>																								
<table border="1"> <thead> <tr> <th>Description</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>1. Date Land Purchased</td> <td></td> </tr> <tr> <td>2. Date Structure Completed</td> <td>11/13/12</td> </tr> <tr> <td>3. If NOT Original Owner, Date of Purchase</td> <td>11/13/12</td> </tr> <tr> <td>4. Date of Initial Licensure</td> <td></td> </tr> <tr> <td>5. Total Licensed Bed Capacity</td> <td>95</td> </tr> <tr> <td>6. Square Footage</td> <td>43,827</td> </tr> <tr> <td>7. Acquisition Cost</td> <td></td> </tr> <tr> <td> a. Land</td> <td></td> </tr> <tr> <td> b. Building</td> <td></td> </tr> </tbody> </table>		Description	Total	1. Date Land Purchased		2. Date Structure Completed	11/13/12	3. If NOT Original Owner, Date of Purchase	11/13/12	4. Date of Initial Licensure		5. Total Licensed Bed Capacity	95	6. Square Footage	43,827	7. Acquisition Cost		a. Land		b. Building				
Description	Total																							
1. Date Land Purchased																								
2. Date Structure Completed	11/13/12																							
3. If NOT Original Owner, Date of Purchase	11/13/12																							
4. Date of Initial Licensure																								
5. Total Licensed Bed Capacity	95																							
6. Square Footage	43,827																							
7. Acquisition Cost																								
a. Land																								
b. Building																								
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage																			
1. Financing a. Type of Financing (e.g., fixed, variable)		Fixed HUD																						
b. Date Mortgage Obtained		09/27/13																						
c. Interest Rate for the Cost Year		5.00%																						
d. Term of Mortgage (number of years)		10																						
e. Amount of Principal Borrowed		2,560,000																						
f. Principal balance outstanding as of _____		2,240,423																						
Complete if Mortgage was Refinanced During Current Cost Year																								
g. Type of Financing (e.g., fixed, variable)																								
h. Date of Refinancing																								
i. New Interest Rate																								
j. Term of Mortgage (number of years)																								
k. Amount of Principal Borrowed																								
l. Principal Outstanding on Note Paid-Off																								
Part C - Arms-Length Leases for Real Property Improvements Only																								
Name and Address of Lessor		Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease																			

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

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

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page of 26 37
Item		Total	CCNH	RHNS	Other
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
2. Second Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
3. Third Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
B. CHEFA Loan Information					
1. Original Loan Amount	\$				
2. Loan Origination Date					
3. Interest Rate %					
4. Term					
5. CHEFA Interest Expense					
12 B7. Total Building Interest Expense (A1 - A4 + B5)	\$				

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page 27	of 37
Item			Total	CCNH	RHNS	Other
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment			\$			
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)			\$			
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)			\$			
12. D. Other Interest Expense (Specify)			\$	(3)	(3)	
INTEREST						
13. Total All Interest Expense (12B7 + 12C3 + 12D)			\$	(3)	(3)	
14. Insurance						
a. Insurance on Property (buildings only)	\$	9,694	9,694			
b. Insurance on Automobiles	\$					
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)	\$	99,892	99,892			
2. Fire and Extended Coverage	\$					
3. Other (Specify)	\$	10,494	10,494			
Other insurance, crime						
14d. Total Insurance Expenditures (14a + b + c)			\$	120,081	120,081	
15. Total All Expenditures (A-13 thru C-14)			\$	13,656,759	13,656,759	

D. Adjustments to Statement of Expenditures

Name of Facility SecureCare Options, LLC			License No. 2389	Report for Year Ended 9/30/2022		Page 28	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
<i>Page 10 - Salaries and Wages</i>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
<i>Page 13 - Professional Fees</i>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<i>Pages 15 & 16 - Administrative and General</i>							
8.			Discriminatory Benefits	\$			
9.	15	C	Bad Debts	\$ (2)	(2)	(2)	
10.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m3	Unallowable Advertising *	\$ 5,505	5,505	5,505	
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m10	Fund Raising / Contributions	\$ 250	250	250	
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 7,386	7,386	7,386	
<i>Page 18 - Dietary Expenditures</i>							
24.			Meals to employees, guests and others who are not residents	\$			
<i>Page 19 - Laundry Expenditures</i>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<i>Page 20 - Housekeeping Expenditures</i>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$ 13,139	\$ 13,139			

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
16	1m13	PENALTIES	\$ 6,747	\$ -	\$ -
16	1m13	LATE FEES	\$ 639	\$ -	\$ -
		PRIOR PERIOD EXPENSES			
		rounding			
Total Other A&G Adjustments			\$ 7,386	\$ -	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility

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

Name of Facility SecureCare Options, LLC				License No. 2389	Report for Year Ended 9/30/2022		Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other	
Subtotals Brought Forward				\$ 13,139	13,139			
Page 20 - Resident Care Supplies***								
27.	20	5a	Prescription Drugs	\$				
28.	20	5d	Ambulance/Limousine	\$				
29.	20	5f	X-rays, etc	\$ 6,369	6,369			
30.	20	5h	Laboratory	\$ 22,287	22,287			
31.			Medical Supplies	\$				
32.			Oxygen (non emergency)	\$				
33.			Occupational Therapy	\$				
34.			Other - See Attached Schedule	\$ 17,836	17,836			
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$				
36.			Depreciation on Unallowable Motor Vehicles	\$				
37.			Unallowable Property and Real Estate Taxes	\$				
38.			Rental of Building Space or Rooms	\$				
39.			Other - See Attached Schedule	\$				
Page 27 - Insurance								
40.			Mortgage Insurance	\$				
41.			Property Insurance	\$				
Other - Miscellaneous								
42.			Other - Indirect	\$				
43.			Interest Income on Account Rec.	\$				
44.			Other - Miscellaneous Administrative	\$				
45.			Management Fees Direct	\$				
46.			Management Fees Indirect	\$				
47.			Other - Direct	\$				
Not For Profit Providers Only								
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$				
49. Total Amount of Decrease (Items 1 - 48)				\$ 59,631	59,631			

*** 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	Non Covered PPS Visits	17,836.28		-
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	-		
13	B9A	ST- Resident Care (for outpatient therapy - see schedule)	-		
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)	-		
Total Other Ancillary Costs			\$ 17,836	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Excess Movable Equipment Depreciation			\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

Attachment Page 29

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

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Unallowable Building Interest			\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page 30 37	
		Item	Total	CCNH	RHNS	Other
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$	13,262,707	13,262,707			
b. Medicaid Room and Board Contractual Allowance **	\$					
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$	412,117	412,117			
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$					
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$	22,117	22,117			
b. Prescription Drugs - Medicare Contractual Allowance **	\$	(22,117)	(22,117)			
c. Prescription Drugs - Non-Medicare	\$	16,006	16,006			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$	(16,006)	(16,006)			
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$	40,212	40,212			
b. Physical Therapy - Medicare Contractual Allowance **	\$	(11,057)	(11,057)			
c. Physical Therapy - Non-Medicare	\$	80,710	80,710			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$	(80,710)	(80,710)			
4. a. Speech Therapy - Medicare	\$	20,262	20,262			
b. Speech Therapy - Medicare Contractual Allowance **	\$	(9,585)	(9,585)			
c. Speech Therapy - Non-Medicare	\$	18,322	18,322			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$	(18,322)	(18,322)			
5. a. Occupational Therapy - Medicare	\$	30,524	30,524			
b. Occupational Therapy - Medicare Contractual Allowance **	\$	(9,625)	(9,625)			
c. Occupational Therapy - Non-Medicare	\$	65,857	65,857			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$	(65,857)	(65,857)			
6. a. Other (<i>Specify</i>) - Medicare	\$	(57,753)	(57,753)			
b. Other (<i>Specify</i>) - Non-Medicare	\$	88,510	88,510			
III. Total Resident Revenue (Section I. thru Section II.)	\$	13,766,313	13,766,313			
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$	28,253	28,253			
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$	(115,488)	(115,488)			
V. Total Other Revenue (1 thru 8)	\$	(87,234)	(87,234)			
VI. Total All Revenue (III +V)	\$	13,679,078	13,679,078			

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	Other
30	Lab Medicare	\$ 4,487		
30	Lab Medicare CA	\$ (4,487)		
30	Oxygen Medicare	\$ -		
30	Oxygen Medicare CA	\$ -		
30	Equipment rental	\$ -		
30	Equipment rental CA	\$ -		
30	Pen Therapy	\$ -		
30	Pen Therapy CA	\$ -		
30	Therapy Beds Medicare	\$ -		
30	Therapy Beds Medicare CA	\$ -		
30	Radiology Medicare	\$ 799		
30	Radiology Medicare CA	\$ (799)		
30	IV Therapy	\$ 4,141		
30	IV Therapy CA	\$ (4,141)		
30	Medical Transportation	\$ -		
30	Medical Transportation CA	\$ -		
30	Glucose testing	\$ -		
30	Glucose testing CA	\$ -		
30	Outpatient therapy Medicare	\$ -		
30	MEDICAID COVID REVENUE	\$ -		
30	CRF MEDICAID REVENUE	\$ 110,298		
30	MEDICAID WAGE & ENHANCEMENT RESERVE	\$ (168,051)		
Total Other Resident Revenue - Medicare		\$ (57,753)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Other
30	Lab	939		
30	Lab CA	(939)		
30	Oxygen	\$ 7,451	\$ -	
30	Oxygen CA	\$ (7,451)	\$ -	
30	Equipment rental	\$ -		
30	Equipment rental CA	\$ -		
30	Pen Therapy	\$ -		
30	Pen Therapy CA	\$ -		
30	Therapy Beds	\$ -		
30	Therapy Beds CA	\$ -		
30	Radiology	\$ 258		
30	Radiology CA	\$ (258)		
30	Medical Transportation	\$ -		
30	Medical Transportation CA	\$ -		
30	Glucose Testing	\$ -		
30	Glucose Testing CA	\$ -		
30	IV therapy	\$ 3,297	\$ -	
30	IV therapy CA	\$ (3,297)	\$ -	
30	Flu shot revenue	\$ 1,835		
30	Outpatient therapy	\$ -		
30	prior period revenue	\$ (23,025)		
30	Optum B	\$ 230,101		
30	Optum B CA	\$ (120,401)		
30	C/A VBP	\$ -		
Total Other Resident Revenue		\$ 88,510	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	Other
30	INTEREST INCOME	\$ 28,253			

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Other
30	MEALS	-		
30	TELEVISION INCOME	-		
30	OTHER INCOME: DMHAS OPERATING REVENUE	-		
30	OTHER INCOME: DMHAS ORGANIZATIONAL REV	80,405.28		
30	OTHER INCOME: DEFERRED REVENUE	-		
30	MEDICARE COVID STIMULUS REVENUE	-		
30	CONCESSIONS / VENDING INCOME	-		
30	RESIDENT LATE FEE REVENUE	-		
30	RESIDENT ATTORNEY FEE REVENUE	-		
30	TELEPHONE INCOME	-		
30	OTHER INCOME	-		
30	OPTUM DIVIDENDS REVENUE	14,715.00		
30	OPTUM OUTLIERS	-		
30	HHS GENERAL FUND REVENUE	-		
30	HHS INFECTION CONTROL REVENUE	(383,135.46)		
30	CARES ACT REVENUE	-		
30	EMPLOYEE TESTING REVENUE	-		
30	COVID ECHO TRAINING REVENUE	-		
30	DMHAS	172,527.68		
Total Other Revenue		(115,487.50)	\$ -	\$ -

G. Balance Sheet

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022	Page 31 37	of
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	4,279,846
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	593,986
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	8,896
5. Prepaid Expenses			\$	119,023
a. Prepaid Insurance	89,554			
b. Prepaid Property Taxes	27,255			
c. Prepaid Expenses Other	2,213			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	(2,333,147)
Due From (to) Related Parties	78,466			
Other Owners reserves	(2,411,612)			
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	2,668,605
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost		\$	
	Accum. Depreciation	_____	Net	
3. Buildings	*Historical Cost		\$	
	Accum. Depreciation	_____	Net	
4. Leasehold Improvements	*Historical Cost	1,007,923	\$	403,806
	Accum. Depreciation	604,117	Net	
5. Non-Movable Equipment	*Historical Cost		\$	
	Accum. Depreciation	_____	Net	
6. Movable Equipment	*Historical Cost	902,250	\$	211,046
	Accum. Depreciation	691,205	Net	
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation	_____	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	18,450
Construction in Progress	18,450			
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	633,302

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref Line Ref Description

Total Prepaid Expenses		\$ -

Schedule of Other Current Assets (itemized) Page 31 Line A8

Page Ref Line Ref Description

Total Other Current Assets (Itemize)		\$ -

Schedule of Other Fixed Assets (Itemize) Page 31 Line B9

Page Ref Line Ref Description

Total Other Other Fixed Assets (Itemize)		\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref Line Ref Description

Total Other Assets		\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref Line Ref Description

Total Notes Payable		\$ -

Schedule of Other Current Liabilities (Itemize) Page 33 Line A12

Page Ref Line Ref Description

Total Other Current Liabilities (Itemize)		\$ -

Schedule of Other Long-Term Liabilities (Itemize) Page 34 Line B4

Page Ref Line Ref Description

Total Other Current Liabilities (Itemize)		\$ -

G. Balance Sheet (cont'd)

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022	Page 32	of 37
Account		Amount		
		Total Brought Forward:		\$ 3,301,906
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements	*Historical Cost Accum. Depreciation	Net	\$	
3. Buildings	*Historical Cost Accum. Depreciation	Net	\$	
4. Non-Movable Equipment	*Historical Cost Accum. Depreciation	Net	\$	
5. Movable Equipment	*Historical Cost Accum. Depreciation	Net	\$	
6. Motor Vehicles	*Historical Cost Accum. Depreciation	Net	\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense	*Historical Cost Accum. Depreciation	864,740 864,740 Net	\$	(0)
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	94,553
Patient Trust Funds		86,853		
Long Term Deposit - primecare		7,700		
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	
See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	94,553
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	3,396,459

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2022	33	37
Account		Amount		
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable			\$	446,086
2. Notes Payable (<i>itemize</i>) Working Capital Line of Credit			\$	
See Schedule				
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)			\$	
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)			\$	226,034
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$	
6. Accrued Payroll Taxes Payable			\$	
7. Medicare Final Settlement Payable			\$	
8. Medicare Current Financing Payable			\$	
9. Mortgage Payable (<i>Current Portion</i>)			\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)			\$	
11. Accrued Income Taxes*			\$	
12. Other Current Liabilities (<i>itemize</i>)			\$	850,201
Related Party Payables				
Accrued Expenses			681,137	
Accrued Resident User Fees			169,064	
Accrued Workers Comp Expense			See Schedule	
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	1,522,320

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022	Page 34	of 37
Account			Amount	
Total Brought Forward:			1,522,320	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)			\$	
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable			\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)			\$ 86,853	
Patient Trust Funds			86,853	
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$ 86,853	
C. Total All Liabilities (Lines A-13 + B-5)			\$ 1,609,173	

G. Balance Sheet (cont'd)

Reserves and Net Worth

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022	Page 35	of 37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	5,000
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	1,759,966
6. Gain or Loss for Period	10/1/2021	thru	9/30/2022	\$ 22,320
7. Total Net Worth			\$	1,787,286
C. Total Reserves and Net Worth			\$	1,787,286
D. Total Liabilities, Reserves, and Net Worth			\$	3,396,459

H. Changes in Total Net Worth

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2021			\$	1,921,156
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	13,679,078
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	13,656,759
D. Net Income or Deficit			\$	22,320
E. Balance			\$	1,943,476
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	
Name and Address (No., City, State, Zip)		Title	Amount	
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose			Amount	
3. Total Deductions			\$	
H. Balance at End of Period		09/30/22	\$	1,943,476

I. Preparer's/Reviewer's Certification

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2022	Page 37	of 37
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Check appropriate category

<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> Other
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Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed
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Printed Name of Preparer

Jon Lanczak

Address Address	Phone Number
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3000 Town Center Suite 400, Southfield, MI 48034	248-223-3569
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Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
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Jon Lanczak	248-223-3569
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Contact Email Address

Jon.Lanczak@plantemoran.com
