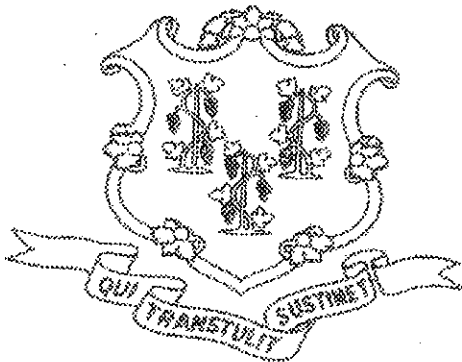


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2019

Name of Facility (as licensed) Meriden Care Center, LLC	
Address (No. & Street, City, State, Zip Code) 33 Roy St. Meriden, CT 06450	
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 2448	RHNS	(Specify)	Medicare Provider 07-5337
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Medicaid Provider Numbers:	CCNH 10660	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) Meriden Care Center, LLC	License No. 2448	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 Meriden Care Center, 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) Raymond Hackling			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 Meriden Care Center, LLC		Period Covered:		From 10/1/2018	To 9/30/2019
Address of Facility 33 Roy St. Meriden, CT 06450					
Report Prepared By iCare Management, LLC		Phone Number 860-570-2140		Date 2/15/2020	
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 203-237-8457		Report for Year Ended 9/30/2019		Page 2	of 37
Name of Facility (as shown on license) Meriden Care Center, LLC			Address (No. & Street, City, State, Zip) 33 Roy St. Meriden, CT 06450		
License Numbers:	CCNH 2448	RHNS	(Specify)	Medicare Provider No. 07-5337	
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 Raymond Hackling			Nursing Home Administrator's License No.:	000853	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		

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2448

Related Parties*

Name of Facility		License No.	Report for Year Ended	Page	of		
Meriden Care Center, LLC		2448C	9/3/2019	4	37		
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No %**				
Bidwell Care Center, LLC	333 Bidwell St. Manchester, CT 06040			Shared Employees		(3,899)	3,899
Chelsea Place Care Center, LLC	25 Lorraine St. Hartford, CT 06105			Shared Employees		(4,424)	4,424
Chestnut Point Care Center, LLC	171 Main St. East Windsor, CT 06088			Shared Employees		(1,530)	1,530
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032			Shared Employees		(2,427)	2,427
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088			Shared Employees		(2,647)	2,647
Meriden Care Center, LLC (Silver Springs)	33 Roy St. Meriden, CT 06450			Shared Employees		-	-
Trinity Hill Care Center, LLC	151 Hillside Ave. Hartford, CT 06106			Shared Employees		16,642	(16,642)
Westside Care Center, LLC	349 Bidwell St. Manchester, CT 06040			Shared Employees		(3,063)	3,063
Wintonbury Care Center, LLC	140 Park Ave. Bloomfield, CT 06002			Shared Employees		(2,825)	2,825
Secure Care Center LLC	60 West Street, Rocky Hill, CT 06067			Shared Employees		2,879	(2,879)
Universal Healthcare Holdings, LLC	5 Greenwood Street, Hartford, CT 06106			Shared Employees		(10,527)	10,527
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 22,22,27,10,9,14	328,193	(328,193)
iCare Management, LLC	341 Bidwell St. Manchester, CT 06040			iCare Helt-Legal, Postage, Emp Recruitment & Marketing	16, 15 M.E	17,708	(17,708)
iCare Health Management, LLC	341 Bidwell St. Manchester, CT 06040			Shared EEs not part of mgmt agmt	20 5j	168,128	(168,128)
				Management Services, Direct	20 5j	222,408	(222,408)
				Management Services, Indirect	20 5j	31,132	(31,132)
				Management Services, Administrative	16 M12	393,874	(393,874)
All Care Centers, mgmt co, reaty cos				Share Common 401k, Pension and Insurance plans, courier, legal and various other services			

* Use additional sheets if necessary.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2019	Page 5	of 37
If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:				
Item	Method of Allocation			
Dietary	Number of meals served to residents			
Laundry	Number of pounds processed			
Housekeeping	Number of square feet serviced			
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants			
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist <i>(See listing page 13)</i>			
Maintenance and operation of plant	Square feet			
Property costs (depreciation)	Square feet			
Employee health and welfare	Gross salaries			
Management services	Appropriate cost center involved			
All other General Administrative expenses	Total of Direct and Allocated Costs			
The preparer of this report must answer the following questions applicable to the cost information provided.				
1. In the preparation of this Report, were all costs allocated as required? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				
2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.				
3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)				
<input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				

General Information and Questionnaire

Accounting Basis

Name of Facility Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2019	Page 7	of 37
The records of this facility for the period covered by this report were maintained on the following basis: <input checked="" type="radio"/> Accrual <input type="radio"/> Cash <input type="radio"/> Modified Cash				
Is the accounting basis for this period the same as for the previous period? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain.				
Independent Accounting Firm				
Name of Accounting Firm 1 O'Connor, Davies LLP 2 3 4		Address (No. & Street, City, State, Zip Code) 100 Great Meadow Road, Ste 401, Wethersfield, CT 06109		
Services Provided by This Firm (<i>describe fully</i>)				
1	Taxes, financial statements, accounting support	\$	8,859	
2		\$		
3		\$		
4		\$		
			Charge for Services Provided	
			\$ 8,859	
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. <input checked="" type="radio"/> Yes <input type="radio"/> No 15D				
Legal Services Information				
Name of Legal Firm or Independent Attorney 1 iCare Health Management, LLC 2 Starble and Harris 3 Durant Nichols / Robinson & Cole, LLP 4 Various others (American Arbitration , Various Arbitration, Murtha Cullina, Jackson Lewis) 5 Starble and Harris, iCare Health Management LLC		Telephone Number 860-570-2140 860-678-7775 860-275-8200 860-678-7775 & 860-570-2140		
Address (No. & Street, City, State, Zip Code) 1 341 Bidwell Street, Manchester CT 2 32 Main Street, Avon, CT 3 280 Trumbull St, Hartford, CT 4 5 32 Main Street, Avon, CT & 341 Bidwell Street, Manchester CT				
Services Provided by This Firm (<i>describe fully</i>)				
1	Lease and contract issues, general legal advice, Labor Law	\$	13,164	
2	Lease and contract issues, general legal advice, union funds advice	\$		
3	Employment law, arbitrations, contract negotiations	\$	(4,460)	
4	Employment Arbitrations, healthcare law	\$	295	
5	Conservatorships & Collections	\$	1,436	
			Charge for Services Provided	
			\$ 10,435	
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. <input checked="" type="radio"/> Yes <input type="radio"/> No 15E				

Schedule of Resident Statistics

Name of Facility Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2019				Page 8	of 37									
		Period 10/1 Thru 6/30		Period 7/1 Thru 9/30												
		Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)			Total	CCNH	RHNS	Total	CCNH	RHNS	Total	(Specify)	
1. Certified Bed Capacity																
A. On last day of PREVIOUS report period		159	159		159									159	159	
B. On last day of THIS report period		159	159		159									159	159	
2. Number of Residents																
A. As of midnight of PREVIOUS report period		156	156		156									157	157	
B. As of midnight of THIS report period		154	154		154									154	154	
3. Total Number of Days Care Provided During Period																
A. Medicare		1,507	1,507		1,507									1,229	1,229	278
B. Medicaid (Conn.)		49,040	49,040		49,040									36,355	36,355	12,685
C. Medicaid (other states)																
D. Private Pay		380	380		380									288	288	92
E. State SSI for RCH																
F. Other (Specify) Insurance		5,943	5,943		5,943									4,619	4,619	1,324
G. Total Care Days During Period (3A thru F)		56,870	56,870		56,870									42,491	42,491	14,379
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)		56,870	56,870		56,870									42,491	42,491	14,379

Schedule of Resident Statistics (Cont'd)

Name of Facility Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2019	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? Yes No

If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(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	3		129		2				
Per Diem Rate									
a. One bed rm.	505.00		249.00		418.00				
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	1,774	1,774		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	416	416		
2. Restorative Treatments	1,868	1,868		
C. Other	3,296	3,296		
D. Total Physical Therapy Treatments	7,354	7,354		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	327	327		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	38	38		
2. Restorative Treatments	90	90		
C. Other	411	411		
D. Total Speech Therapy Treatments	866	866		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,882	1,882		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	929	929		
2. Restorative Treatments	1,521	1,521		
C. Other	4,102	4,102		
D. Total Occupational Therapy Treatments	8,434	8,434		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Meriden Care Center, LLC	2448	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)	165,134	2,086				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	205,311	9,650				
5. Dietary Service						
a. Head Dietitian	9,331	207				
b. Food Service Supervisor	56,482	2,086				
c. Dietary Workers	524,774	29,892				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	59,314	2,022				
b. Other Maintenance Workers	42,040	2,124				
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	212,658	3,747				
b. RN						
1. Direct Care	473,642	9,673				
2. Administrative**	319,888	8,529				
c. LPN						
1. Direct Care	1,468,493	48,229				
2. Administrative**						
d. Aides and Attendants	2,306,709	133,518				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	189,200	9,284				
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	204,871	5,899				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	34,205	2,069				
<i>A-13. Total Salary Expenditures</i>	6,272,054	269,014				

* 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.

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

Name of Facility		License No.		Report for Year Ended		Page	of		
Meriden Care Center, LLC		2448		9/30/2019		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.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Meriden Care Center, LLC	2448	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	5,288	118				
2. Dentist						
3. Pharmacist	30,516	416				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	64,262	489				
b. Other						
6. Social Worker	76,294	1,368				
7. Recreation Worker	18,953	35+Cable				35+Cable
8. Physicians						
a. Medical Director (entire facility)	36,000	257				
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	18,042	69				
9. Speech Therapist						
a. Resident Care	23,470	305				
b. Other						
10. Occupational Therapist						
a. Resident Care	76,830	840				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	29,683	408				
2. Administrative***	(29,675)	(783)				
b. LPN						
1. Direct Care	3,291	76				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	254,058	5,793				
B-13 Total Fees Paid in Lieu of Salaries	607,011	9,356				

* 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 Meriden Care Center, LLC		License No. 2448	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		
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	
Pharm Scripts	Pharmacy Contract	<input type="radio"/>	<input checked="" type="radio"/>		
Guardian Consulting Srv	Pharmacy Consulting	<input type="radio"/>	<input checked="" type="radio"/>		
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"/>		
IPC Hospitalists	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"/>		
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		<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 Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2019	Page 15	of 37
Item	Total	CCNH	RHNS	(Specify)
I. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 285,726	285,726		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$			
4. Social Security (F.I.C.A.)	\$ 537,723	537,723		
5. Health Insurance	\$ 1,118,480	1,118,480		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 369,972	369,972		
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$ 45,619	45,619		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 34,600	34,600		
d. Accounting and Auditing	\$ 8,859	8,859		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 10,435	10,435		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 23,002	23,002		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 26,373	26,373		
2. Cellular Phones	\$ 1,633	1,633		
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	\$ 1,195,407	1,195,407		
Subtotal	\$ 3,658,078	3,658,078		

* 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	\$ 45,619		\$ -
Total	\$ 45,619	\$ -	\$ -

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2019	16	37
Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	3,658,078	3,658,078		
i. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$ 2,186	2,186		
3. Gifts to Staff and Residents	\$ 162	162		
4. Employee Travel	\$ 4,331	4,331		
5. Education Expenses Related to Seminars and Conventions	\$ 7,035	7,035		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$			
7. Other (<i>Specify</i>) See Attached Schedule	\$ 199	199		
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 14,175	14,175		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$			
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 27,890	27,890		
4. Fund-Raising***	\$			
5. Medical Records	\$			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$			
7. Postage	\$ 4,196	4,196		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 10,754	10,754		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$			
10. Contributions*** See Attached Schedule	\$ 360	360		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 128,875	128,875		
12. Administrative Management Services**	\$ 393,874	393,874		
13. Other (<i>Specify</i>) See Attached Schedule	\$ 21,003	21,003		
C-14 Total Administrative & General Expenditures	\$ 4,273,119	4,273,119		

* 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	\$ 199		\$ -
Total Other Travel and Entertainment	\$ 199	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
COMMUNICATIONS SPECIAL EVENTS	\$ 27,890		\$ -
Total Other Advertising	\$ 27,890	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
ALTCFM			
CAHCF Dues	\$ 10,594		\$ -
OTHER DUES	\$ 160		\$ -
Total Dues	\$ 10,754	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
CONTRIBUTIONS	\$ 360		\$ -
Total Contributions	\$ 360	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
SOCIAL SERVICE SUPPLIES	\$ 247		\$ -
SOC SVC MINOR EQUIPMENT	\$ -		\$ -
ADMINISTRATIVE MINOR EQUIPMENT	\$ 127		\$ -
EMPLOYEE RELATIONS	\$ 3,417		\$ -
EMPLOYEE RELATIONS-OTHER	\$ 182		\$ -
PERMITS & LICENSES	\$ 1,815		\$ -
VOLUNTEER EXPENSE	\$ -		\$ -
BANK FEES	\$ 12,954		\$ -
CMS REVISIT USER FEES	\$ -		\$ -
PENALTIES	\$ -		\$ -
LATE FEES	\$ 394		\$ -
INTERNET EXPENSES	\$ 1,868		\$ -
Rounding	\$ 0		\$ -
Total Other Administrative and General	\$ 21,003	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Meriden Care Center, LLC	2448	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	393,874	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	222,408	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	31,132	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 Meriden Care Center, LLC		License No. 2448	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	\$ 368,745	368,745		
2.	Non-Food Supplies	\$ 42,104	42,104		
3.	Other (Specify) _____ DIETARY SUPPLEMENTS	\$ 16,717	16,717		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$ 3,426	3,426		
c. Other (Specify) _____ DIETARY MINOR EQUIPMENT		\$ 8,271	8,271		
2D. Total Dietary Expenditures (2a + b + c + d)		\$ 439,262	439,262		
2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F.	Resident Meals: Total no. of meals served per day:*	467	467		
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 Meriden Care Center, LLC		License No. 2448	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. \$	744	744	
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)		\$	416,509	416,509	
c. Other (Specify) LAUNDRY MINOR EQUIPMENT		\$	297	297	
3D. Total Laundry Expenditures (3a + b + c)		\$	417,550	417,550	
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
Meriden Care Center, LLC		2448	9/30/2019		20	37
Item		Total	CCNH	RHNS	(Specify)	
4.	Housekeeping	Sq. Ft. Serviced				
	a. In-House Care	by Personnel				
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	32,931	32,931		
	b. Purchased Services (<i>by contract other than through Management Services</i>)	Sq. Ft. Serviced				
	(<i>Complete Schedule C-2 att. Page 21</i>)	by Personnel				
		Amt. \$	458,379	458,379		
	C. Other (<i>Specify</i>)	\$				
	HOUSEKEEPING MINOR EQUIPMENT					
4D.	Total Housekeeping Expenditures (4a + b + c)	\$	491,309	491,309		
5.	Resident Care (Supplies)**					
	a. Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from PHARMACY	\$	285,107	285,107		
	b. Medicine Cabinet Drugs	\$	4,552	4,552		
	c. Medical and Therapeutic Supplies	\$	124,600	124,600		
	d. Ambulance/Limousine***	\$	7,962	7,962		
	e. Oxygen					
	1. For Emergency Use	\$	4,730	4,730		
	2. Other***	\$				
	f. X-rays and Related Radiological Procedures***	\$	3,446	3,446		
	g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
	h. Laboratory***	\$	12,600	12,600		
	i. Recreation	\$				
	j. Direct Management Services*	\$				
	k. Indirect Management Services*	\$				
	l. Other (Specify)**** See Attached Schedule	\$	329,836	329,836		
5M.	Total Resident Care Expenditures (5a - 5j)	\$	772,833	772,833		

* 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	\$ 111		\$ -
NURSING MINOR EQUIP	\$ 5,238		\$ -
MEDICAL RECORDS SUPPLIES	\$ 1,569		\$ -
MEDICAL RECORDS MINOR EQUIPMENT	\$ -		\$ -
MANAGEMENT ALLOCATIONS - DIRECT	\$ 222,408		\$ -
NON-COVERED PPS DR. VISITS	\$ 7,278		\$ -
RESIDENT CARE SUPPLIES	\$ -		\$ -
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 11,638		\$ -
PERSONAL CARE SUPPLIES	\$ 467		\$ -
INCONTINENCY SUPPLIES	\$ 817		\$ -
VACCINE RESIDENTS	\$ (3,898)		\$ -
PATIENT SPECIAL NEEDS	\$ -		\$ -
PHYSICAL THERAPY SUPPLIES	\$ -		\$ -
PHYSICAL THERAPY EQUIPMENT RENT	\$ -		\$ -
PHYSICAL THERAPY MINOR EQUIPMENT	\$ -		\$ -
OCCUPATIONAL THERAPY SUPPLIES	\$ -		\$ -
OCCUPATIONAL THERAPY EQUIP RENTAL	\$ -		\$ -
OCCUPATIONAL THERAPY MINOR EQUIP	\$ -		\$ -
SPEECH THERAPY SUPPLIES	\$ -		\$ -
SPEECH THERAPY EQUIPMENT RENT	\$ -		\$ -
SPEECH THERAPY MINOR EQUIPMENT	\$ -		\$ -
RENTALS FOR NURSING EQUIPMENT NON BILLABLE	\$ 24,206		\$ -
EQUIPMENT RENTAL: AIDS UNIT	\$ -		\$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ -		\$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ -		\$ -
HI LOW BED RENTAL & MATTRESSES	\$ -		\$ -
IV THERAPY SUPPLIES	\$ 7,765		\$ -
IV THERAPY CONTRACT SERVICE	\$ -		\$ -
MEDICAL WASTE CONTRACT SERVICE	\$ 2,138		\$ -
ACTIVITIES SUPPLIES	\$ 13,165		\$ -
ACTIVITIES MINOR EQUIPMENT	\$ 439		\$ -
MANAGEMENT ALLOCATION - INDIRECT	\$ 31,132		\$ -
ADMISSIONS SUPPLIES	\$ -		\$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$ -		\$ -
STRIKE COSTS NON REIMBURSABLE	\$ 5,364		\$ -
Total Other Resident Care	\$ 329,836	\$ -	\$ -

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

Name of Facility Meriden Care Center, LLC		License No. 2448		Report for Year Ended 9/30/2019		Page of 21 37			
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS (Specify)	Pg	Line
		Yes	No						
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	O	⊙	VENDOR	Housekeeping Services	458,379		20	4b
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	O	⊙	VENDOR	Laundry Services	416,509		19	3b
Eagle Elevator		O	⊙	VENDOR	Elevator Contract	9,189		22	6F
Bioserve, Inc.		O	⊙	VENDOR	Medical Waste	2,138		22	6F
Brightview Landscaping/Amaya Landscaping		O	⊙	VENDOR	Snow Removal/Landscaping	26,882		22	6F
CWPM		O	⊙	VENDOR	Trash removal	46,858		22	6F
American HealthTech		O	⊙	VENDOR	Software Maintenance Contract	12,713		16	M11
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	O	⊙	VENDOR	Payroll Services	49,593		16	M11
National Datacare Corp		O	⊙	VENDOR	Resident Trust Software	3,791		16	M11
Prime Care Technology services		O	⊙	VENDOR	Computer Consulting Services	31,810		16	M11
Priority Express		O	⊙	VENDOR	Courier Services	3,345		16	M11
Point Right Inc		O	⊙	VENDOR	Nursing Software	4,680		16	M11
		O	⊙	VENDOR				22	6F
		O	⊙	VENDOR					

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

** Refer to Page 4 for definition of related.

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
Meriden Care Center, LLC	2448	9/30/2019		22	37
Item	Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 58,231	58,231			
b. Heat	\$ 36,673	36,673			
c. Light & Power	\$ 125,594	125,594			
d. Water	\$ 90,496	90,496			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 47,867	47,867			
f. Other (<i>itemize</i>)	\$ 118,657	118,657			
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 477,517	477,517			
7. Depreciation (<i>complete schedule page 23*</i>)					
a. Land Improvements	\$				
b. Building & Building Improvements	\$ 23,223	23,223			
c. Non-Movable Equipment	\$				
d. Movable Equipment	\$ 51,459	51,459			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 74,682	74,682			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)					
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$ 50,135	50,135			
d. Other (<i>Specify</i>)	\$				
*8e. Total Amortization Costs (8a + b + c + d)	\$ 50,135	50,135			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 585,265	585,265			
10. Property Taxes					
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$ 153,391	153,391			
c. Personal property taxes	\$ 13,392	13,392			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 876,865	876,865			

* 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)
PLANT SUPPLIES	\$ 8,541		\$ -
PLANT CONTRACT SERVICE LABOR	\$ -		\$ -
ELEVATOR CONTRACT SERVICE	\$ 9,189		\$ -
FIRE/SPRINKLER CONTRACT SERVICE	\$ 8,937		\$ -
LANDSCAPING CONTRACT SERVICE	\$ 9,015		\$ -
SNOW REMOVAL CONTRACT SERVICE	\$ 17,867		\$ -
TRASH REMOVAL CONTRACT SERVICE	\$ 46,858		\$ -
HVAC CONTRACT SERVICE	\$ -		\$ -
SECURITY CONTRACT SERVICE	\$ -		\$ -
PLANT CONTRACT SERVICE OTHER	\$ 8,940		\$ -
PLANT MINOR EQUIPMENT	\$ 9,311		\$ -
RENT AUTO	\$ -		\$ -
RENT EQUIPMENT	\$ -		\$ -
RENT OTHER	\$ -		\$ -
Total Other Repairs and Maintenance	\$ 118,657	\$ -	\$ -

State of Connecticut
Annual Report of Long-Term Care Facility
 CSP-23 Rev. 10/2006

Depreciation Schedule

Name of Facility		License No.		Report for Year Ended				Page	of
Meriden Care Center, LLC		2448		9/30/2019				23	37
Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals	
									Is a mileage logbook maintained?
		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. Van Repair: Hillside Automotive Ctr									
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									
							51,459	74,682	
							23,223	23,223	
							46,183		
							5,277		

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 Meriden Care Center, LLC	License No. 2448		Report for Year Ended 9/30/2019		Page 24	of 37
	Date of Acquisition		Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**		
Item	Month	Year			Length of Amortization	Cost to Be Amortized
A. Organization Expense						
1.						
2.						
3.						
A-4. Subtotal						
B. Mortgage Expense						
1.				692,068	379,433	
2.						
3.						
B-4. Subtotal						
C. Leasehold Improvements and Other						
1. Acquired prior to this report period				692,068	46,631	
2. Disposals (attach schedule)						
3. Acquired during this report period (attach schedule)				62,847	3,504	
C-4. Subtotal						50,135
D. Total Amortization						50,135

* 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 Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2019	Page 25	of 37
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II. 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	12/01/03
2. Date Structure Completed	
3. If NOT Original Owner, Date of Purchase	
4. Date of Initial Licensure	12/01/03
5. Total Licensed Bed Capacity	159
6. Square Footage	65,790
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)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
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
Summit Meriden, LLC	33 Roy Street, Meriden, CT	08/09/17		\$598,500 yr 1

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

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

Name of Facility Meriden Care Center, LLC		License No. 2448	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
Meriden Care Center, LLC		2448		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)				\$	12,931	12,931	
INTEREST							
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	12,931	12,931	
14. Insurance							
a. Insurance on Property (buildings only)				\$	9,367	9,367	
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$	71,009	71,009	
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$	6,913	6,913	
Other insurance, crime							
14d. Total Insurance Expenditures (14a + b + c)				\$	87,289	87,289	
15. Total All Expenditures (A-13 thru C-14)				\$	14,727,740	14,727,740	

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC				2448	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.			Bad Debts	\$	34,600	34,600	
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.			Unallowable Advertising *	\$	27,890	27,890	
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$	32,043	32,043	
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)				\$	94,533	94,533	

* 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.

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Meriden Care Center, LLC			2448	9/30/2019	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 94,533	94,533		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$			
28.			Ambulance/Limousine	\$ 7,962	7,962		
29.			X-rays, etc	\$ 3,446	3,446		
30.			Laboratory	\$ 12,600	12,600		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 7,278	7,278		
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)				\$ 125,819	125,819		

*** 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)
20	5J		7,278.30		-
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	-		
13	B9A	ST- Resident Care (for outpatient therapy - see schedule)	-		
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)	-		
Total Other Ancillary Costs			\$ 7,278	\$ -	\$ -

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)
20	4A1	Houskeeping Supplies (for Outpatient Therapy - see schedule)	\$ -		
20	4B	Housekeeping purchased services (for Outpatient Therapy see schedule)	\$ -		
22	6B	Heat (for outpatient Therapy see schedule)	\$ -		
22	6C	Light and Power (for outpatient therapy see schedule)	\$ -		
22	6D	water (for outpatient therapy see schedule)	\$ -		
22	6A	Repair&Maint (for outpatient therapy see schedule)	\$ -		

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

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(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 Meriden Care Center, LLC		License No. 2448		Report for Year Ended 9/30/2019		Page 30		of 37	
Item				Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue									
1.	a.	Medicaid Residents (CT only)	\$	12,201,718	12,201,718				
	b.	Medicaid Room and Board Contractual Allowance **	\$						
2.	a.	Medicaid (All other states)	\$						
	b.	Other States Room and Board Contractual Allowance **	\$						
3.	a.	Medicare Residents (all inclusive)	\$	769,597	769,597				
	b.	Medicare Room and Board Contractual Allowance **	\$						
4.	a.	Private-Pay Residents and Other	\$	2,189,202	2,189,202				
	b.	Private-Pay Room and Board Contractual Allowance **	\$						
II. Other Resident Revenue									
1.	a.	Prescription Drugs - Medicare	\$	69,382	69,382				
	b.	Prescription Drugs - Medicare Contractual Allowance **	\$	(69,382)	(69,382)				
	c.	Prescription Drugs - Non-Medicare	\$	320,835	320,835				
	d.	Prescription Drugs - Non-Medicare Contractual Allowance **	\$	(146,538)	(146,538)				
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	\$	121,763	121,763				
	b.	Physical Therapy - Medicare Contractual Allowance **	\$	(83,360)	(83,360)				
	c.	Physical Therapy - Non-Medicare	\$	119,587	119,587				
	d.	Physical Therapy - Non-Medicare Contractual Allowance **	\$	(119,587)	(119,587)				
4.	a.	Speech Therapy - Medicare	\$	37,592	37,592				
	b.	Speech Therapy - Medicare Contractual Allowance **	\$	(21,275)	(21,275)				
	c.	Speech Therapy - Non-Medicare	\$	29,365	29,365				
	d.	Speech Therapy - Non-Medicare Contractual Allowance **	\$	(29,365)	(29,365)				
5.	a.	Occupational Therapy - Medicare	\$	129,807	129,807				
	b.	Occupational Therapy - Medicare Contractual Allowance **	\$	(82,474)	(82,474)				
	c.	Occupational Therapy - Non-Medicare	\$	144,952	144,952				
	d.	Occupational Therapy - Non-Medicare Contractual Allowance **	\$	(144,191)	(144,191)				
6.	a.	Other (Specify) - Medicare	\$						
	b.	Other (Specify) - Non-Medicare	\$	200,177	200,177				
III. Total Resident Revenue (Section I. thru Section II.)				\$	15,637,805	15,637,805			
IV. Other Revenue*									
1.	Meals sold to guests, employees & others			\$					
2.	Rental of rooms to non-residents			\$					
3.	Telephone			\$					
4.	Rental of Television and Cable Services			\$					
5.	Interest Income (Specify)			\$	229	229			
6.	Private Duty Nurses' Fees			\$					
7.	Barber, Coffee, Beauty and Gift shops			\$					
8.	Other (Specify)			\$	11,130	11,130			
V. Total Other Revenue (1 thru 8)				\$	11,358	11,358			
VI. Total All Revenue (III + V)				\$	15,649,163	15,649,163			

* 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	\$ 3,167		
	Lab Medicare CA	\$ (3,167)		
	Oxygen Medicare	\$ 191		
	Oxygen Medicare CA	\$ (191)		
	Equipment rental	\$ 821		
	Equipment rental CA	\$ (821)		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds Medicare	\$ -		
	Therapy Beds Medicare CA	\$ -		
	Radiology Medicare	\$ 713		
	Radiology Medicare CA	\$ (713)		
	IV Therapy	\$ 109		
	IV Therapy CA	\$ (109)		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose testing	\$ -		
	Glucose testing CA	\$ -		
	Outpatient therapy Medicare	\$ -		
	Total Other Resident Revenues - Medicare	\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Lab	9,047.39		
	Lab CA	(9,047.39)		
	Oxygen	\$ 980		\$ -
	Oxygen CA	\$ (980)		\$ -
	Equipment rental	\$ 10,127		
	Equipment rental CA	\$ (10,127)		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds	\$ -		
	Therapy Beds CA	\$ -		
	Radiology	\$ 2,733		
	Radiology CA	\$ (2,733)		
	Medical Transportation	\$ 14,367		
	Medical Transportation CA	\$ (14,367)		
	Glucose Testing	\$ -		
	Glucose Testing CA	\$ -		
	IV therapy	\$ 436		\$ -
	IV therapy CA	\$ (436)		\$ -
	Flu shot revenue	\$ 3,672		
	Outpatient therapy	\$ -		
	Outpatient therapy CA	\$ -		
	prior period revenue	\$ 116,760		
	Ophun B	\$ 113,367		
	Ophun B CA	\$ (33,867)		
	CIA VBP	\$ 246		
	rounding	\$ -		
	Total Other Resident Revenue	\$ 209,177	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	INTEREST INCOME		\$ 229		
	Total Interest Income		\$ 229	\$ -	\$ -

Schedule of Other Revenues

Page Ref	Description	CCNH	RHNS	(Specify)
	MEALS	\$ -		
	TELEVISION INCOME	\$ -		
	CONCESSIONS / VENDING INCOME	\$ 209		
	RESIDENT LATH FEE REVENUE	\$ -		
	RESIDENT ATTORNEY FEE REVENUE	\$ -		
	TELEPHONE INCOME	\$ -		
	OTHER INCOME	\$ 155		
	OPTUM DIVIDENDS REVENUE	\$ 8,225		
	OPTUM OUTLIERS	\$ 2,540		
	OTHER INCOME- DEFERRED REVENUE	\$ -		
	ALL DMHAS REVENUE	\$ -		
	Total Other Revenue	\$ 11,130	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2019	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	(27)
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,410,792
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	820,078
a. Prepaid Insurance	780,685			
b. Prepaid Property Taxes	37,982			
c. Prepaid Expenses Other	1,411			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	(569,799)
Due From (to) Related Parties	(17,853)			
Other Owners reserves	(551,945)			
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	2,661,045
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost 416,163		\$	315,593
	Accum. Depreciation 100,570	Net		
4. Leasehold Improvements	*Historical Cost 754,915		\$	325,348
	Accum. Depreciation 429,568	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost 891,351		\$	213,550
	Accum. Depreciation 677,802	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
Construction in Progress				
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	854,490

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

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 Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2019	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$ 3,515,535	
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				
\$ 338,904				
3. Organization Expense				
		*Historical Cost		
		Accum. Depreciation	Net	
\$				
4. Goodwill (Purchased Only)				
\$				
5. Investments Related to Resident Care (<i>itemize</i>)				
			81,845	\$ 84,400
		Long Term Deposit - primecare	2,555	
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)				
\$ 423,304				
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)				
\$ 3,938,839				

* 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 Meriden Care Center, LLC		License No. 2448	Report for Year Ended 9/30/2019	Page 34	of 37
Account				Amount	
				Total Brought Forward:	
				3,187,644	
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 Funds		81,845			
See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 81,845	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 3,269,490	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	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			\$	25,000
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(277,074)
6. Gain or Loss for Period			\$	921,423
	10/1/2018	thru 9/30/2019		
7. Total Net Worth			\$	669,349
C. Total Reserves and Net Worth			\$	669,349
D. Total Liabilities, Reserves, and Net Worth			\$	3,938,839

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	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>)			\$	15,649,163
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	14,727,740
D. Net Income or Deficit			\$	921,423
E. Balance			\$	921,423
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>			\$	921,423
09/30/19				

I. Preparer's/Reviewer's Certification

Name of Facility Meriden Care Center, LLC	License No. 2448	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				
iCare Management, LLC				
Address Address			Phone Number	
341 Bidwell Street, Manchester, CT 06040			860-570-2140	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Contact Email Address				