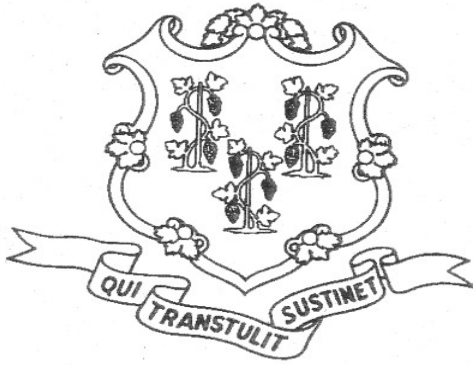


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2020

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 type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020

License Numbers:	CCNH 2389	RHNS	(Specify)	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 9/30/2020	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, 2019 and ending September 30, 2020, 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) Chris Wright		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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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 10/1/2019	To 9/30/2020
Address of Facility 60 West Street Rocky Hill CT				
Report Prepared By PKF O'Connor Davies, LLP		Phone Number 860-257-1875	Date 2/8/2020	
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 860-529-0880	Report for Year Ended 9/30/2020	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. 07-5442
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 9/30/2020	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 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 Related Parties*

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2020	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes 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? Yes 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	%**				
See attached pg 4		<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.
 ** 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 9/30/2020	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? Yes No If "No," explain fully why such allocation was not made.

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

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

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

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility		License No.		Report for Year Ended			Page of	
SecureCare Options, LLC		2389		9/30/2020			6	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	<input type="radio"/>	<input checked="" type="radio"/>	Time Clocks and Payroll Punch Equip	07/01/13	automatic renewals	4,233	4,233	
Banker Leasing	<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, Philadelphai, PA 19101	<input type="radio"/>	<input checked="" type="radio"/>	Copier	05/01/13	automatic renewals	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	automatic renewals	970	970	
	<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"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input checked="" type="radio"/> No	Total ***
							13,253	

* 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 9/30/2020	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	\$ 10,350
3	\$
4	\$
	Charge for Services Provided
	\$ 10,350

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

Legal Services Information

Name of Legal Firm or Independent Attorney 1 iCare Health Management, LLC 2 American Arbitration 3 State Marshall 4 Treasurer State of CT 5 Kainen, Escalera, McKale	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	\$ 4,306
2 Employment arbitrations, healthcare law, conservatorships	\$ 325
3 Employment arbitrations, healthcare law, conservatorships	\$ 340
4 Employment arbitrations, healthcare law, conservatorships	\$ 1,408
5 Employment arbitrations, healthcare law, conservatorships	\$ 167
	Charge for Services Provided
	\$ 6,546

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

Schedule of Resident Statistics

Name of Facility SecureCare Options, LLC			License No. 2389		Report for Year Ended 9/30/2020				Page 8	of 37			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	95	95			95	95							
B. On last day of THIS report period	95	95							95	95			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	93	93			93	93							
B. As of midnight of THIS report period	86	86							86	86			
3. Total Number of Days Care Provided During Period													
A. Medicare	432	432			341	341			91	91			
B. Medicaid (Conn.)	29,505	29,505			21,954	21,954			7,551	7,551			
C. Medicaid (other states)													
D. Private Pay													
E. State SSI for RCH													
F. Other (Specify) DMHAS	864	864			680	680			184	184			
G. Total Care Days During Period (3A thru F)	30,801	30,801			22,975	22,975			7,826	7,826			
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)	30,801	30,801			22,975	22,975			7,826	7,826			

Schedule of Resident Statistics (Cont'd)

Name of Facility SecureCare Options, LLC			License No. 2389			Report for Year Ended 9/30/2020			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		85										
Per Diem Rate													
a. One bed rm.	745.00		400.00										
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								1,269	1,269				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								1,540	1,540				
2. Restorative Treatments								343	343				
C. Other								2,697	2,697				
D. Total Physical Therapy Treatments								5,849	5,849				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								214	214				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								489	489				
2. Restorative Treatments								30	30				
C. Other								403	403				
D. Total Speech Therapy Treatments								1,136	1,136				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								725	725				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								1,692	1,692				
2. Restorative Treatments								265	265				
C. Other								2,774	2,774				
D. Total Occupational Therapy Treatments								5,456	5,456				

Report of Expenditures - Salaries & Wages

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2020	Page 10	of 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)	162,648	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	101,626	3,167				
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	98,180	2,421				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services	97,741	4,701				
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	289,758	4,402				
b. RN						
1. Direct Care	589,539	12,534				
2. Administrative**	565,867	13,012				
c. LPN						
1. Direct Care	1,090,000	33,060				
2. Administrative**						
d. Aides and Attendants	2,049,594	100,824				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	234,294	8,167				
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	331,229	10,207				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	65,167	2,182				
<i>A-13. Total Salary Expenditures</i>	<i>5,675,643</i>	<i>196,757</i>				

* 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 Secretaries	\$ 1,369	91				
Central Supply	\$ 63,798	2,091				
Total	\$ 65,167	2,182	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Med Records	\$ (264)	(91)				
Respiratory Therapy	\$ 838	2				
Admissions	\$ 31,058	662				
Central Supply Contract service	\$ (50,332)	(1,440)				
Total	\$ (18,700)	(867)	\$ -	-	\$ -	-

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

Name of Facility				License No.	Report for Year Ended				Page	of
SecureCare Options, LLC				2389	9/30/2020				11	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	9/30/2020			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	(Specify)							
Section III - Administrators***										
Jessica Dering	162,648			Same as employees less Union funds		2,080	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.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
SecureCare Options, LLC	2389	9/30/2020	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	16,077	190				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	63,207	1,211				
b. Other						
6. Social Worker	(13,224)	(320)				
7. Recreation Worker	12,746	35				
8. Physicians						
a. Medical Director (entire facility)	49,500	222				
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)	6,626	30				
9. Speech Therapist						
a. Resident Care	19,571	375				
b. Other						
10. Occupational Therapist						
a. Resident Care	55,240	1,058				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	67,413	503				
2. Administrative***	(60,955)	(1,263)				
b. LPN						
1. Direct Care	12,225	216				
2. Administrative***						
c. Aides	35,378	381				
d. Other						
12. Other (Specify) See Attached Schedule	(18,700)	(867)				
B-13 Total Fees Paid in Lieu of Salaries	245,104	1,771				

* 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 9/30/2020	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 type="radio"/>	<input checked="" type="radio"/>	Common Ownership		
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Shared Employees	<input type="radio"/>	<input checked="" 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 type="radio"/>	<input checked="" type="radio"/>	Common Ownership		
Claris Health	Medical Director	<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	License No.	Report for Year Ended		Page	of
SecureCare Options, LLC	2389	9/30/2020		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 170,845	170,845			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$				
4. Social Security (F.I.C.A.)	\$ 474,441	474,441			
5. Health Insurance	\$ 751,998	751,998			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 202,124	202,124			
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$ 20,270	20,270			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 77	77			
d. Accounting and Auditing	\$ 10,350	10,350			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 6,546	6,546			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 56,809	56,809			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 38,970	38,970			
2. Cellular Phones	\$ 2,984	2,984			
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	\$ 639,007	639,007			
Subtotal	\$ 2,374,421	2,374,421			

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

(Carry Subtotals forward to next page)

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	9/30/2020		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:	2,374,421	2,374,421			
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 324	324			
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 5,443	5,443			
5. Education Expenses Related to Seminars and Conventions	\$ 1,340	1,340			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$ 7,481	7,481			
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 5,746	5,746			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 1,799	1,799			
4. Fund-Raising***	\$				
5. Medical Records	\$ 54	54			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 2,160	2,160			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 6,447	6,447			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 3,340	3,340			
10. Contributions*** See Attached Schedule	\$ 400	400			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 156,231	156,231			
12. Administrative Management Services**	\$ 309,602	309,602			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 115,381	115,381			
C-14 Total Administrative & General Expenditures	\$ 2,990,169	2,990,169			

* 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)
Travel Meals	\$ 929		
Covid 19 Facility Meals	\$ 6,552		
Total Other Travel and Entertainment	\$ 7,481	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
See pg 28	\$ 1,799		
Total Other Advertising	\$ 1,799	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF Dues	\$ 6,447		
Total Dues	\$ 6,447	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Contributions (See pg 28)	\$ 400		
Total Contributions	\$ 400	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
ADMINISTRATIVE C/S INTER FAC	\$ 16,788		
ADMINISTRATIVE C/S LABOR	\$ 95,031		
EMPLOYEE RELATIONS	\$ 349		
EMPLOYEE RELATIONS-OTHER	\$ 537		
PERMITS & LICENSES	\$ 2,341		
BANK FEES	\$ 30		
LATE FEES	\$ 305		
Total Other Administrative and General	\$ 115,381	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2020	Page 17	of 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #	
iCare Management, LLC/iCare Health Management, LLC	309,602	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12	
iCare Management, LLC/iCare Health Management, LLC	131,484	MANAGEMENT FEES- DIRECT CARE	Pg 20 j	
iCare Management, LLC/iCare Health Management, LLC	26,057	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 9/30/2020	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 15,172	15,172		
2.	Non-Food Supplies	\$ 47,959	47,959		
3.	Other (Specify) _____	\$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)					
		\$ 1,136,417	1,136,417		
c. Other (Specify) _____					
		\$			
2D. Total Dietary Expenditures (2a + b + c + d)		\$ 1,199,548	1,199,548		
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		License No.	Report for Year Ended	Page	of
SecureCare Options, LLC		2389	9/30/2020	19	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. \$	153	153	
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)		\$	260,582	260,582	
c. Other (Specify) Supplies		\$	10,844	10,844	
3D. Total Laundry Expenditures (3a + b + c)		\$	271,579	271,579	
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	9/30/2020		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. \$	17,306	17,306		
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. \$	332,020	332,020		
C.	Other (<i>Specify</i>)	\$				
4D.	Total Housekeeping Expenditures (4a + b + c)	\$	349,326	349,326		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from	\$	52,468	52,468		
b.	Medicine Cabinet Drugs	\$	14,196	14,196		
c.	Medical and Therapeutic Supplies	\$	110,501	110,501		
d.	Ambulance/Limousine***	\$				
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	4,752	4,752		
f.	X-rays and Related Radiological Procedures***	\$	1,694	1,694		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	10,385	10,385		
i.	Recreation	\$	8,386	8,386		
j.	Direct Management Services*	\$	131,484	131,484		
k.	Indirect Management Services*	\$	26,057	26,057		
l.	Other (Specify)**** See Attached Schedule	\$	219,847	219,847		
5M.	Total Resident Care Expenditures (5a - 5j)	\$	579,770	579,770		

* 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.

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 9/30/2020	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	(Specify)	Pg	Line
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Housekeeping Services	266,114			20	4b
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Laundry Services	260,582			19	3b
Eagle Elevator		<input type="radio"/>	<input checked="" type="radio"/>		Elevator Contract	744			22	6F
Bioserve, Inc.		<input type="radio"/>	<input checked="" type="radio"/>		Medical Waste	1,042			22	6F
Plummer All Season Landscaping		<input type="radio"/>	<input checked="" type="radio"/>		Snow Removal/Landscaping	25,168			22	6F
All Waste Inc		<input type="radio"/>	<input checked="" type="radio"/>		Trash removal	22,874			22	6F
American HealthTech		<input type="radio"/>	<input checked="" type="radio"/>		Software Maintenance Contract	11,534			16	M11
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Services	44,696			16	M11
National Datacare Corp		<input type="radio"/>	<input checked="" type="radio"/>		Resident Trust Software	3,112			16	M11
Prime Care Technology services		<input type="radio"/>	<input checked="" type="radio"/>		Computer Consulting Services	58,850			16	M11
Priority Express		<input type="radio"/>	<input checked="" type="radio"/>		Courier Services	1,967			16	M11
Point Right Inc		<input type="radio"/>	<input checked="" type="radio"/>		Nursing Software	4,681			16	M11
US SecurityAssociate		<input type="radio"/>	<input checked="" type="radio"/>		Security Contract Services	191,038			22	6F
Health Services Group		<input type="radio"/>	<input checked="" type="radio"/>		Dietary/Raw Food	1,131,020			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	License No.	Report for Year Ended			Page	of
SecureCare Options, LLC	2389	9/30/2020			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 49,707	49,707				
b. Heat	\$ 37,000	37,000				
c. Light & Power	\$ 76,128	76,128				
d. Water	\$ 43,256	43,256				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 13,253	13,253				
f. Other (<i>itemize</i>)	\$ 347,498	347,498				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 566,842	566,842				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 69,958	69,958				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 69,958	69,958				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 75,240	75,240				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 75,240	75,240				
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	\$ 72,171	72,171				
c. Personal property taxes	\$ 11,632	11,632				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 580,646	580,646				

* 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)
COVID-19 PLANT CONTRACT SRV	\$ 4,257		
COVID-19 SECURITY	\$ 7,195		
ELEVATOR CONTRACT SERVICE	\$ 744		
FIRE/SPRINKLER CONTRACT SERVICE	\$ 3,703		
LANDSCAPING CONTRACT SERVICE	\$ 14,841		
MEDICAL WASTE CONTRACT SERVICE	\$ 1,042		
SNOW REMOVAL CONTRACT SERVICE	\$ 10,327		
TRASH REMOVAL CONTRACT SERVICE	\$ 22,874		
SECURITY CONTRACT SERVICE	\$ 191,038		
PLANT (POOL) CONTRACT SERVICE OTHER	\$ 67,799		
PLANT CONTRACT SERVICE OTHER	\$ 16,819		
RENT EQUIPMENT	\$ 6,859		
Total Other Repairs and Maintenance	\$ 347,498	\$ -	\$ -

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

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
12/6/2019	Freezer Refrigerator	\$ 4,776	10	\$ 358
3/18/2020	Beds	\$ 11,879	5	\$ 1,187
12/31/2019	Laptop Computers	\$ 22,358	3	\$ 5,589
Total additions for Movable Equipment		\$ 39,013		\$ 7,134 *
Deletions:				
Total deletions for Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
12/18/2019	AC Split system	\$ 64,705	10	\$ 4,853
10/30/2019	AC Repairs	\$ 8,873	15	\$ 542
5/29/2020	Elevator Repairs	\$ 4,935	20	\$ 82
Total additions for Leasehold Improvement		\$ 78,513		\$ 5,477 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility SecureCare Options, LLC			License No. 2389		Report for Year Ended 9/30/2020			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.				870,024	870,024				
2.				4,271	4,271				
3.				(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				918,125	375,270			69,763	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				78,513				5,477	
C-4. Subtotal									75,240
D. Total Amortization									75,240

* 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 9/30/2020	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.
*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		43,827		
7. Acquisition Cost				
a. Land				
b. Building				
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd 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		License No.	Report for Year Ended		Page	of
SecureCare Options, LLC		2389	9/30/2020		26	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		9/30/2020		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 (<i>Specify</i>)				\$			
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 (<i>Specify</i>)				\$			
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$			
14. Insurance							
a. Insurance on Property (buildings only)				\$ 14,783	14,783		
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (<i>Blanket Coverage</i>)			\$ 69,081	69,081			
2. Fire and Extended Coverage			\$				
3. Other (<i>Specify</i>)			\$ 4,929	4,929			
Other Ins, Crime							
14d. Total Insurance Expenditures (14a + b + c)				\$ 88,793	88,793		
15. Total All Expenditures (A-13 thru C-14)				\$ 12,547,420	12,547,420		

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
SecureCare Options, LLC				2389	9/30/2020	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	\$ 77	77		
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 *	\$ 1,799	1,799		
19.			Income Tax / Corporate Business Tax	\$			
20.	16	10	Fund Raising / Contributions	\$ 400	400		
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 305	305		
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)				\$ 2,581	2,581		

* 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	\$ 305		
Total Other A&G Adjustments			\$ 305	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
SecureCare Options, LLC				2389	9/30/2020	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 2,581	2,581		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$			
28.			Ambulance/Limousine	\$			
29.	20	5f	X-rays, etc	\$ 1,694	1,694		
30.	20	5h	Laboratory	\$ 10,385	10,385		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 5,498	5,498		
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)				\$ 20,158	20,158		

*** 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)
20a		Non Covered PPS Visits	\$ 5,498		
Total Other Ancillary Costs			\$ 5,498	\$ -	\$ -

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			\$ -	\$ -	\$ -

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			\$ -	\$ -	\$ -

Schedule of Other - Direct 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	9/30/2020			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 11,780,439	11,780,439				
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>)	\$ 227,980	227,980				
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$ 1,229,916	1,229,916				
b. Private-Pay Room and Board Contractual Allowance **	\$ (741,465)	(741,465)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 9,579	9,579				
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$ 43,654	43,654				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
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	\$ 18,084	18,084				
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$ 67,395	67,395				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 3,879	3,879				
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$ 25,090	25,090				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 9,620	9,620				
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$ 74,830	74,830				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$ (28,777)	(28,777)				
b. Other (<i>Specify</i>) - Non-Medicare	\$ (67,721)	(67,721)				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 12,652,503	12,652,503				
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>)	\$ 25	25				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 95,094	95,094				
V. Total Other Revenue (1 thru 8)	\$ 95,119	95,119				
VI. Total All Revenue (III +V)	\$ 12,747,622	12,747,622				

* 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 MEDICARE A	\$ 2,168		
	EQUIPMENT RENTAL MEDICARE A	\$ 220		
	RADIOLOGY MEDICARE A	\$ 850		
	IV THERAPY MEDICARE A	\$ 1,194		
	IV THERAPY MANAGED MEDICARE	\$ 3,746		
	C/A MEDICARE A ANCILLARY	\$ (36,956)		
	C/A MANAGED MEDICARE ANCILLARY	\$ 1		
	Total Other Resident Revenue - Medicare	\$ (28,777)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	LAB MEDICAID CCNH	\$ 1,175		
	LAB MANAGED MEDICARE	\$ 1,181		
	LAB DMHAS	\$ 2,516		
	OXYGEN MEDICAID CCNH	\$ 810		
	EQUIPMENT RENTAL MEDICAID CCNH	\$ 25,668		
	RADIOLOGY MEDICAID CCNH	\$ 276		
	IV THERAPY MEDICAID CCNH	\$ 10,647		
	OPTUM B	\$ 170,899		
	MED TRANS SVC MANAGED CARE B	\$ 1,296		
	MED TRANS SVC DMHAS	\$ 942		
	DMHAS ANCILLARY REVENUE	\$ 12,289		
	PRIOR YEAR ADJ -PAYOR CHANGES	\$ 3,699		
	C/A MEDICAID ANCILLARY	\$ (215,540)		
	C/A INS/MGD CARE ANCILLARY	\$ (1)		
	C/A OPTUM ANCILLARY	\$ (78,995)		
	C/A DMHAS ANCILLARY	\$ (4,555)		
	C/A VBP	\$ (28)		
	Total Other Resident Revenue	\$ (67,721)	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
			\$ 25		
	Total Interest Income		\$ 25	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	RESIDENT LATE FEE REVENUE	\$ 75		
	OTHER INCOME: DMHAS ORGANIZATIONAL REV	\$ 91,484		
	OTHER INCOME	\$ 500		
	PRIOR YEAR ADJ - RATE ADJUSTMENTS	\$ 3,035		
	Total Other Revenue	\$ 95,094	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
SecureCare Options, LLC	2389	9/30/2020	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	5,880,290
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	689,003
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	8,896
5. Prepaid Expenses			\$	190,331
a. _____				
b. _____				
c. _____				
d. See Schedule		190,331		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	(5,028,302)

See Schedule		(5,028,302)		
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,740,218
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>996,638</u>		\$	546,128
	Accum. Depreciation <u>450,510</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>819,167</u>		\$	256,798
	Accum. Depreciation <u>562,369</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	802,926

* 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	
		Prepaid Workers Comp	\$ 108,379
		Prepaid General Liability	\$ 43,432
		Prepaid Insur. Property Tax	\$ 1,797
		Prepaid Insurance	\$ 6,725
		Prepaid Tax Real Estate	\$ 23,519
		Prepaid Personal Prop. Tax	\$ 3,382
		Prepaid Phone	\$ 436
		Prepaid Misc	\$ 1,881
		Prepaid Misc.	\$ 780
		Total Prepaid Expenses	\$ 190,331

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

Page Ref	Line Ref	Description	
		MEDICARE COVID ADVANCE	\$ (566,097)
		MEDICAID COVID ADVANCE	\$ (892,495)
		A/R MEDICAID ADDTL AUDIT RESERVE	\$ (239,867)
		A/R MEDICAID ADDTL AUDIT RESERVE PY	\$ (2,501,509)
		A/R DMHAS	\$ (210,189)
		A/R DMHAS PY	\$ (446,622)
		INFCT CTRL COVID FUNDS	\$ (147,749)
		I/C REC(PAY) CUR YR: CHELSEA PL CC	\$ 1,040
		I/C REC(PAY) CUR YR: CHESTNUT PT CC	\$ 423
		I/C REC(PAY) CUR YR: KETTLE BR CC	\$ 5,374
		I/C REC(PAY) CUR YR: TRINITY HILL CC	\$ 640
		I/C REC(PAY) CUR YR: WINTONBURY CC	\$ 666
		I/C REC(PAY) CUR YR: BIDWELL CC	\$ 1,804
		I/C REC(PAY) CUR YR: FARMINGTON CC	\$ 466
		I/C REC(PAY) CUR YR: MERIDEN CC	\$ 706
		I/C REC(PAY) CUR YR: WESTSIDE CC	\$ 720
		I/C REC(PAY) CUR YR: UNIV HLTH PARK CC	\$ 2,442
		I/C REC(PAY) CUR YR: SECURECARE REALTY	\$ (6)
		I/C REC ICARE MGT : FAREEN	\$ 24,300
		I/C REC SECURE CARE MGT	\$ (62,349)
		Total Other Current Assets (Itemize)	\$ (5,028,302)

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	
		A/P ACCRUED EXPENSES	\$ 73,195
		DEFERRED REVENUE: DHMAS	\$ 790,977
		WORKERS' COMP INS PAYABLE	\$ 81,013
		ACCRUED PROVIDER USE TAX LIABILITY	\$ 4,372
		SOC SECURITY EMPLOYER DEFERRAL LIAB	\$ 163,726
		UNION DUES PAYABLE	\$ 632
		Total Other Current Liabilities (Itemize)	\$ 1,113,915

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	License No.	Report for Year Ended	Page	of
SecureCare Options, LLC	2389	9/30/2020	32	37
Account			Amount	
Total Brought Forward:			\$	2,543,144
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>)			\$	75,431
	Patient Trust Funds	75,431		
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)			\$	75,431
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	2,618,575

* 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 SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2020		Page 34	of 37
Account				Amount	
Total Brought Forward:				1,512,757	
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>)				\$ 45,360	
Name and Address of Lender	Amount	Loan Date			
	45,360				
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 1,167,531	
PPE Loan		1,092,100			
Patient Trust Funds		75,431			
See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 1,212,891	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 2,725,648	

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

Name of Facility	License No.	Report for Year Ended	Page	of
SecureCare Options, LLC	2389	9/30/2020	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			\$	(312,275)
6. Gain or Loss for Period			\$	200,202
	10/1/2019	thru	9/30/2020	
7. Total Net Worth			\$	(107,073)
C. Total Reserves and Net Worth			\$	(107,073)
D. Total Liabilities, Reserves, and Net Worth			\$	2,618,575

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
SecureCare Options, LLC	2389	9/30/2020	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2019			\$	
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$ 12,747,622	
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$ 12,547,420	
D. Net Income or Deficit			\$ 200,202	
E. Balance			\$ 200,202	
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. Balance at End of Period			\$ 200,202	
09/30/20				

I. Preparer's/Reviewer's Certification

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2020	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				
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Kartik Patel			860-570-2140	
Contact Email Address				