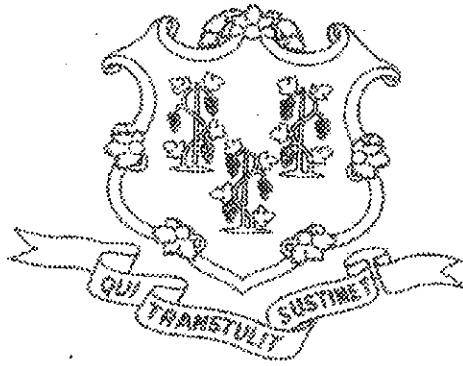


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2019

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 type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019

License Numbers:	CCNH 2389	RHNS	(Specify)	Medicare Provider 07-5264
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Medicaid Provider Numbers:	CCNH	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 9/30/2019	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, 2018 and ending September 30, 2019, 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) Jessica Dering			Printed Name (Owner)		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
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 10/1/2018	To 9/30/2019
Address of Facility 60 West Street Rocky Hill CT				
Report Prepared By PKF O'Connor Davies, LLP		Phone Number 860-257-1875	Date 2/10/2020	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid \$				
2. Laundry wages paid \$				
3. Housekeeping wages paid \$				
4. Nursing wages paid \$				
5. All other wages paid \$				
6. Total Wages Paid \$				
7. Total salaries paid \$				
8. Total Wages and Salaries Paid (As per page 10 of Report) \$				

Wages - Compensation computed on an hourly wage rate.

Salaries - Compensation computed on a weekly or other basis which does not generally vary, based on the number of hours worked.

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-243-9591		Report for Year Ended 9/30/2019	Page 2	of 37
Name of Facility (as shown on license) SecureCare Options, LLC		Address (No. & Street, City, State, Zip) 60 West Street Rocky Hill CT		
License Numbers:	CCNH 2389	RHNS (Specify)	Medicare Provider No. 07-5264	
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
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		License No.:		

General Information and Questionnaire
Partners/Members

Name of Facility SecureCare Options, LLC		License No. 2389	Report for Year Ended 9/30/2019	Page 3	of 37
Legal Name of Partnership/LLC SecureCare Options, LLC		Business Address 60 West Street Rocky Hill		State(s) and/or Town(s) in Which Registered 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 802211	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 9/30/2019	Page 3A	of 37
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If this facility is owned or operated as a corporation, provide the following information:

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

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each

Names of Stockholders Owning at Least 10% of Shares			

State of Connecticut
 Annual Report of Long-Term Care Facility
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Related Parties*

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 %**				
Secure Care Center, LLC							
Bidwell Care Center, LLC	335 Bidwell St. Manchester, CT 06040			Shared Employees		(13,924)	13,924
Chelsea Place Care Center, LLC	25 Lorraine St. Hartford, CT 06105			Shared Employees		(19,160)	19,160
Chestnut Point Care Center, LLC	171 Main St. East Windsor, CT 06088			Shared Employees		(11,207)	11,207
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032			Shared Employees		(14,132)	14,132
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088			Shared Employees		(4,275)	4,275
Meriden Care Center, LLC (Silver Springs)	33 Roy St. Meriden, CT 06450			Shared Employees		(2,879)	2,879
Trinity Hill Care Center, LLC	151 Hillside Ave. Hartford, CT 06106			Shared Employees		(30,419)	30,419
Westside Care Center, LLC	349 Bidwell St. Manchester, CT 06040			Shared Employees		(10,440)	10,440
Wintonbury Care Center, LLC	140 Park Ave. Bloomfield, CT 06002			Shared Employees		(2,854)	2,854
Secure Care Center, LLC	60 West Street, Rocky Hill, CT 06067			Shared Employees		-	-
Universal Healthcare Holdings, LLC	5 Greenwood Street, Hartford, CT 06106			Shared Employees		(23,006)	23,006
Touchpoints at Homecare, LLC	1838 Silas Deane Hwy, Rocky Hill, CT 06067			Shared Employees		-	-
Elevate Counseling Services, LLC	341 Bidwell St. Manchester, CT 06040			Shared Employees		-	-
Touchpoints Therapy, LLC	341 Bidwell St. Manchester, CT 06040			OT/PT/ST Building Lease & Rent	13 5,8,10 22,27,27,10,9,14	179,285 351,645	(179,285) (351,645)
iCare Management, LLC	341 Bidwell St. Manchester, CT 06040			iCare Health-Legal, Postage, Emp. Recruitment & Marketing	16, 15 MLE	19,824	(19,824)
iCare Health Management, LLC	341 Bidwell St. Manchester, CT 06040			Shared EEs not part of mgmt. agmt Management Services, Direct Management Services, Indirect Management Services, Administrative	20, 5 20, 5 16 M12	163,746 166,286 23,308 294,887	(163,746) (166,286) (23,308) (294,887)
All Care Centers, mgmt. co., realty.ccs				Share Common 401k, Pension and Insurance plans, courier, legal and various other services			

* Use additional sheets if necessary.

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

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2019	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 (See listing page 13)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

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

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

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 SecureCare Options, LLC		License No. 2389	Report for Year Ended 9/30/2019		Page 6	of 37	
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
ADP, Inc., One ADP Drive MS-100, Augusta, GA 30909 Banker Leasing	<input type="radio"/>	<input checked="" type="radio"/>	Time Clocks and Payroll Punch Equip	07/01/13	60 months & automatic	2,641	2,641
	<input type="radio"/>	<input checked="" type="radio"/>	Copier	04/01/14	Month to Month	3,815	3,815
GE Capital C/O Ricoh USA, P.O.Box 41564, Philadelphia, PA 19101	<input type="radio"/>	<input checked="" type="radio"/>	Copier	05/01/13	36 months & automatic	4,235	4,235
Mail Finance/Neopost New England, 25881 Newtwork Place, Chicago, IL 60673	<input type="radio"/>	<input checked="" type="radio"/>	Postage Meter Rental	07/01/13	36 months & automatic	969	969
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
						Total ****	11,660

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

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

** Attach copies of newly acquired leases.

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

General Information and Questionnaire
Accounting Basis

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2019	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 2 PKF O'Connor, Davies LLP 3 4	Address (No. & Street, City, State, Zip Code) 100 Great Meadow Rd. Wethersfield CT
---	---

Services Provided by This Firm (<i>describe fully</i>)	
1	\$
2 Taxes, financial statements, accounting support	\$ 10,994
3	\$
4	\$
	Charge for Services Provided
	\$ 10,994

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 1 iCare Health Management, LLC 2 #REF! 3 #REF! 4 American Arbitration, Kainen, Escalera, McKale 5 State Marshall and Treasurer State of CT	Telephone Number 860-570-2140
---	----------------------------------

Address (<i>No. & Street, City, State, Zip Code</i>) 1 341 Bidwell St. Manchester CT 2 3 4 5
--

Services Provided by This Firm (<i>describe fully</i>)	
1 Lease and contract issues, general legal advice, labor law	\$ 17,410
2	\$
3	\$
4 Employment Arbitrations (\$650), General Consultation (\$114)	\$ 764
5 Conservatorships (see pg 28)	\$ 293
	Charge for Services Provided
	\$ 18,467

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No 15e

Schedule of Resident Statistics

Name of Facility SecureCare Options, LLC	License No. 2389		Report for Year Ended 9/30/2019						Page	of
			Period 10/1 Thru 6/30		Period 7/1 Thru 9/30		8	37		
			Total CCNH Level	Total RHNS Level	Total CCNH Level	Total RHNS Level	Total	Total	CCNH	RHNS
1. Certified Bed Capacity										
A. On last day of PREVIOUS report period	95	95	95	95	95	95	95	95		
B. On last day of THIS report period	95	95	95	95	95	95	95	95		
2. Number of Residents										
A. As of midnight of PREVIOUS report period	87	87	87	87	87	87	87	93		
B. As of midnight of THIS report period	90	90	90	90	90	90	90	90		
3. Total Number of Days Care Provided During Period										
A. Medicare	790	790	790	790	689	689	101	101		
B. Medicaid (Conn.)	30,977	30,977	30,977	30,977	22,822	22,822	8,155	8,155		
C. Medicaid (other states)										
D. Private Pay	210	210	210	210	210	210				
E. State SSI for RCH										
F. Other (Specify)	730	730	730	730	546	546	184	184		
G. Total Care Days During Period (3A thru F)	32,707	32,707	32,707	32,707	24,267	24,267	8,440	8,440		
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										
Total Resident Days (3G + 4A + 4B)	32,707	32,707	32,707	32,707	24,267	24,267	8,440	8,440		

Schedule of Resident Statistics (Cont'd)

Name of Facility SecureCare Options, LLC			License No. 2389			Report for Year Ended 9/30/2019			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(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.													
Change in Resident Days								CCNH	RHNS	(Specify)			
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	1	89											
Per Diem Rate													
a. One bed rm.			400.00		607.00								
b. Two bed rms.													
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								1,495	1,495				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								940	940				
2. Restorative Treatments								547	547				
C. Other								2,133	2,133				
D. Total Physical Therapy Treatments								5,115	5,115				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								378	378				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								88	88				
2. Restorative Treatments								153	153				
C. Other								309	309				
D. Total Speech Therapy Treatments								928	928				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								1,125	1,125				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								847	847				
2. Restorative Treatments								320	320				
C. Other								1,657	1,657				
D. Total Occupational Therapy Treatments								3,949	3,949				

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
SecureCare Options, LLC	2389	9/30/2019	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	159,986	2,086				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	60,561	2,046				
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						
b. Other Maintenance Workers	89,414	2,384				
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	278,406	4,354				
b. RN						
1. Direct Care	591,519	13,280				
2. Administrative**	568,974	13,950				
c. LPN						
1. Direct Care	1,039,051	32,871				
2. Administrative**						
d. Aides and Attendants	2,111,990	107,545				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	244,701	9,032				
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	448,331	14,687				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	150,208	6,776				
<i>A-13. Total Salary Expenditures</i>	5,743,141	209,011				

* 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		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Unit Secretary	\$ 6,027	402				
Central Supply	\$ 61,367	2,086				
Plant Security Salaries	\$ 82,814	4,288				
Total	\$ 150,208	6,776	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Medical Records	\$ (4,617)	(306)				
Admissions Contracted Serv	\$ 31,741	665				
Central Supply Contracted Serv.	\$ (30,971)	(899)				
Respiratory Therapy	\$ 1,313					
Nursing Contracted Service IC	\$ (70,763)	(1,710)				
Total	\$ (73,297)	(2,250)	\$ -	-	\$ -	-

**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 9/30/2019		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 (Specify)							
Section I - Operators/Owners									
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).									

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

** Include all employment worked during the cost year.

**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		9/30/2019			12	37
Name	Salary Paid		Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS (Specify)						
Section III - Administrators***								
Jessica Derring	159,986			2,086	A2			
Section IV - Assistant Administrators								

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

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

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

Annual Report of Long-Term Care Facility

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
SecureCare Options, LLC	2389	9/30/2019	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist	16,689	222				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	70,181	1,344				
b. Other						
6. Social Worker	29,190	428				
7. Recreation Worker	21,919	35				
8. Physicians						
a. Medical Director (entire facility)	69,700	245				
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	26,476	104				
9. Speech Therapist						
a. Resident Care	24,321	466				
b. Other						
10. Occupational Therapist						
a. Resident Care	25,838	495				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	33,980	410				
2. Administrative***						
b. LPN						
1. Direct Care	39,077	847				
2. Administrative***						
c. Aides	243	10				
d. Other						
12. Other (Specify) See Attached Schedule	(73,297)	(2,250)				
B-13 Total Fees Paid in Lieu of Salaries	284,317	2,356				

* 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*

Name of Facility SecureCare Options, LLC		License No. 2389		Report for Year Ended 9/30/2019	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Pharm Scripts	Pharmacy Consulting	<input type="radio"/>	<input checked="" type="radio"/>			
Tocuhpoints Therapy	Therapy	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Shared Employees	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Healthdrive Physician Services	Audiology, Dental and Podiatry	<input type="radio"/>	<input checked="" type="radio"/>			
Ready Nurse, Nurse Network	Nursing pool (RN, LPN,CNA)	<input type="radio"/>	<input checked="" type="radio"/>			
Starling Physicians	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
Various patient entertainment activities	Recreation	<input type="radio"/>	<input checked="" type="radio"/>			
Ressinger Resources Grroup	Social Services	<input type="radio"/>	<input checked="" type="radio"/>			
CT Rehabilitation Spasticity Care	Physician services	<input type="radio"/>	<input checked="" type="radio"/>			
Procare	Respiratory therapy	<input type="radio"/>	<input checked="" type="radio"/>			
Admissions	Icare	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			

* 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 9/30/2019	Page 15	of 37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 158,018	158,018		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$			
4. Social Security (F.I.C.A.)	\$ 499,426	499,426		
5. Health Insurance	\$ 751,303	751,303		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 176,375	176,375		
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$ 20,867	20,867		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 72	72		
d. Accounting and Auditing	\$ 10,994	10,994		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 18,467	18,467		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 48,468	48,468		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 37,171	37,171		
2. Cellular Phones	\$ 3,010	3,010		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 250	250		
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	\$ 687,501	687,501		
Subtotal	\$ 2,411,922	2,411,922		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Union Training	\$ 20,867		
Total	\$ 20,867	\$ -	\$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Total	\$ -	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of	
SecureCare Options, LLC	2389	9/30/2019	16	37	
Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,411,922	2,411,922		
I. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	895	895		
3. Gifts to Staff and Residents	\$	1,109	1,109		
4. Employee Travel	\$	10,610	10,610		
5. Education Expenses Related to Seminars and Conventions	\$	7,643	7,643		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>)	\$	469	469		
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	24,871	24,871		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)***	\$	5,051	5,051		
See Attached Schedule					
4. Fund-Raising***	\$				
5. Medical Records	\$	740	740		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$	2,086	2,086		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>)	\$	6,483	6,483		
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions***	\$	210	210		
See Attached Schedule					
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	137,780	137,780		
12. Administrative Management Services**	\$	294,887	294,887		
13. Other (<i>Specify</i>)	\$	133,196	133,196		
See Attached Schedule					
C-14 Total Administrative & General Expenditures		\$ 3,037,952	3,037,952		

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

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Meals	\$ 469		
Total Other Travel and Entertainment	\$ 469	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Communications Special Events	\$ 5,051		
Total Other Advertising	\$ 5,051	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF Dues	\$ 6,323		
Other Dues	\$ 160		
Total Dues	\$ 6,483	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Contributions	\$ 210		
Total Contributions	\$ 210	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Employee Relations	\$ 3,874		
Employee Relations	\$ 774		
Permits and Licenses	\$ 1,750		
Bank Fees	\$ 304		
Late Fees (see pg 28a)	\$ 29		
Insurance Deductable/Claims	\$ 7		
Admin Intercompany	\$ 37,204		
Administrative Contracted Service Labor	\$ 89,254		
Total Other Administrative and General	\$ 133,196	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
SecureCare Options, LLC	2389	9/30/2019	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	294,887	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	166,286	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	23,308	MANAGEMENT FEES- INDIRECT CARE	Pg 20 j

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

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 9/30/2019	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 19,349	19,349		
2.	Non-Food Supplies	\$			
3.	Other (Specify) _____ Supplies, Minor equipm Maint.	\$ 18,636	18,636		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$ 1,272,720	1,272,720		
c. Other (Specify) _____		\$			
2D. Total Dietary Expenditures (2a + b + c + d)		\$ 1,310,705	1,310,705		
2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F.	Resident Meals: Total no. of meals served per day:*				
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 at monthly staff meetings, board meetings) provided to employees included in 2D?	<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 9/30/2019	Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*		Lbs.			
1.	Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	973	973	
2.	Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.			
		Amt. \$			
3.	Personal clothing of residents washed, ironed, and/or processed.***	Lbs.			
		Amt. \$			
4.	Repair and/or purchase of linens.***	Lbs.			
		Amt. \$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	267,246	267,246	
c. Other (Specify) Supplies		\$	6,299	6,299	
3D. Total Laundry Expenditures (3a + b + c)		\$	274,518	274,518	
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		License No.	Report for Year Ended		Page	of
SecureCare Options, LLC		2389	9/30/2019		20	37
Item		Total	CCNH	RHNS	(Specify)	
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
1.	Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	28,955	28,955		
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. \$	237,305	237,305		
C.	Other (<i>Specify</i>)	\$				
4D.	Total Housekeeping Expenditures (4a + b + c)	\$	266,260	266,260		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from	\$	90,490	90,490		
b.	Medicine Cabinet Drugs	\$	9,282	9,282		
c.	Medical and Therapeutic Supplies	\$	120,241	120,241		
d.	Ambulance/Limousine***	\$				
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	4,461	4,461		
f.	X-rays and Related Radiological Procedures***	\$	2,397	2,397		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	9,578	9,578		
i.	Recreation	\$	8,463	8,463		
j.	Direct Management Services*	\$	166,286	166,286		
k.	Indirect Management Services*	\$	23,308	23,308		
l.	Other (Specify)**** See Attached Schedule	\$	91,999	91,999		
5M.	Total Resident Care Expenditures (5a - 5j)	\$	526,505	526,505		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Nursing Admin Supplies	\$ 678		
Nursing Minor Equipment	\$ 16,121		
Central Supplies	\$ 6,488		
Non Covered Doc	\$ 11,256		
Med Supplies Billable	\$ 8,584		
Vaccines Residents	\$ 253	\$ -	
Patient Special Needs	\$ 4,914		
IV Supplies	\$ 1,505		
Pen Therapy Supplies	\$ 7,405		
Medical Courier Service for Special Prescriptions	\$ 2,828		
Equip Rental	\$ 24,200		
Cable TV	\$ 7,767		
Total Other Resident Care	\$ 91,999	\$ -	\$ -

**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 9/30/2019	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS (Specify)	Pg	Line
			Yes	No						
Health Services Group			<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Housekeeping Services	237,305		20	4b
Health Services Group/Unitex Textile Rental Services			<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Laundry Services	267,246		19	3b
Eagle Elevator			<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Elevator Contract	744		22	6F
Bioserve, Inc.			<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Medical Waste Snow	1,110		22	6F
Plummer All Season Landscaping			<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Removal/Landscaping	25,864		22	6F
All Waste Inc			<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Trash removal	17,159		22	6F
American HealthTech			<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Software Maintenance Contract	10,448		16	M11
Automatic Data Processing			<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Payroll Services	43,531		16	M11
National Datacare Corp			<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Resident Trust Software Computer Consulting Services	2,722		16	M11
Prime Care Technology services			<input type="radio"/>	<input checked="" type="radio"/>	VENDOR		51,871		16	M11
Priority Express			<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Courier Services	1,999		16	M11
Point Right Inc			<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Nursing Software Security Contract Services	183,818		16	M11
US Security Inc			<input type="radio"/>	<input checked="" type="radio"/>	VENDOR				22	6F
Health Services Group			<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Dietary/Raw Food	1,276,331		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 9/30/2019	Page 22	of 37
Item	Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant				
a. Repairs & Maintenance	\$ 64,808	64,808		
b. Heat	\$ 34,189	34,189		
c. Light & Power	\$ 80,114	80,114		
d. Water	\$ 56,782	56,782		
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 11,660	11,660		
f. Other (<i>itemize</i>)	\$ 270,892	270,892		
See Attached Schedule				
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 518,445	518,445		
7. Depreciation (<i>complete schedule page 23*</i>)				
a. Land Improvements	\$			
b. Building & Building Improvements	\$			
c. Non-Movable Equipment	\$			
d. Movable Equipment	\$ 112,326	112,326		
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 112,326	112,326		
8. Amortization (<i>Complete att. Schedule Page 24*</i>)				
a. Organization Expense	\$			
b. Mortgage Expense	\$			
c. Leasehold Improvements	\$ 84,061	84,061		
d. Other (<i>Specify</i>)	\$			
*8e. Total Amortization Costs (8a + b + c + d)	\$ 84,061	84,061		
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 351,645	351,645		
10. Property Taxes				
a. Real estate taxes paid by owner	\$			
b. Real estate taxes paid by lessor	\$ 185,849	185,849		
c. Personal property taxes	\$ 11,993	11,993		
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 745,874	745,874		

* Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 24.

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Elevator Service	\$ 744		
Fire Sprinkler	\$ 11,367		
Landscaping	\$ 13,964		
Medical Waste Removal	\$ 1,110		
Snow Removal	\$ 11,901		
Trash Removal	\$ 17,159		
Security Service	\$ 183,818		
Plant Contract	\$ 15,123		
Rent minor equipment	\$ 8,531		
	\$ 7,175		
Total Other Repairs and Maintenance	\$ 270,892	\$ -	\$ -

Depreciation Schedule

Name of Facility SecureCare Options, LLC		License No. 2389	Report for Year Ended 9/30/2019				Page 23	of 37
Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
Yes	No	Month	Year					
A. Land Improvements								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. Building and Building Improvements								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. Non-Movable Equipment								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								
D. Movable Equipment								
1. Motor Vehicles (Specify name, model and year of each vehicle)								
a.								
b.								
c.								
d.								
2. Movable Equipment								
a. Acquired prior to this report period								
b. Disposals (attach schedule)								
c. Acquired during this report period (attach schedule)								
D-3. Subtotal								
E. Total Depreciation								
							49,974	
							380,085	
							62,352	
							112,326	
							112,326	

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

Amortization Schedule*

Name of Facility		License No.		Report for Year Ended		Page		of	
SecureCare Options, LLC		2389		9/30/2019		24		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. Organization Expense - Start-up Cos			5	870,024	870,024				
2. Organization Expense - Start-up Cos			5	4,271	4,271				
3. Organization Expense - Start-up Cos				(9,555)	(9,555)				
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period				520,268	291,209			31,918	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal				397,857				52,143	
D. Total Amortization									
									84,061
									84,061

* 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 9/30/2019	Page 25	of 37
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11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?*

Yes

No

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

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

Description	Total				
1. Date Land Purchased					
2. Date Structure Completed					
3. If NOT Original Owner, Date of Purchase	11/13/12				
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	95				
6. Square Footage	60,838				
7. Acquisition Cost					
a. Land					
b. Building					
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)	Fixed HUD				
b. Date Mortgage Obtained	05/30/13				
c. Interest Rate for the Cost Year	3.25%				
d. Term of Mortgage (number of years)	24				
e. Amount of Principal Borrowed					
f. Principal balance outstanding as of					
Complete if Mortgage was Refinanced During Current Cost Year					
g. Type of Financing (e.g., fixed, variable)					
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
l. Principal Outstanding on Note Paid-Off					

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

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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 SecureCare Options, LLC		License No. 2389	Report for Year Ended 9/30/2019		Page 26	of 37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
SecureCare Options, LLC		2389		9/30/2019		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$			
12. D. Other Interest Expense (Specify)				\$			
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$			
14. Insurance							
a. Insurance on Property (buildings only)				\$ 17,772	17,772		
b. Insurance on Automobiles				\$ 65,061	65,061		
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$			
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$ 3,795	3,795		
Other Ins, Crime							
14d. Total Insurance Expenditures (14a + b + c)				\$ 86,628	86,628		
15. Total All Expenditures (A-13 thru C-14)				\$ 12,794,345	12,794,345		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
SecureCare Options, LLC			2389	9/30/2019	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 72	72		
10.			Accounting	\$			
10a.			Legal	\$ 293	293		
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 *	\$ 5,051	5,051		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 29	29		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 5,445	5,445		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16a		Late Fees	\$ 29		
Total Other A&G Adjustments			\$ 29	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
SecureCare Options, LLC			2389	9/30/2019	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 5,445	5,445		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$			
28.			Ambulance/Limousine	\$			
29.	20	5f	X-rays, etc	\$ 2,397	2,397		
30.	20	5h	Laboratory	\$ 9,578	9,578		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 11,255	11,255		
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)				\$ 28,675	28,675		

*** 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	(Specify)
		Pg 20 5j	\$ 11,255		
Total Other Ancillary Costs			\$ 11,255	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)

Total Other Adjustments			\$ -	\$ -	\$ -

Schedule of Other - Miscellaneous Administrative Adjustments

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

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

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
SecureCare Options, LLC	2389	9/30/2019			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 12,945,835	12,945,835				
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>)	\$ 286,066	286,066				
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$ 1,209,008	1,209,008				
b. Private-Pay Room and Board Contractual Allowance **	\$ (1,456,812)	(1,456,812)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 26,160	26,160				
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$ 81,587	81,587				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
2. a. Medical Supplies - Medicare	\$ 24	24				
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$ 397	397				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$ 57,755	57,755				
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$ 57,838	57,838				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 23,974	23,974				
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$ 21,210	21,210				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 47,377	47,377				
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$ 47,770	47,770				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$ (81,599)	(81,599)				
b. Other (<i>Specify</i>) - Non-Medicare	\$ (134,373)	(134,373)				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 13,132,217	13,132,217				
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>)	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 148,607	148,607				
V. Total Other Revenue (1 thru 8)	\$ 148,607	148,607				
VI. Total All Revenue (III + V)	\$ 13,280,824	13,280,824				

* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.
 ** Facility should report all contractual allowances and/or payer discounts.

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Lab	\$ 4,403		
	Oxygen	\$ 52		
	Equipment	\$ 620		
	Radiology	\$ 2,285		
	IV Therapy	\$ 50		
	Contractual Allowance	\$ (89,009)		
Total Other Resident Revenue - Medicare		\$ (81,599)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Lab	\$ 2,879		
	Oxygen	\$ 775		
	Equipment	\$ 19,252		
	Radiology	\$ 446		
	IV Therapy	\$ 3,195		
	Optum	\$ 69,569		
	Med Trans	\$ 8,208		
	DHMAS Reve	\$ 7,597		
	CA Ancillary	\$ (204,814)		
	CA Optum	\$ (40,827)		
	CA VBP	\$ (653)		
Total Other Resident Revenue		\$ (134,373)	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Total Interest Income			\$ -	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Other Income	\$ 2,491		
	DMHAS Organization Revenue	\$ 146,406		
	Prior Yr Adjustment	\$ (290)		
Total Other Revenue		\$ 148,607	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
SecureCare Options, LLC	2389	9/30/2019	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (on hand and in banks)			\$	2,427,998
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,113,141
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	(49,214)
4. Inventories			\$	8,896
5. Prepaid Expenses			\$	179,902
a. Prepaid Taxes	44,906			
b. Prepaid Insurance	130,623			
c. Prepaid other	4,373			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (itemize)			\$	(3,034,509)
Due From (To) Related Parties	112,761			
Other Owners Reserves	(3,147,270)			
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	646,214
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 <u>918,125</u>		\$	542,855
	Accum. Depreciation <u>375,270</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>780,154</u>		\$	287,743
	Accum. Depreciation <u>492,411</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (itemize)			\$	64,705
Construction in Progress	64,705			
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	895,303

* 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 (Itemize) 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 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 Long-Term Liabilities (Itemize)			\$

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
SecureCare Options, LLC	2389	9/30/2019	32	37
Account			Amount	
Total Brought Forward:			\$	1,541,517
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	864,740		
	Accum. Depreciation	864,740	Net	\$
4. Goodwill (Purchased Only)				
\$				
5. Investments Related to Resident Care (<i>itemize</i>)				
Patient Trust Funds				40,269
\$ 40,269				
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)				
\$ 40,269				
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)				
\$ 1,581,786				

* 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
SecureCare Options, LLC	2389	9/30/2019	33	37
Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				\$ 182,561
2. Notes Payable (<i>itemize</i>)				\$

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>)				\$ 198,682
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>)				\$ 1,072,075
Related Party Payables				69,027
Accrued Expense				936,932
Accrued Resident User Fees				(652)
Accrued Workers Comp Expense				66,768 See Schedule
A-13. Total Current Liabilities (Lines A1 thru 12)				\$ 1,453,318

* 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 9/30/2019	Page 34	of 37
Account				Amount	
Total Brought Forward:				1,453,318	
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>)				\$	
Patient Trust Funda		40,269			
See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 40,269	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 1,493,587	

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

Name of Facility	License No.	Report for Year Ended	Page	of
SecureCare Options, LLC	2389	9/30/2019	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<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			\$	
2. Capital Stock			\$	5,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(378,492)
6. Gain or Loss for Period			\$	486,479
	10/1/2018	thru 9/30/2019		
7. Total Net Worth			\$	112,987
C. Total Reserves and Net Worth			\$	112,987
D. Total Liabilities, Reserves, and Net Worth			\$	1,606,574

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of	
SecureCare Options, LLC	2389	9/30/2019	36	37	
Account			Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2018			\$		
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$ 13,280,824		
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$ 12,794,345		
D. Net Income or Deficit			\$ 486,479		
E. Balance			\$ 486,479		
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 <i>(No., City, State, Zip)</i>		Title	Amount		
2. Other Withdrawings <i>(Specify)</i>			\$		
Purpose		Amount			
3. Total Deductions			\$		
H. <i>Balance at End of Period</i>			\$ 486,479		
09/30/19					

I. Preparer's/Reviewer's Certification

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2019	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>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.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
PKF O'Connor Davies LLP				
Address: Address			Phone Number	
100 Great Meadow Rd, Wethersfield CT			860-257-1875	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Kartik Patel			860-570-2140	
Contact Email Address				