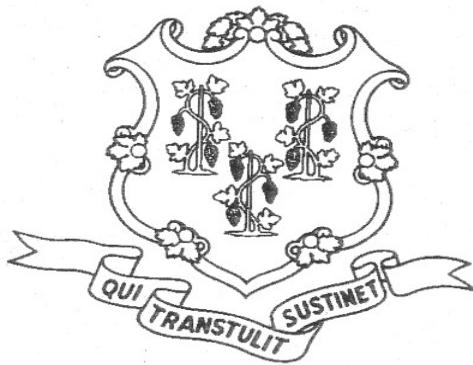


State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2020

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

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 9/30/2020	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 Meriden Care Center, 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) Raymond Hackling		Printed Name (Owner) Chris Wright		
Subscribed and Sworn to before me:	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 10/1/2019	To 9/30/2020
Address of Facility 33 Roy St. Meriden, CT 06450			
Report Prepared By iCare Management, LLC	Phone Number 860-570-2140	Date 2/15/2021	
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	Report for Year Ended	Page	of
203-237-8457	9/30/2020	2	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 <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> 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?		○ Yes	◎ No	If "Yes," explain fully.

Administrator

Name of Administrator Raymond Hackling	Nursing Home Administrator's License No.:	000853
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Other Operators/Owners who are assistant administrators (full or part time) of this facility.	
Name	License No.:

State of Connecticut

Annual Report of Long-Term Care Facility

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General Information and Questionnaire
Partners/Members

Name of Facility Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2020	Page of 3 37
Legal Name of Partnership/LLC		Business Address	State(s) and/or Town(s) in Which Registered
Meriden Care Center, LLC		33 Roy St. Meriden, CT 06450	CT
Name of Partners/Members	Business Address	Title	% Owned
Executive Advisors, LLC	341 Bidwell St. Manchester, CT 06040	Member	47.5
Apex Advisors LLC	341 Bidwell St. Manchester, CT 06040	Member	47.5
Christopher Wright	341 Bidwell St. Manchester, CT 06040	Member	5

General Information and Questionnaire

Corporate Owners

Name of Facility Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2020	Page 3A	of 37
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If this facility is owned or operated as a corporation, provide the following information:

General Information and Questionnaire

Individual Proprietorship

Name of Facility Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2020	Page 3B	of 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

General Information and Questionnaire

Related Parties*

Name of Facility Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2020			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.				
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?				<input checked="" type="radio"/> Yes <input type="radio"/> No If "Yes," provide the following information:				
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
See Attached		<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.

Related Parties*

Name of Facility Meriden Care Center, LLC		License No. 2448		Report for Year Ended 9/30/2020				Page 4	of 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		Cost Reported	Actual Cost to the Related Party
		Yes	No	%**		Page # / Line #			
Bidwell Care Center, LLC	333 Bidwell St. Manchester, CT 06040				Shared Employees			(2,626)	2,626
Chelsea Place Care Center, LLC	25 Lorraine St. Hartford, CT 06105				Shared Employees			(3,969)	3,969
Chestnut Point Care Center, LLC	171 Main St. East Windsor, CT 06088				Shared Employees			(1,018)	1,018
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032				Shared Employees			(832)	832
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088				Shared Employees			(1,979)	1,979
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			23,923	(23,923)
Westside Care Center, LLC	349 Bidwell St. Manchester, CT 06040				Shared Employees			(2,748)	2,748
Wintonbury Care Center, LLC	140 Park Ave. Bloomfield, CT 06002				Shared Employees			(5,119)	5,119
Secure Care Center LLC	60 West Street, Rocky Hill, CT 06067				Shared Employees			6,743	(6,743)
Universal Healthcare Holdings, LLC	5 Greenwood Street, Hartford, CT 06106				Shared Employees			(1,050)	1,050
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	13 5,8,10		303,129	(303,129)
Realty	N/A				Workers Comp Direct Treatments				
iCare Management, LLC	341 Bidwell St. Manchester, CT 06040				Building Lease & Rent	22,22,27	10,9,14		-
iCare Health Management, LLC	341 Bidwell St. Manchester, CT 06040				iCare Helt-Legal, Postage, Emp Recruitment & Marketing, Equipment Rental	16, 15, 22	M,E, 6f	9,954	(9,954)
					Shared EEs not part of mgmt agmt			237,945	(237,945)
					Management Services, Direct	20 5j		189,720	(189,720)
					Management Services, Indirect	20 5j		37,599	(37,599)
					Management Services, Administrative	16 M12		446,574	(446,574)
All Care Centers, mgmt co, realty 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 9/30/2020	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 9/30/2020			Page 6	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers			Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
		Yes	No					
Accelerated Care Plus Corp. Joule Street, Suite A-1	4850 Reno, NV	<input type="radio"/>	<input checked="" type="radio"/>	Omnistim Electrotherapy and Omnisound Therapeutic Ultrasound Equipment	05/18/10	automatic annual	4,701	4,701
ADP, Inc., One ADP Drive MS-100, Augusta, GA 30909		<input type="radio"/>	<input checked="" type="radio"/>	Time Clocks and Payroll Punch Equip	06/01/10	automatic renewals	8,272	8,272
Mail Finance/Neopost New England, 25881 Newtwork Place, Chicago, IL 60673		<input type="radio"/>	<input checked="" type="radio"/>	Postage Meter Rental		Monthly	513	513
CIT Finance LLC		<input type="radio"/>	<input checked="" type="radio"/>	Copier		41949	23,276	23,276
		<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 ***	36,761

* 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 Meriden Care Center, LLC	License No. 2448	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?

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1	Taxes, financial statements, accounting support	\$	8,379
2		\$	
3		\$	
4		\$	
		Charge for Services Provided	
		\$	8,379

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

- Yes No 15D

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 iCare Health Management, LLC	860-570-2140
2 Starble and Harris	860-678-7775
3 Durant Nichols / Robinson & Cole, LLP	860-275-8200
4 Various others (American Arbitration , Various Arbitration, Murtha Cullina,Jackson Lewis))	
5 Starble and Harris, iCare Health Management LLC	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 (*describe fully*)

1	Lease and contract issues, general legal advice, Labor Law	\$	3,478
2	Lease and contract issues, general legal advice, union funds advice	\$	
3	Employment law, arbitrations, contract negotiations	\$	7,237
4	Employment Arbitrations, healthcare law & Conservatorships	\$	3,636
5	Collections	\$	276
		Charge for Services Provided	
		\$	14,627

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

- Yes No

Schedule of Resident Statistics

Name of Facility Meriden Care Center, LLC			License No. 2448			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					159	159						
A. On last day of PREVIOUS report period	159	159										
B. On last day of THIS report period	159	159							159	159		
2. Number of Residents					154	154						
A. As of midnight of PREVIOUS report period	154	154										
B. As of midnight of THIS report period	145	145							145	145		
3. Total Number of Days Care Provided During Period					1,634	1,634						
A. Medicare	2,067	2,067							433	433		
B. Medicaid (Conn.)	46,655	46,655			35,079	35,079			11,576	11,576		
C. Medicaid (other states)												
D. Private Pay	411	411			334	334			77	77		
E. State SSI for RCH												
F. Other (Specify) Insurance	5,672	5,672			4,358	4,358			1,314	1,314		
G. Total Care Days During Period (3A thru F)	54,805	54,805			41,405	41,405			13,400	13,400		
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)	54,805	54,805			41,405	41,405			13,400	13,400		

Schedule of Resident Statistics (Cont'd)

Name of Facility Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2020	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)					

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			
1st change						
2nd change						
3rd change						
4th change						

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	4	126		15				
Per Diem Rate								
a. One bed rm.	643.00	253.00		347.00				
b. Two bed rms.								
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B		TOTAL	CCNH	RHNS	(Specify)
		2,089	2,089		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments		831	831		
2. Restorative Treatments		1,715	1,715		
C. Other		4,934	4,934		
D. Total Physical Therapy Treatments		9,569	9,569		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		253	253	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments		227	227	
2. Restorative Treatments		91	91	
C. Other		511	511	
D. Total Speech Therapy Treatments		1,082	1,082	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		1,705	1,705	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments		633	633	
2. Restorative Treatments		1,638	1,638	
C. Other		4,361	4,361	
D. Total Occupational Therapy Treatments		8,337	8,337	

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2020		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
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	165,419	2,091			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	219,445	9,765			
5. Dietary Service					
a. Head Dietitian	12,438	276			
b. Food Service Supervisor	60,074	2,091			
c. Dietary Workers	545,829	29,364			
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers					
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	62,398	2,028			
b. Other Maintenance Workers	49,041	2,203			
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	203,989	3,695			
b. RN					
1. Direct Care	545,999	10,347			
2. Administrative**	322,482	8,218			
c. LPN					
1. Direct Care	1,523,137	46,934			
2. Administrative**					
d. Aides and Attendants	2,294,773	121,379			
e. Physical Therapists					
f. Speech Therapists					
g. Occupational Therapists					
h. Recreation Workers	177,395	8,631			
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	211,487	6,119			
n. Marketing					
o. Other (Specify)					
See Attached Schedule	33,965	2,129			
<i>A-13. Total Salary Expenditures</i>	<i>6,427,870</i>	<i>255,273</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)

Schedule of Other Fees (Page 13)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

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

Name of Facility Meriden Care Center, LLC			License No. 2448		Report for Year Ended 9/30/2020			Page 11	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

State of Connecticut

Annual Report of Long-Term Care Facility

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page of	
Meriden Care Center, LLC				2448		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***										
Raymond Hackling	165,419			same as employees less union funds	Administrator	2,091	A2			
				same as employees less union funds	Administrator		A2			
				same as employees less union funds	Administrator		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 Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2020		Page 13	of 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	32,676	327			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	159,756	3,060			
b. Other					
6. Social Worker	13,650	186			
7. Recreation Worker	15,718	35+Cable			35+Cable
8. Physicians					
a. Medical Director (entire facility)	36,000	240			
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	9,211	48			
9. Speech Therapist					
a. Resident Care	26,399	506			
b. Other					
10. Occupational Therapist					
a. Resident Care	116,974	2,241			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	103,170	565			
2. Administrative***	(7,532)	(322)			
b. LPN					
1. Direct Care	64,528	986			
2. Administrative***					
c. Aides	136,523	2,060			
d. Other					
12. Other (Specify)					
See Attached Schedule	236,656	6,638			
B-13 Total Fees Paid in Lieu of Salaries	943,729	16,535			

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

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

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

Report of Expenditures

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

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2020		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	212,054	212,054		
2. Disability Insurance	\$				
3. Unemployment Insurance	\$				
4. Social Security (F.I.C.A.)	\$	538,878	538,878		
5. Health Insurance	\$	1,157,748	1,157,748		
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$	367,336	367,336		
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$	45,039	45,039		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$	45,910	45,910		
d. Accounting and Auditing	\$	8,379	8,379		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$	14,627	14,627		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$	19,175	19,175		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	26,281	26,281		
2. Cellular Phones	\$	1,465	1,465		
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	\$	1,106,955	1,106,955		
Subtotal	\$	3,543,846	3,543,846		

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

(Carry Subtotals forward to next page)

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

Attachment Page 15

Schedule of Other Employee Benefits

Schedule of Other Taxes

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

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

Name of Facility Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2020		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
	<i>Subtotals Brought Forward:</i>	3,543,846	3,543,846		
I. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	1,405	1,405		
3. Gifts to Staff and Residents	\$	300	300		
4. Employee Travel	\$	3,792	3,792		
5. Education Expenses Related to Seminars and Conventions	\$	1,854	1,854		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	239	239		
7. Other (<i>Specify</i>) See Attached Schedule	\$	2,047	2,047		
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	12,951	12,951		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	17,437	17,437		
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	\$	6,045	6,045		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	10,769	10,769		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	350	350		
10. Contributions*** See Attached Schedule	\$	1,511	1,511		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	136,126	136,126		
12. Administrative Management Services**	\$	446,574	446,574		
13. Other (<i>Specify</i>) See Attached Schedule	\$	18,455	18,455		
C-14 Total Administrative & General Expenditures	\$	4,203,704	4,203,704		

* 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	\$ 2,047		\$ -
Total Other Travel and Entertainment	\$ 2,047	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
COMMUNICATIONS SPECIAL EVENTS	\$ 17,437		\$ -
Total Other Advertising	\$ 17,437	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
ALTCFM			
CAHCF Dues	\$ 10,609		\$ -
OTHER DUES	\$ 160		\$ -
Total Dues	\$ 10,769	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
CONTRIBUTIONS	\$ 1,511		\$ -
Total Contributions	\$ 1,511	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
SOCIAL SERVICE SUPPLIES	\$ 69		\$ -
SOC SVC MINOR EQUIPMENT	\$ -		\$ -
ADMINISTRATIVE MINOR EQUIPMENT	\$ 432		\$ -
EMPLOYEE RELATIONS	\$ 909		\$ -
EMPLOYEE RELATIONS-OTHER	\$ 149		\$ -
PERMITS & LICENSES	\$ 1,961		\$ -
VOLUNTEER EXPENSE	\$ -		\$ -
BANK FEES	\$ 3,545		\$ -
CMS REVISIT USER FEES	\$ -		\$ -
PENALTIES	\$ 8,419		\$ -
LATE FEES	\$ 785		\$ -
INTERNET EXPENSES	\$ 2,187		\$ -
Rounding	\$ -		
Total Other Administrative and General	\$ 18,455	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2020	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
iCare Management, LLC/iCare Health Management, LLC	446,574	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	189,720	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	37,599	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	License No.	Report for Year Ended		Page of
		9/30/2020		18 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 374,284	374,284		
2. Non-Food Supplies	\$ 47,238	47,238		
3. Other (Specify) _____ DIETARY SUPPLEMENTS	\$ 12,244	12,244		
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 23,966	23,966		
c. Other (Specify) _____ DIETARY MINOR EQUIPMENT	\$ 6,796	6,796		
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 464,530	464,530		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	450	450		
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 9/30/2020		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. \$	1,098	1,098		
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. \$				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. \$				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. \$				
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$	426,654	426,654		
c. Other (Specify) LAUNDRY MINOR EQUIPMENT	\$	135	135		
3D. Total Laundry Expenditures (3a + b + c)	\$	427,888	427,888		
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 Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2020		Page 20	of 37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 39,972	39,972		
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)					
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel				
	Amt.	\$ 514,116	514,116		
C. Other (<i>Specify</i>)	\$				
HOUSEKEEPING MINOR EQUIPMENT					
4D. Total Housekeeping Expenditures (4a + b + c)	\$	554,088	554,088		
5. Resident Care (Supplies)**					
a. Prescription Drugs***	\$				
1. Own Pharmacy	\$				
2. Purchased from PHARMACY	\$	227,215	227,215		
b. Medicine Cabinet Drugs	\$	3,231	3,231		
c. Medical and Therapeutic Supplies	\$	143,860	143,860		
d. Ambulance/Limousine***	\$				
e. Oxygen	\$				
1. For Emergency Use	\$	4,024	4,024		
2. Other***	\$				
f. X-rays and Related Radiological Procedures***	\$	3,803	3,803		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	25,772	25,772		
i. Recreation	\$				
j. Direct Management Services*	\$	189,720	189,720		
k. Indirect Management Services*	\$	37,599	37,599		
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	148,997	148,997		
5M. Total Resident Care Expenditures (5a - 5j)	\$	784,221	784,221		

* 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	\$ 54,101		\$ -
NURSING MINOR EQUIP	\$ 3,398		\$ -
MEDICAL RECORDS SUPPLIES	\$ 2,298		\$ -
MEDICAL RECORDS MINOR EQUIPMENT	\$ -		\$ -
			\$ -
NON-COVERED PPS DR. VISITS	\$ 8,779		\$ -
RESIDENT CARE SUPPLIES	\$ 283		\$ -
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 18,377		\$ -
PERSONAL CARE SUPPLIES	\$ 99		\$ -
INCONTINENCY SUPPLIES	\$ -		\$ -
VACCINE RESIDENTS	\$ 19		\$ -
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	\$ 13		\$ -
SPEECH THERAPY SUPPLIES	\$ -		\$ -
SPEECH THERAPY EQUIPMENT RENT	\$ -		\$ -
SPEECH THERAPY MINOR EQUIPMENT	\$ -		\$ -
RENTALS FOR NURSING EQUIPMENT NON BILLABLE	\$ 32,644		\$ -
EQUIPMENT RENTAL: AIDS UNIT	\$ -		\$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ -		\$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ 391		\$ -
HI LOW BED RENTAL & MATTRESSES	\$ 272		\$ -
IV THERAPY SUPPLIES	\$ 6,028		\$ -
IV THERAPY CONTRACT SERVICE	\$ -		\$ -
MEDICAL WASTE CONTRACT SERVICE	\$ 1,042		\$ -
ACTIVITIES SUPPLIES	\$ 9,462		\$ -
ACTIVITIES MINOR EQUIPMENT	\$ -		\$ -
			\$ -
ADMISSIONS SUPPLIES	\$ -		\$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$ 11,791		\$ -
STRIKE COSTS NON REIMBURSABLE	\$ -		\$ -
COVID NON REIMBURSABLE	\$ -		\$ -
Total Other Resident Care	\$ 148,997	\$ -	\$ -

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 9/30/2020				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"/>	VENDOR	Housekeeping Services	469,549			20	4b
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Laundry Services	426,658			19	3b
Eagle Elevator		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Elevator Contract	9,189			22	6F
Bioserve, Inc.		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Medical Waste	1,042			22	6F
Brightview Landscapes LLC/Amaya Landscaping LLC		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Snow Removal/Landscaping	29,975			22	6F
CWPM LLC		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Trash removal	49,212			22	6F
American HealthTech		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Software Maintenance Contract	15,730			16	M11
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Payroll Services	44,491			16	M11
National Datacare Corp		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Resident Trust Software	3,901			16	M11
Prime Care Technology services		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Computer Consulting Services	38,689			16	M11
Priotiry Express		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Courier Services	3,292			16	M11
Point Right Inc		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Nursing Software	4,680			16	M11
Facility Complain		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Plant Contract Services				22	6F
		<input type="radio"/>	<input checked="" type="radio"/>	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 Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2020			Page 22 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 38,569	38,569			
b. Heat	\$ 28,571	28,571			
c. Light & Power	\$ 117,102	117,102			
d. Water	\$ 61,388	61,388			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 36,761	36,761			
f. Other (<i>itemize</i>)	\$ 146,739	146,739			
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 429,129	429,129			
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	\$ 70,394	70,394			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 93,617	93,617			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)					
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$ 45,435	45,435			
d. Other (<i>Specify</i>)	\$				
*8e. Total Amortization Costs (8a + b + c + d)	\$ 45,435	45,435			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 587,010	587,010			
10. Property Taxes					
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$ 152,239	152,239			
c. Personal property taxes	\$ 13,556	13,556			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 891,858	891,858			

* 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	\$ 11,570		\$ -
PLANT CONTRACT SERVICE LABOR	\$ -		\$ -
ELEVATOR CONTRACT SERVICE	\$ 9,189		\$ -
FIRE/SPRINKLER CONTRACT SERVICE	\$ 2,324		\$ -
LANDSCAPING CONTRACT SERVICE	\$ 8,705		\$ -
SNOW REMOVAL CONTRACT SERVICE	\$ 21,270		\$ -
TRASH REMOVAL CONTRACT SERVICE	\$ 49,212		\$ -
HVAC CONTRACT SERVICE	\$ -		\$ -
SECURITY CONTRACT SERVICE	\$ -		\$ -
PLANT CONTRACT SERVICE OTHER	\$ 37,422		\$ -
PLANT MINOR EQUIPMENT	\$ 6,858		\$ -
RENT AUTO	\$ -		\$ -
RENT EQUIPMENT	\$ 189		\$ -
RENT OTHER	\$ -		\$ -
Total Other Repairs and Maintenance	\$ 146,739	\$ -	\$ -

Depreciation Schedule

Schedule of Land Improvements Acquired during this report period

***Ties to Page 23, Line A3**

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

***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:				
10/11/2019	Patient Lifter: Direct Supply inv# 27498001	\$ 3,704	60	\$ 679
10/30/2019	Electric Beds and Mattresses Medline	\$ 15,283	60	\$ 2,802
1/9/2020	Excercise Trainer: Medline	\$ 8,208	120	\$ 547
1/17/2020	Diathermy Equipment: Medline	\$ 10,529	120	\$ 702
2/17/2020	Ice Cuber: Direct Supply	\$ 2,656	120	\$ 155
2/12/2020	Bed: Medline	\$ 18,339	60	\$ 2,140
3/27/2020	Bed, Board, Head, Mattress: Medline	\$ 35,211	60	\$ 3,521
6/25/2020	Mattress: Direct Supply	\$ 4,395	60	\$ 220
10/30/2019	Wifi Install: Primecare Technologies	\$ 2,548	36	\$ 779
12/31/2019	Laptop Purchase: Primecare	\$ 4,965	36	\$ 1,241
2/29/2020	Laptop Purchase: Primecare	\$ 3,741	36	\$ 727
7/31/2020	Wifi & Firewall upgraded: Prime Care	\$ 3,375	36	\$ 188
Total additions for Movable Equipment		\$ 112,953		\$ 13,700 *
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

Amortization Schedule*

Name of Facility Meriden Care Center, LLC			License No. 2448		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.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period				754,915	429,568			42,121	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				94,576				3,315	
C-4. Subtotal									45,435
D. Total Amortization									45,435

* 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 9/30/2020	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.																				
<p>*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.</p>																								
<table border="1"> <thead> <tr> <th>Description</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>1. Date Land Purchased</td> <td>12/01/03</td> </tr> <tr> <td>2. Date Structure Completed</td> <td></td> </tr> <tr> <td>3. If NOT Original Owner, Date of Purchase</td> <td></td> </tr> <tr> <td>4. Date of Initial Licensure</td> <td>12/01/03</td> </tr> <tr> <td>5. Total Licensed Bed Capacity</td> <td>159</td> </tr> <tr> <td>6. Square Footage</td> <td>65,790</td> </tr> <tr> <td>7. Acquisition Cost</td> <td></td> </tr> <tr> <td> a. Land</td> <td></td> </tr> <tr> <td> b. Building</td> <td></td> </tr> </tbody> </table>		Description	Total	1. Date Land Purchased	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				
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	15 years with year extensor	\$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	License No.	Report for Year Ended 9/30/2020			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 9/30/2020			Page 27	of 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)		\$	9,340	9,340		
INTEREST						
13. Total All Interest Expense (12B7 + 12C3 + 12D)		\$	9,340	9,340		
14. Insurance						
a. Insurance on Property (buildings only)		\$	10,984	10,984		
b. Insurance on Automobiles		\$				
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$	70,735	70,735		
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$	8,789	8,789		
Other insurance, crime						
14d. Total Insurance Expenditures (14a + b + c)		\$	90,508	90,508		
15. Total All Expenditures (A-13 thru C-14)		\$	15,226,864	15,226,864		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of	
Item No.	Page No.	Line No.		2448	9/30/2020	28 37	
			Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<i>Page 10 - Salaries and Wages</i>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
<i>Page 13 - Professional Fees</i>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<i>Pages 15 & 16 - Administrative and General</i>							
8.			Discriminatory Benefits	\$			
9.	15	c	Bad Debts	\$ 45,910	45,910		
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 *	\$ 17,437	17,437		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 9,203	9,203		
<i>Page 18 - Dietary Expenditures</i>							
24.			Meals to employees, guests and others who are not residents	\$			
<i>Page 19 - Laundry Expenditures</i>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<i>Page 20 - Housekeeping Expenditures</i>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$ 72,550	\$ 72,550			

* 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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16a		PENALTIES	\$ 8,419		\$ -
16a		LATE FEES	\$ 785		\$ -
16a		PRIOR PERIOD EXPENSES			
		rounding			
		Provider User Fee for Medicare days	\$ -		\$ -
Total Other A&G Adjustments			\$ 9,203	\$ -	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-29 Rev. 9/2018

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

Name of Facility			License No.	Report for Year Ended		Page	of
Item No.	Page No.	Line No.	2448	9/30/2020		29	37
Item Description				Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 72,550	72,550		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$			
28.	20	5d	Ambulance/Limousine	\$			
29.	20	5f	X-rays, etc	\$ 3,803	3,803		
30.	20	5h	Laboratory	\$ 25,772	25,772		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 8,779	8,779		
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)		\$ 110,903		110,903		

*** 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

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Schedule of Other - Indirect Adjustments

Attachment Page 29

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

Schedule of Other - Direct Adjustments

Schedule of Unallowable Building Interest

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended 9/30/2020			Page 30	of 37
		Item	Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$	11,797,474	11,797,474			
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>)	\$	1,405,276	1,405,276			
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$	2,127,354	2,127,354			
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$	63,989	63,989			
b. Prescription Drugs - Medicare Contractual Allowance **	\$	(63,989)	(63,989)			
c. Prescription Drugs - Non-Medicare	\$	497,508	497,508			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$	(497,508)	(497,508)			
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	\$	134,526	134,526			
b. Physical Therapy - Medicare Contractual Allowance **	\$	(89,475)	(89,475)			
c. Physical Therapy - Non-Medicare	\$	139,927	139,927			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$	(139,927)	(139,927)			
4. a. Speech Therapy - Medicare	\$	21,164	21,164			
b. Speech Therapy - Medicare Contractual Allowance **	\$	(15,075)	(15,075)			
c. Speech Therapy - Non-Medicare	\$	33,346	33,346			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$	(33,346)	(33,346)			
5. a. Occupational Therapy - Medicare	\$	123,392	123,392			
b. Occupational Therapy - Medicare Contractual Allowance **	\$	(91,651)	(91,651)			
c. Occupational Therapy - Non-Medicare	\$	129,837	129,837			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$	171,160	171,160			
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$	135,088	135,088			
III. Total Resident Revenue (Section I. thru Section II.)		\$ 15,849,070	15,849,070			
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$	6,550	6,550			
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$	706,137	706,137			
V. Total Other Revenue (1 thru 8)		\$ 712,688	712,688			
VI. Total All Revenue (III +V)		\$ 16,561,758	16,561,758			

* 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	\$ 6,888		
	Lab Medicare CA	\$ (6,888)		
	Oxygen Medicare	\$ 190		
	Oxygen Medicare CA	\$ (190)		
	Equipment rental	\$ 930		
	Equipment rental CA	\$ (930)		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds Medicare	\$ -		
	Therapy Beds Medicare CA	\$ -		
	Radiology Medicare	\$ 1,864		
	Radiology Medicare CA	\$ (1,864)		
	IV Therapy	\$ 1,600		
	IV Therapy CA	\$ (1,600)		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose testing	\$ -		
	Glucose testing CA	\$ -		
	Outpatient therapy Medicare	\$ -		
	Total Other Resident Revenue - Medicare	\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Lab	17,029		
	Lab CA	(17,029)		
	Oxygen	\$ 1,035	\$ -	
	Oxygen CA	\$ (1,035)	\$ -	
	Equipment rental	\$ 8,819		
	Equipment rental CA	\$ (8,819)		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds	\$ -		
	Therapy Beds CA	\$ -		
	Radiology	\$ 2,380		
	Radiology CA	\$ (2,380)		
	Medical Transportation	\$ 7,456		
	Medical Transportation CA	\$ (7,456)		
	Glucose Testing	\$ -		
	Glucose Testing CA	\$ -		
	IV therapy	\$ 195	\$ -	
	IV therapy CA	\$ (195)	\$ -	
	Flu shot revenue	\$ -		
	Outpatient therapy	\$ -		
	prior period revenue	\$ 26,457		
	Optum B	\$ 200,284		
	Optum B CA	\$ (72,684)		
	C/A VBP	\$ (18,970)		
	rounding	\$ 1		
	Total Other Resident Revenue	\$ 135,088	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	INTEREST INCOME	\$ 6,550			
	Total Interest Income	\$ 6,550	\$ -	\$ -	

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	MEALS	\$ -		
	TELEVISION INCOME	\$ -		
	OTHER INCOME: DMHAS OPERATING REVENUE	\$ -		
	OTHER INCOME: DMHAS ORGANIZATIONAL REV	\$ -		
	OTHER INCOME: DEFERRED REVENUE	\$ -		
	MEDICARE COVID STIMULUS REVENUE	\$ -		
	MEDICAID COVID REVENUE	\$ 660,810		
	CONCESSIONS / VENDING INCOME	\$ -		
	RESIDENT LATE FEE REVENUE	\$ -		
	RESIDENT ATTORNEY FEE REVENUE	\$ -		
	TELEPHONE INCOME	\$ -		
	OTHER INCOME	\$ 501		
	OPTUM DIVIDENDS REVENUE	\$ 44,826		
	OPTUM OUTLIERS	\$ -		
	Total Other Revenue	\$ 706,137	\$ -	\$ -

G. Balance Sheet

Name of Facility Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2020	Page 31	of 37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$ 4,382,144	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 2,416,172	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$ 144,473	
a. _____		103,911		
b. _____		38,294		
c. _____		2,267		
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$ (1,811,645)	
		3,810		
		(1,815,454)		
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$ 5,131,144	
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	Accum. Depreciation	Net	\$
3. Buildings	*Historical Cost	416,163		\$ 292,370
	Accum. Depreciation	123,793	Net	
4. Leasehold Improvements	*Historical Cost	849,492		\$ 374,489
	Accum. Depreciation	475,003	Net	
5. Non-Movable Equipment	*Historical Cost	Accum. Depreciation	Net	\$
6. Movable Equipment	*Historical Cost	1,004,304		\$ 256,109
	Accum. Depreciation	748,195	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)			\$ 922,967	

* 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

Page Ref	Line Ref	Description	
Total Prepaid Expenses			\$ -

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

Page Ref Line Ref Description

Total Other Current Assets (Itemize)		\$ -

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

Page Ref Line Ref Description

Total Other Other Fixed Assets (Itemize)		\$	-

Schedule of Other Assets Page 32 Line D7

Page Ref Line Ref Description

Total Other Assets		\$	-

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref Line Ref Description

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

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

Page Ref Line Ref Description

Total Other Current Liabilities (Itemize)		\$ -

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

Page Ref Line Ref Description

Total Other Current Liabilities (Itemize)		\$	-

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Meriden Care Center, LLC	2448	9/30/2020	32 37
Account	Amount		
	Total Brought Forward:		
			\$ 6,054,111
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			\$ 427,570
3. Organization Expense	*Historical Cost	Accum. Depreciation	Net
4. Goodwill (Purchased Only)			\$
5. Investments Related to Resident Care (<i>itemize</i>)			\$ 165,895
Patient Trust Funds	163,340		
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)			\$ 593,465
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 6,647,576

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of		
Meriden Care Center, LLC	2448	9/30/2020	33	37		
Liabilities	Account	Amount				
A. Current Liabilities						
1. Trade Accounts Payable						
2. Notes Payable (<i>itemize</i>) Working Capital Line of Credit						
See Schedule						
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)						
Name of Lender	Purpose	Amount	Date Due			
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)						
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)						
6. Accrued Payroll Taxes Payable						
7. Medicare Final Settlement Payable						
8. Medicare Current Financing Payable						
9. Mortgage Payable (<i>Current Portion</i>)						
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)						
11. Accrued Income Taxes*						
12. Other Current Liabilities (<i>itemize</i>)						
Related Party Payables						
Accrued Expenses						
Accrued Resident User Fees						
Accrued Workers Comp Expense						
A-13. Total Current Liabilities (Lines A1 thru 12)						

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2020	Page 34	of 37
Account				Amount
Total Brought Forward:				4,562,084
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>)				\$ 163,340
Patient Trust Funds				163,340
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 163,340
C. Total All Liabilities (Lines A-13 + B-5)				\$ 4,725,424

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	9/30/2020	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				\$ 25,000
2. Capital Stock				\$
3. Paid-in Surplus				\$
4. Treasury Stock				\$
5. Cumulated Earnings				\$ 562,258
6. Gain or Loss for Period	10/1/2019	thru	9/30/2020	\$ 1,334,894
7. Total Net Worth				\$ 1,922,152
C. Total Reserves and Net Worth				\$ 1,922,152
D. Total Liabilities, Reserves, and Net Worth				\$ 6,647,576

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Meriden Care Center, LLC	2448	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>)				\$ 16,561,758		
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 15,226,864		
D. Net Income or Deficit				\$ 1,334,894		
E. Balance				\$ 1,334,894		
F. Additions						
1. Additional Capital Contributed (<i>itemize</i>)						
2. Other (<i>itemize</i>)						
F-3. Total Additions				\$		
G. Deductions						
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)				\$		
Name and Address (No., City, State, Zip)		Title	Amount			
2. Other Withdrawings (<i>Specify</i>)				\$		
Purpose		Amount				
3. Total Deductions				\$		
H. Balance at End of Period				\$ 1,334,894		

I. Preparer's/Reviewer's Certification

Name of Facility Meriden Care Center, LLC	License No. 2448	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

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

Signature of Preparer	Title	Date Signed
Printed Name of Preparer		
iCare Management, LLC		
Address Address 341 Bidwell Street, Manchester, CT 06040		Phone Number 860-570-2140
Contacted Person Regarding Additional Information Needed Regarding This Report Kartik Patel		Phone Number 860-570-2140
Contact Email Address Kpatel@icarehn.com		