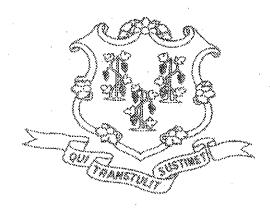
State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2018

Name of Facility (as li	icensed)						
Meriden Care Center,	LLC						
Address (No. & Stree	t, City, State, Zi	p Code)					
33 Roy St. Meriden, (CT 06450						
Type of Facility							
Chronic and Control Nursing Home	onvalescent e only (CCNH)	☑	Rest Home with Supervision onl (RHNS)	_	☑ Other		
Report for Year Begu	nning		Report for Year	Ending			
10/1/2017	J		9/30/2018				
License Numbers:		CCNH 2153-C	RHNS		Other	Me	dicare Provider 07-5337
Medicaid Provider N	umbers:	CO	CNH	RF	INS	IC:	F-IID
Tredicate Frontier 11	uinosis.	10660	I		934		
For Department Use	e Only						
Sequence Number Assigned	Signed and Notarized	Date Received	Sequence N Assign		Signed and Nota	rized	Date Received
					1		

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2153-C	9/30/2018	1	37

Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISIONMENT 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, 2017 and ending September 30, 2018, 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.

				1		
Signed (Administrator)		Date	Signed (Owner)	1. 11	Date	
			Thin A.W.	uall	2/13/19	
Printed Name (Administrator)			Printed Name (Owner)	1		
Raymond Hackling			Chris Wright		7	
Subscribed and Sworn	State of	Date	Signed (Notary Public)	The state of the second st	Comm. Expires	den en e
to before me: //4 //	en	0/01		Notary	BRENDA WALSH Public-Connecti	Armadille
Branda Walsh	C/	12/19/19	I PALALA (Val)		ommission Expire	
Address of Notary Public		, ,		Fe	:bruary 29, 2020	
- -	- / A.			A STATE OF THE PROPERTY OF THE		
341 Bidwill	St., Ma	nonesta	r, (1 06041)	7		

(Notary Seal)

CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2153-C	9/30/2018	11	37

Administrator's/Owner's Certification

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Signed (Administrator)		Date	Signed (Owner)	Date	
	~	02-11-19			
Printed Name (Administrator)			Printed Name (Owner)		
Raymond Hackling			Chris Wright		
·				SANDRA M. H	OLLIS
Subscribed and Sworn	State of	Date	Signed (Notary Public)	MY COMMISSION EXPIRES A	LIC DD 20 2010
to before me:	CT	02-11-19	adunter	/ /	rn. 30, 2013
Address of Notary Public					
341 BIDWELL, S	NSST N	MUNTEST	FR CT (1002	4 0	

(Notary Seal)

Table of Contents

Gene	ral Information - Administrator's/Owner's Certification	1
Gene	eral Information and Questionnaire - Data Required for Real Wage Adjustment	1A
Gene	eral Information and Questionnaire - Type of Facility - Organization Structure	2 3
Gene	eral Information and Questionnaire - Partners/Members	to be a second s
Gene	eral Information and Questionnaire - Corporate Owners	3A
Gene	eral Information and Questionnaire - Individual Proprietorship	3B
Gene	eral Information and Questionnaire - Related Parties	4
Gene	eral Information and Questionnaire - Basis for Allocation of Costs	5
	eral Information and Questionnaire - Leases	6
Gene	eral Information and Questionnaire - Accounting Basis	7
Sche	dule of Resident Statistics	8
Sche	dule of Resident Statistics (Cont'd)	9
A,	Report of Expenditures - Salaries & Wages	10
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant	
	Administrators and Other Relatives	11
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant	
	Administrators and Other Relatives (Cont'd)	12
В.	Report of Expenditures - Professional Fees	13
	Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee	
	for Service Basis	14
C.	Expenditures Other than Salaries - Administrative and General	15
C.	Expenditures Other than Salaries (Cont'd) - Administrative and General	16
	Schedule C-1 - Management Services	17
C.	Expenditures Other than Salaries (Cont'd) - Dietary	18
C.	Expenditures Other than Salaries (Cont'd) - Laundry	19
C.	Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
	Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C.	Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
,	Depreciation Schedule	23
	Amortization Schedule	24
C.	Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C.	Expenditures Other than Salaries (Cont'd) - Interest	26
C.	Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D.	Adjustments to Statement of Expenditures	28
D.	Adjustments to Statement of Expenditures (Cont'd)	29
F.	Statement of Revenue	30
G.	Balance Sheet	31
G.	Balance Sheet (Cont'd)	32
G.	Balance Sheet (Cont'd)	33
G.	Balance Sheet (Cont'd)	34
G.	Balance Sheet (Cont'd) - Reserves and Net Worth	35
H.	Changes in Total Net Worth	36
I.	Preparer's/Reviewer's Certification	37

State of Connecticut **Department of Social Services**

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	tm	ent		Page	of
^				1A	37
Name of Facility		Period Cov	ered:	From	To
Meriden Care Center, LLC				10/1/2017	9/30/2018
Address of Facility					
33 Roy St. Meriden, CT 06450		1		T	
Report Prepared By		Phone Nun		Date	
iCare Management, LLC		860-570-2	140	2/15/2019	
Item		Total	CCNH	RHNS	Other
1. Dietary wages paid	\$				
2. Laundry wages paid	\$				
3. Housekeeping wages paid	\$				
4. Nursing wages paid	\$				
5. All other wages paid	\$				
6. Total Wages Paid	\$				
7. Total salaries paid	\$				
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire Type of Facility - Organization Structure

		Pho	ne No. of Faci	lity	Report for Ye	ar Ended	Page	***	of
			-237-5457		9/30/2018		2		37
Name of Facility (as shown on license)			Address (No	. & S	Street, City, Sta	ite, Zip)			
Meriden Care Center, LLC			33 Roy St. N	1erid	en, CT 06450				
	CCNH		RHNS		Other		Medicare I	rovid	er No.
	2153-C	<u></u>					07-5337		
Type of Facility (Check appropriate box(es))	1								
Chronic and Convalescent Nursing Home only (CCNH)	Ø		t Home with I ervision only			Other			
			CI VISIOII OIII y	(1(111	115)				
Type of Ownership (Check appropriate box)						_		_	
O Proprietorship O LLC O	Partnership	0	Profit Corp.		Non-Profit Cor			0	Trust
				Date	e Opened	Date Clo	sed		
If this facility opened or closed during report	t year provide	:							
						<u> </u>		 -	
Has there been any change in ownership		^	Van	•	No	If "Vac "	' explain full	X 7	
or operation during this report year?			Yes	•	140	11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	explain full	<u>y.</u>	
Administrator									
Name of Administrator					Nursing H				
Raymond Hackling					Administra	ŀ	000853		
·					License	No.:			
Other Operators/Owners who are assistant a	ndministrators	(full	or part time)	of th	is facility.				
Name					License	No.:			
		·····							

Annual Report of Long-Term Care Facility

CSP-3 Rev. 10/2005

General Information and Questionnaire Partners/Members

Name of Facility Meriden Care Center, LLC		License No. 2153-C	Report for 9/30/2018	Year Ended	Page of 3 37
reference Care Caller, ELC		[2133-0	17/30/2016	State(s) and	d/or Town(s) in
Legal Name of Part	tnership/LLC	Business	Address		Registered
Meriden Care Center, LLC		33 Roy St. Mer. 06450	iden, CT	СТ	
Name of Partners/Members	Business A	Address		Title	% Owned
Executive Advisors, LLC	341 Bidwell St. Mand	chester, CT 06040	Member		47.5
Apex Advisors LLC	341 Bidwell St. Mand	chester, CT 06040	Member		47.5
Christopher Wright	341 Bidwell St. Mane	chester, CT 06040	Member	1.0	5
				naver for helder for the first party.	

General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year	Ended	Page of
Meriden Care Center, LLC	2153-C	9/30/2018		3A 37
If this facility is owned or operated as a corpo	ration, provide the	following information	ation:	
Legal Name of Corporation		ss Address		ch Incorporated
-				
Name of Directors, Officers	Busine	ss Address	Title	No. Shares Held by Each
Names of Stockholders Owning at Least 10%				
of Shares				
	100000000000000000000000000000000000000			
		· · · · · · · · · · · · · · · · · · ·		
				and the second s

General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page of
Meriden Care Center, LLC	2153-C	9/30/2018	3B 37
If this facility is owned or operated as an individu	al proprietorship, i	provide the following informa	ition:
	ner(s) of Facility		
	.,		

			~ **
			
			-
			40 - 444 - 521 - 14 - 14 - 14 - 14 - 14 - 14 - 14 -
			31.77
		The state of the s	
			W.V.

State of Connecticut Annual Report of Long-Term Care Facility CSP-4 Rev. 10/2005

Related Parties*

Name of Facility Meriden Care Center, L	i.e	License No. 2153	e No. 2153-C	Nepoli ioi iteai ciided 9/3/2018		4 4	37
Name of Related	Business A Adress	Also P Goods/Serr Related	Goods/Services to Non-Related Parties	Description of Goods/Services	Indicate Where Costs are Included in Annual Report	Cost	Actual Cost to the Related Party
Bidwell Care Center,	333 Bidwell St. Manchester,		╬	Sharad Funitoties	+	(2.413)	2.413
Chelsea Place Care	25 Lorraine St. Hartford, CT			Shared Employees		(4,310)	4,310
Chestnut Point Care	171 Main St. East Windsor,			Laundry Services	19 3		1
Chestnut Point Care				Shared Employees	į	(2,949)	2,949
Farmington Care	(v) E			Bank Fees	M 9I	1	i i
Farmington Care	20 Scott Swamp Rd. Farmington, CT 06032			Shared Employees	1	(1,348)	1,348
Kettle Brook Care	96 Prospect Hill Rd. East Windsor, CT 06088			Laundry Services	19 3		
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088			Shared Employees	1	(2,578)	2,578
Meriden Care Center, LLC (Silver Springs)	33 Roy St. Meriden, CT 06450			Shared Employees	1	1	,
Trinity Hill Care	151 Hillside Ave. Harfford, CT 06106			Shared Employees	,	(941)	941
Westside Care	12 9			Shared Employees	,	(2,984)	2,984
Wintonbury Care	140 Park Ave. Bloomfield, CT 06002			Shared Employees		(995)	995
Secure Care Center	60 West Street, Rocky Hill, CT 06067			Shared Employees	,	12,534	(12,534)
Touchpoints at	1838 Silas Deane Hwy, Rocky Hill CT 06067			Shared Employees	1	,	,
Touchpoints therapy	171 Main St. East Windsor, CT 06088			OT/PT/ST	13 5,8,10	393,545	(393,545)
Bidwell Realty, LLC	 ← 0			Building Lease & Rent	22,22,27 10,9,14		-
iCare Management,	341 Bidwell St. Manchester, CT 06040			Postage & Legai	16, 15 M.E	11,378	(11,378)
iCare Health	341 Bidwell St. Manchester,			Shared EEs not part of memt agmt	:	170,171	(170,171)
ימומקכוווכווו, כדכ	,	***************************************		Management Services, Direct	20 5j	180,919	(180,919)
1				Management Services, Indirect	20	24,800	(24,800)
-		-		Management Services, Administrative	16 M12	406,105	(406,105)
	- Committee of the Comm						
	made/HV/		1		- I		-
					-		ı
3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3				# house	1		***
1100	1100 TOTAL T				-		
All 9 Care Centers,				and the state of t		1	

* 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	License No.		Report for Year Ended	Page	of		
Meriden Care Center, LLC	2153-C		9/30/2018	5	37		
If the facility is licensed as CDH and/or RCH or	r provides Al	DS or TBI	services with special Medicaid	rates, cos	ts		
must be allocated to CCNH and RHNS as follow							
Item			Method of Allocation				
Dietary			meals served to residents	***			
Laundry			pounds processed				
Housekeeping			square feet serviced		•		
	- 1		hours of routine care provided	•			
Nursing			lassification, i.e., Director (or C				
			Nurses, Licensed Practical Nur	ses, Aides	and		
		Attendants		1 20 1 20	<u>*</u>		
Direct Resident Care Consultants			hours of resident care provided	by EACI	1		
			(See listing page 13)		H		
Maintenance and operation of plant		Square feet					
Property costs (depreciation)		Square feet		····			
Employee health and welfare		Gross salar					
Management services			e cost center involved				
All other General Administrative expenses		<u> </u>	rect and Allocated Costs	• 1 1			
The preparer of this report must answer the follo	owing questi	ons applica					
1. In the preparation of this Report, were all	• Yes	O No	If "No," explain fully why sucl	h allocatic	n was		
costs allocated as required?	- 100	- * + •	not made.				
2. Explain the allocation of related company ex	penses and a	ttach copy	or appropriate supporting data.				
0. 10.10.10.10.10.10.10.10.10.10.10.10.10.1	10 11	1	1	10.55-4	store?		
3. Did the Facility appropriately allocate and se				ie cost cei	ncis!		
(e.g., Assisted Living, Home Health, Outpati	ient Services	, Adult Day					
	⊙ Yes	O No	If "No," explain fully why suc not made.	h allocatio	on was		
				. –	_		

Annual Report of Long-Term Care Facility State of Connecticut CSP-6 Rev. 9/2002

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.

SHOULD HOUSE IN CASS CHINGRIES.							
Name of Facility			License No.	Report for Year Ended	ear Ended		Page of
Meriden Care Center, LLC			2153-C	9/30/2018			6 37
	Related * to	d * to					
	Owners,	ers,					
	Operators,	tors,				Annual	
	Officers	cers		Date of	Term of	Amount	Amount
Name and Address of Lessor	Yes	οN	Description of Items Leased	Lease**	Lease	ofLease	Claimed
	0	0	Omnistim Electrotherapy and Omnisound	05/18/10		14,102	14.102
4850 Joule Street, Suite A-1 ADP, Inc., One ADP Drive MS-100,	0	0	instapeum Charsonia Equipinem Time Clocks and Payroll Punch Equip	01/10/90	શ્ચ	9.058	9.058
Augusta, GA 30909 Mail Finance/Neopost New England, 25881 Newtwork	0	0	Postage Meter Rental			727	727
Flace, Chicago, IL 6007.5 CIT Finance LLC	0	0	Copier		41949	18,931	18,931
	0	0					
	0	0		444 AAAAA			
	0	0					
	0	•					
	0	0					
	0	0					
Tr. a Millord I on Dook Maintained for All I seed Wehirles		hicles ?	O Yes	•	o No	Total ***	42.819

Is a Mileage Log Book Maintained for All Leased Vehicles?

Total ***

* 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	License No.	Report for Year Ended		Page	OI
Meriden Care Center, LLC	2153-C	9/30/2018		7	37
The records of this facility for the p	period covered by this report	were maintained on the following basis:			
• Accrual • Cash • O	Modified Cash				
Is the accounting basis for this		WELL-PART TO THE PART TO THE P			
_	Yes	If "No," explain.			
previous period?	No	-			
			new		
Independent Accounting Firm	······································				
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)		0.61.00	
1 O'Connor, Davies LLP		100 Great Meadow Road, Ste 401, Weth	ersheld, C1	06109	
2					
3					
4					
Services Provided by This Firm (de	escribe fully)				
I Taxes, financial statements, accounting	g support		\$	9,749	
2			\$		
3			\$		
4			\$		
			Charge for S	Services Prov	ided
			\$	9,749	
Are These Charges Reflected in the Expend	liture Portion of This Report? If Yo	es, Specify Expense Classification and Line No.	•		
O Yes O No	15D				
Legal Services Information					
Name of Legal Firm or Independen	nt Attorney		Telephone N	lumber –	
1 iCare Health Management, LL	.C		860-570-21	40	
2 Starble and Harris			860-678-77		
3 Durant Nichols / Robinson &			860-275-820	00	
		ı, Murtha Cullina,Jackson Lewis))			
5 Starble and Harris, iCare Heal			860-678-77	75 & 860-57	0-2140
Address (No. & Street, City, State,	•				
1 341 Bidwell Street, Manchest	er C1				
2 32 Main Street, Avon, CT	P.				
3 280 Trumbull St, Hartford, C7					
5 32 Main Street, Avon, CT &	2/1 Ridwell Street Manches	star CT			
Services Provided by This Firm (de		SKI O1			
I Lease and contract issues, general leg.	al advice, Labor Law		\$	10,574	.,
2 Lease and contract issues, general leg-	al advice, union funds advice		\$	1,689	
3 Employment law, arbitrations, contra	et negotiations		\$	18,500	
4 Employment Arbitrations, healthcare	law		\$	5,271	
5 Conservatorships & Collections			\$	93	
			Charge for S	Services Prov	rided
a universal and a second a second and a second a second and a second a second and a second and a second and a			\$	36,127	
Are These Charges Reflected in the Expend	diture Portion of This Report? If Y	es, Specify Expense Classification and Line No.			
	15E				
⊙ Yes O No					

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 9/2002

Schedule of Resident Statistics

Name of Facility			License No.	Jo.			Report for	Report for Year Ended	ps		Page	fo
Meriden Care Center, LLC			21	2153-C			9/30/2018				∞	37
					I	eriod 10/	Period 10/1 Thru 6/30	30		Period 7/1	Period 7/1 Thru 9/30)
	Total All	Total CCNH	Total RHNS									
	Levels	Level	Level	Total Other	Total	CCNH	RHINS	Other	Total	CCNH	RHNS	Other
		1					•		(9	•	
A. On last day of PREVIOUS report period	159	158	-		159	158	1		159	158		THE PERSON NAMED IN COLUMN NAM
B. On last day of THIS report period	159	159			159	158	1		159	159		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	156	155			156	155	1		156	155		
B. As of midnight of THIS report period	156	156			156	155	1		156	156		
3. Total Number of Days Care Provided During Period			: :				•					
A. Medicare	1,897	1,897			1,381	1,381			516	516		
B. Medicaid (Conn.)	49,651	49,311	340		37,340	37,067	273		12,311	12,244	1.9	
C. Medicaid (other states)								4				
D. Private Pay	409	409			317	317			92	92		
E. State SSI for RCH								***************************************				
F. Other (Specify) Insurance	4,968	4,968			3,425	3,425			1,543	1,543		
G. Total Care Days During Period (3A thru F)	56,925	56,585	340		42,463	42,190	273		14,462	14,395	19	
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds	(2)											
5. Total Resident Days (3G + 4A + 4B)	56,925	56,585	340		42,463	42,190	273		14,462	14,395	19	

Schedule of Resident Statistics (Cont'd)

Name of Facil	lity			Licer	ise No.				Report	for Year	Ended		Page	of
Meriden Care	Center,	, LLC		2	153-C					9/30/201	.8		9	37
1			in the certified b		pacity du	ring t	he repo	rt yea	r?	0	Yes	•	No	and interest the state of the s
			f Change		Ch	ange	in Bed	s		Car	pacity Afte	er Change		
Date of	_	RHNS	Other		Lost	-	T	Gaine	d		•			
G1							·			1				
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Other	Reason fo	or Change

							<u> </u>							
	L													
5. If there v	vas anv	change :	in certified bed o	apaci	ty during	the r	eport ye	ear (as	s report	ed in iten	1 4 above)	provide the nun	nber of	
I	_	_	90 days followin	_	-		1		1		,	•		
1430201	21.11 121.		20 44,0 101101111	5 410	onunge.									
			Change in Re	esider	of Dave					CC	CNH	RHNS	Ot	her
1st chan	ee		Change in 10	outdoi	it Days						21111	141110		
2nd char								··············						
3rd chan	ge													
4th chan														
6. Number	of Resid	lents an	d Rates on Septe	mber			ar							
			Medicare		Medi	caid				Se	elf-Pay		Other Sta	e Assisted
1														
													D 0 77	
77 67	Item		CCNH		CNH	R.	HNS	CO	CNH	RI	INS	Other	R.C.H.	ICF-MR
No. of R Per Dien		3	8	20000000	131			****	17					
a. One b			488.00		243.00				304.00					
	bed rms		486.00		245.00				304.00					***************************************
c. Three														
bed 1														
	ALIO.			<u> </u>		<u> </u>		I						
7. Total Nu	ımber of	Physica	al Therapy Treat	ments	}					ТО	TAL	CCNH	RHNS	Other
		are - Par									1,874	1,863	11	
В.			lusive of Part B)	i										
			e Treatments								339	326	12	
		torative	Treatments								1,751	1,751	127	
	Other	Dhueical	Therapy Treati	wante	,			······································			4,228 8,192	4,181 8,121	71	
			Therapy Treatm								6,172	6,121	/1	
		are - Par		спо							255	253	2	
B.	Medica	aid (Exc	lusive of Part B))					***************************************					
			e Treatments							001000000000000000	119	118	1	***************************************
	2. Res	torative	Treatments								61	61		,
	Other										490	485	5	
			Therapy Treatm								925	917	7	***************************************
			ational Therapy	Treati	nents									
		are - Par									3,251	3,232	19	
B.			lusive of Part B) ce Treatments)							1 107	1.072	1.2	
			Treatments								1,087 1,540	1,072 1,540	16	
С	Other	uuv0	11 outilities							1	5,766	5,703	63	
		Оссира	ional Therapy T	reati	nents					1	11,644	11,546	98	

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	- Daiair			Dana	- F
Meriden Care Center, LLC	2153-C		Report for Year 9/30/2018	Ended	Page 10	of 37
			9/30/2018	····		3/
Are time records maintained by all individuals receiving con	npensation?	•	Yes	0	No	
			Total Cost a	nd Hours		
Item	CCNH	Hours	RHNS	Hours	Other	Hours
Salaries and Wages* Operators/Owners (Complete also Sec. I						
of Schedule A1)						
2. Administrator(s) (Complete also Sec. III						
of Schedule A1)	157,486	2,074	913	12		
3. Assistant Administrator (Complete also Sec. IV						
of Schedule A1)						.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
4. Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)	198,744	9,352	1,152	54		
5. Dietary Service						
a. Head Dietitian b. Food Service Supervisor	\$4200	2.061	215	12		
c. Dietary Workers	54,329 517,150	2,061 29,110	315 2,999	12 169		
6. Housekeeping Service	317,150	25,110	2,377	107		
a. Head Housekeeper			340040000000000000000000000000000000000	100000000000000000000000000000000000000	*************************	>>0000000000000000000000000000000000000
 b. Other Housekeeping Workers 						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	57,340	2,010	332	12		
b. Other Maintenance Workers	44,473	2,247	258	13		******************************
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				***********************		220022000000000000000000000000000000000
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	209,254	3,988	1,213	23		7000070000000000000
b. RN	500 105	10 044	2.052	62		
Direct Care Administrative**	509,195 300,482	10,844 7,903	2,953 1,742	63 46		
c. LPN	300,482	1,203	1,142	70		
1. Direct Care	1,415,681	46,924	8,209	272	*****************	100000000000000000000000000000000000000
2. Administrative**		,				
d. Aides and Attendants	2,211,754	129,641	12,825	752		
e. Physical Therapists						
f. Speech Therapists	-					
g. Occupational Therapists h. Recreation Workers	180,464	8,600	1,046	52		
i. Physicians		500000000000000000000000000000000000000	1,040			
Medical Director						***************************************
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists 1. Podiatrists		· · · · · · · · · · · · · · · · · · ·				
l. Podiatrists m. Social Workers/Case Management	193,100	5,812	1,120	34		
n. Marketing	193,100	2,012	1,120	34		
o. Other (Specify)						
See Attached Schedule	33,220	1,961	193	11		V-000000000000000000000000000000000000
A-13. Total Salary Expenditures	6,082,672	262,527				

^{*} 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)

		CC.	NH		RH	NS	Oth	ier
Position		\$	Hours		S	Hours	\$	Hours
UNIT SECRETARIES SALARIES	\$	30,436	1,777	\$	176	10		
MEDICAL RECORDS SALARIES	\$		÷ 3	\$	10 € 10 € 10 € 10 € 10 € 10 € 10 € 10 €			
CENTRAL SUPPLY SALARIES	\$	2,784	184	\$	16	1		
RESPIRATORY THERAPY SALARIES	\$	-		\$			300 20 48 80 80	
		# (7% B %)						
	2000	Chia kati ng						
	5000							
				99000		000 W 000 W 000 W		
		<u> </u>		3000 Y				
				500,000 000,000				
				10.4100				
	34 5 C			organiere totalisation				
	0.00.0						300000000000000000000000000000000000000	
				0.00000000				
				Sec. 346	33.1850			
				(Service)				
					1000 A 100 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
				to Your St.				
Total	\$	33,220	1,961	\$	193	11	\$ -	•

Schedule of Other Fees (Page 13)

		CCI	NH		RH	NS	Oth	er
Service		\$	Hours		\$	Hours	\$	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$	5,798	and the second	\$	34	s, s. s. s. e. +		
ADMISSIONS C/S LABOR	\$	50,599	1,094	\$	-	6		
CENTRAL SUPPLY CONTRACT SERVICE	\$	586	17	\$	5	0		
ADMINISTRATIVE CONTRACT SERVICE LABOR	. 8	100,629	3,315	\$	- 5	19		
RESPIRATORY THERAPY CONTRACT SERVICES	\$	•		\$		¥.		
PHYSICAL THERAPY C/S MEDICIAD	\$	42,795	562	\$				
SPEECH THERAPY C/S Medicaid	S	7,495	99	\$	43			
OCCUPATIONAL THERAPY C/S MEDICIAD	\$	50,729	670	\$	294			
		Çerêleyê ye.						
				33203				
		.c.: (279)						
	S. S. S. 17 (75.)							
Total	\$	258,631	5,757	\$	371	26	\$ -	

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*

Nome of Becility		*	Transcare I	Ticense No	I icense No	Report for	Renort for Year Finded		Ряое	of
region of recitity				or agreement		To Take			D -	
Meriden Care Center, LLC				2153-C		9/30/2018			11	3/
		Salary Paid	Į							
				ringe Benents and/or Other		Total	Line Where		Total	
Name	CCNH	RHINS	Other	Payments (describe fully)	Full Description of Services Rendered	Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours Worked	Compensation Received
Section I - Operators/Owners										
The state of the s										
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).										
			Taraking and a second a second and a second							
		֧֓֞֟֝֟֝֟֝֟֝֟֝֟֟֝֟֟֝֟֟֟ ֓֞֓֞֓֞֞֓֞֞֓֞֞֞֞֓֞֞֞֓֓֞֞֞֞֞֞֓֞֓֞֞֞֞֩֞֞֩֞֞		A CONTRACTOR OF THE CONTRACTOR		 -	-			

^{*} 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 CSP-12 Rev. 10/2005

Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties*

Money of Benility (an lineared)			S	None No		Denort for Vest Ended	ser Ended		Раде	Û
Iname of Facility (as ficensed)				LUCCIING INO.		Including I	ימו דיווחרת		- 400 r	5
Meriden Care Center, LLC				2153-C		9/30/2018			12	37
		Salary Paid								
				Fringe Benefits and/or Other	Endl Decomination of	Line Where		Name and Address of All	Total	Commencation
Name	CCNH	RHINS	Other	rayments (describe fully)	Services Rendered	Worked		Other Employment**	Worked	Received
Section III - Administrators***		•								
				same as						
Raymond Hackling	157,486	913		empioyees less union funds	Administrator	2,086 A2	A2			
	,			same as						
				employees less	,					
				union funds	Administrator		A2			
				same as						
				employees less	Administrator		۲۷			
				WILDER PURIORS	1 TOTAL MINE AND T			The state of the s		
Section IV - Assistant Administrators										

].] ·		1 F .	1.1.2. 1.3. 1.1. 1.1. 1.1. 1.1. 1.1. 1.1					

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

^{**} Include all other employment worked during the cost year.

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

Annual Report of Long-Term Care Facility

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

B. Report of Ex	License No.		Report for Y		Родо	of
Name of Facility Meriden Care Center, LLC	License No. 2153		9/30/2018	ear Ended	Page 13	37
Menden Care Center, ELC	213.)-C	Total Cost a	a d Tlassa	1.3	31
			Total Cost a	ma riours		
Item	CCNH	Hours	RHNS	Hours	Other	Hours
*B. Direct care consultants paid on a fee	CCNH	пошь	KHIND	1101113	Other	110018
for service basis in lieu of salary						
(For all such services complete Schedule B1)						
1. Dietitian	35,355	777	205	5		
2. Dentist	33,333	,,,	203			
3. Pharmacist	20,767	296		2		
4. Podiatrist	20,707	270				
5. Physical Therapy						
a. Resident Care	114,525	1,512		12		
b. Other	11 (,020	1,512				
6. Social Worker	1,408		8			
7. Recreation Worker		35+Cable		Recreation \		
8. Physicians						
a. Medical Director (entire facility)	35,785	241	215	1	800000000000000000000000000000000000000	100000000000000000000000000000000000000
b. Utilization Review						
(Title 18 and 19 only) monthly meeting		5		0		
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee				.000.0000.00000000000000000000000000000		
(Quarterly meetings)						
2. Pharmaceutical Committee		·				
(Quarterly meetings) 3. Staff Development Committee						
(Once annually)						
e. Other (Specify)						
Physician Care Contract Services	22,798	112				
9. Speech Therapist						
a. Resident Care	27,324	374	158	3		
b. Other	:					
10. Occupational Therapist						
a. Resident Care	148,639	1,959	862	16		
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	9,958	81	58			
2. Administrative***	10,110	201	59	1		
b. LPN						
1. Direct Care	3,984	92	23	1		
2. Administrative***						
c. Aides	(5,132)	(127)	(30)	(1)		
d. Other						
12. Other (Specify)						
See Attached Schedule	258,631	5,757	371	26		
B-13 Total Fees Paid in Lieu of Salaries	703,174	11,280	2,044	65		

^{*} 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		License No.		Report for Y	ear Ended	Page	of
Meriden Care Center, LLC		2153-C		9/30/2018		14	37
				to Owners,			
Name & Address of Individual	Full Expla	nation of Service		s, Officers	Expla	nation of R	elationship
			Yes	No			
Omnicare/ Pharm Scripts	Pharm	acy Consulting	0	0			
Tocuhpoints Therapy		Therapy	0	0	Common Own	ership	
Chelsea Place, Chestnut Point, Kettle Brook,	Shar	ed Employees			Common Own	ership	
Trinity Hill, Wintonbury, Farmington, Silver							
Springs, Westside Care Centers, iCare Health and			⊙	0			
iCAre Management, SecureCare Options, Home							
Care Healthdrive Physician Services	Audiology,	Dental and Podiatry	0	0			
Ready Nurse, Nurse Network	Nursing po	ol (RN, LPN,CNA)	0	0			
IPC Hospitalists	Мес	lical Director	0	0			
	***************************************		0	0			
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			0	0			
			0	0			
			0	0			

^{*} 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 Ye	ar Ended	Page	of	
Meriden Care Center, LLC 2153-C			9/30/2018		15	37	
Item			Total	CCNH	RHNS	Other	
Administrative and General							
a. Employee Health & Welfare Benefits							
Workmen's Compensation		\$	499,994	497,111	2,883		
Disability Insurance		\$					
3. Unemployment Insurance		\$					
4. Social Security (F.I.C.A.)		\$	536,553	533,460	3,093		
5. Health Insurance		\$	1,074,645	1,068,449	6,196		
6. Life Insurance (employees only)							
(not-owners and not-operators)		\$					
7. Pensions (Non-Discriminatory)		\$	356,567	354,511	2,056		
(not-owners and not-operators)							
8. Uniform Allowance		\$					
9. Other (Specify)		\$	43,824	43,571	253	*************************	
See Attached Schedule							
b. Personal Retirement Plans, Pensions, a	ınd	\$					
Profit Sharing Plans for Owners and							
Operators (Discriminatory)*							
c. Bad Debts*		\$	(126,605)	(125,875)	(730)		
d. Accounting and Auditing		\$	9,749	9,693	56		
e. Legal (Services should be fully descri	bed on Page 7)	\$	36,127	35,919	208		
f. Insurance on Lives of Owners and		\$					
Operators (Specify)*							
g. Office Supplies		\$	12,960	12,885	75		
h. Telephone and Cellular Phones							
1. Telephone & Pagers		\$	24,032	23,893	139		
2. Cellular Phones		\$	1,705	1,695	10		
i. Appraisal (Specify purpose and		\$					
attach copy)*							
j. Corporation Business Taxes (franchis	re tax)	\$					
k. Other Taxes (Not related to property							
1. Income*		\$					
2. Other (Specify)		\$					
See Attached Schedule							
3. Resident Day User Fee		\$	1,196,564	1,189,665	6,899		
Subtotal		\$		3,644,978	21,136		
			·	(0 0 1 .	stale forward t		

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

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

Meriden Care Center, LLC 9/30/2018

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Other		
UNION TRAINING	\$ 43,571	\$ 253			
Total	\$ 43,571	\$ 253	\$ -		

Schedule of Other Taxes

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

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

Name of Facility	License No.		Report for Y	ear Ended	Page	of
Meriden Care Center, LLC	2153-C		9/30/2018		16	37
Item			Total	CCNH	RHNS	Other
Subtotal	s Brought Forwar	d:	3,666,115	3,644,978	21,136	
Travel and Entertainment						
Resident Travel and Entertainment		\$				
2. Holiday Parties for Staff		\$	1,452	1,443	8	
Gifts to Staff and Residents		\$	140	139	1	
4. Employee Travel		\$	3,780	3,759	22	
Education Expenses Related to Seminars and	Conventions	\$	4,461	4,436	26	
6. Automobile Expense (not purchase or depre	ciation)	\$				*****
7. Other (<i>Specify</i>)		\$	220	218	1	
See Attached Schedule						
m. Other Administrative and General Expenses						
1. Advertising Help Wanted (all such expenses)	\$	5,831	5,797	34	
2. Advertising Telephone Directory (all such ex	cpenses)***	\$				
3. Advertising Other (Specify)***		\$	16,298	16,204	94	
See Attached Schedule						
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		\$	3,565	3,545	21	
* 8. Dues and Membership Fees to Professional		\$	11,289	11,224	65	
Associations (Specify)						
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other Non-A	Allowable Org.***	\$				
9. Subscriptions		\$				
10. Contributions***		\$	1,572	1,563	9	
See Attached Schedule						
11. Services Provided by Contract (Specify and	Complete	\$	119,336	118,648	688	
Schedule C-2, Page 21 for each firm or indi	vidual)					
12. Administrative Management Services**		\$	406,105	403,764	2,341	
13. Other (Specify)		\$	24,237	24,097	140	
See Attached Schedule						
C-14 Total Administrative & General Expenditures		\$	4,264,401	4,239,816	24,586	

^{*} 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

CCNH	RHNS	Other
\$ 218	\$ 1	
950, 150, 100, 100, 100, 100		
3/1/28/5/2019/20		
\$ 218	\$ 1	\$ -
	\$ 218	

Schedule of Other Advertising

Description	CCNH	RHNS	Other
COMMUNICATIONS SPECIAL EVENTS	\$ 16,204	\$ 94	
		Similaritan fa	734742751355415555
Total Other Advertising	\$ 16,204	\$ 94	\$ -

Schedule of Dues

Description	CCNH	RHNS	Other
ALTCFM			
CAHCF Dues	\$ 11,065	\$ 64	
OTHER DUES	\$ 159	\$	
	n disercent decimal confi		
			(86.350.00) 630.3
Total Dues	\$ 11,224	\$ 65	\$.

Schedule of Contributions

Description	CCNH	RHNS	Other
CONTRIBUTIONS	\$ 1,563	\$ 9	
Total Contributions	\$ 1,563	\$ 9	\$

Schedule of Other Administrative and General

Description	CCNH	RHNS	Other
SOCIAL SERVICE SUPPLIES	\$ 789	\$ 5	
SOC SVC MINOR EQUIPMENT	\$ -	\$	
ADMINISTRATIVE MINOR EQUIPMENT	\$ 893	\$ 5	
EMPLOYEE RELATIONS	\$ 4,188	\$ 24	
EMPLOYEE RELATIONS-OTHER	\$ 758	\$ 4	
PERMITS & LICENSES	\$ 1,983	\$ 11	
VOLUNTEER EXPENSE	\$	\$	
BANK FEES	\$ 8,344	\$ 48	8
CMS REVISIT USER FEES	\$	\$:	10.0000000
PENALTIES	s -	\$ -	
LATE FEES	\$ 5,425	\$ 31	
INTERNET EXPENSES	\$ 1,717	\$ 10	200
Rounding		\$ -	38.0
Total Other Administrative and General	\$ 24,097	\$ 140	\$

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Meriden Care Center, LLC	2153-C	9/30/2018	17 37
Name & Address of Individual or Company Supplying Service iCare Management, LLC/iCare Health	Cost of Management Service 406,105	Full Description of Mgmt. Service Provided Management of financial	Indicate Where Costs are Included in Annual Report Page #/Line # Pg 16 M12
Management, LLC	·	statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	
iCare Management, LLC/iCare Health Management, LLC	179,876	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	24,652	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)

Item		-		~~~		No.	TD.	nort for Va	or Ended	Dag		of	\neg
Item	Name of Facility License No. Report for Year Ended									-	ت ا	37	
2. Dietary a. In-House Preparation & Service 1. Raw Food 2. Non-Food Supplies 3. 335,741 333,806 1,936 2. Non-Food Supplies 3. 38,992 38,668 224 3. Other (Specify) 5 21,327 21,204 123 DIETARY SUPPLEMENTS b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) c. Other (Specify) 5 4,540 DIETARY MINOR EQUIPMENT 2D. Total Dietary Expenditures (2a + b + c + d) 5 406,773 404,427 2,345 2F. Dietary Questionnaire 7 Total CCNH RHNS Othe G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes O No I. Did you receive revenue from employees? O Yes O No If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other K. than employees or residents (i.e., Board Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes O No If yes, specify cost. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) If yes, specify amt. If yes, specify amt. If yes, specify amt.	re Center, LLC	=	 			2133~C	<u> </u>	7/30/2010		10		31	_
a. In-House Preparation & Service 1. Raw Food \$3335,741 3333,806 1,936 2. Non-Food Supplies \$38,892 38,668 224 3. Other (Specify) \$21,327 21,204 123 DIETARY SUPPLEMENTS b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) c. Other (Specify) \$4,540 4,514 26 DIETARY MINOR EQUIPMENT 2D. Total Dietary Expenditures (2a + b + c + d) \$406,773 404,427 2,345 2F. Dietary Questionnaire Total CCNH RHNS Other G. Resident Meals: Total no. of meals served per day:* 468 468 H. Is cost of employee meals included in 2E? O Yes O No I. Did you receive revenue from employees? O Yes O No J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other K. than employees or residents (i.e., Board O Yes O No Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks M. at monthly staff meetings beard meetings) O Yes O No If yes, specify and the monthly staff meetings beard meetings of Yes O No If yes, specify and the monthly staff meetings beard meetings of Yes O No If yes, specify and the monthly staff meetings beard meetings of Yes O No If yes, specify and the monthly staff meetings beard meetings of Yes O No If yes, specify and the monthly staff meetings beard meetings of Yes O No If yes, specify and the monthly staff meetings beard meetings of Yes O No If yes, specify and the monthly staff meetings beard meetings of Yes O No If yes, specify and	Item		Item			Total		CCNH	RHNS	:	О	ther	
1. Raw Food \$ 335,741 333,806 1,936 2. Non-Food Supplies \$ 38,892 38,668 224 3. Other (Specify) \$ 21,327 21,204 123 DIETARY SUPPLEMENTS b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) c. Other (Specify) \$ 4,540 4,514 26 DIETARY MINOR EQUIPMENT 2D. Total Dietary Expenditures (2a + b + c + d) \$ 406,773 404,427 2,345 2. DIETARY MINOR EQUIPMENT 2F. Dietary Questionnaire Total CCNH RHNS Other G. Resident Meals: Total no. of meals served per day:* 468 468 468 468 468 468 468 468 468 468													
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b. Purchased Services (by contract other \$ 6,272 6,236 36 than through Management Services) (Complete Schedule C-2 att. Page 21) c. Other (Specify) \$ 4,540 4,514 26 DIETARY MINOR EQUIPMENT 2D. Total Dietary Expenditures (2a + b + c + d) \$ 406,773 404,427 2,345 2F. Dietary Questionnaire						1	ļ		ATTACA TO 1	<u> </u>			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) c. Other (Specify) DIETARY MINOR EQUIPMENT 2D. Total Dietary Expenditures (2a + b + c + d) \$ 406,773 404,427 2,345 2F. Dietary Questionnaire Total CCNH RHNS Other G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes O No I. Did you receive revenue from employees? O Yes O No I. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other K. than employees or residents (i.e., Board O Yes O No If yes, specify cost. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks No at monthly staff meetings hoard meetings) N. At monthly staff meetings hoard meetings of the cost Report? (Page/Line Item) If yes, specify amt.					\$	21,327	 348888888	21,204	123		******	***********	*****
than through Management Services) (Complete Schedule C-2 att. Page 21) c. Other (Specify) \$ 4,540	DIETARY SUPPLEMENTS		PLEMENTS										
c. Other (Specify) \$ 4,540 4,514 26 DIETARY MINOR EQUIPMENT 2D. Total Dietary Expenditures (2a + b + c + d) \$ 406,773 404,427 2,345 2F. Dietary Questionnaire Total CCNH RHNS Other G. Resident Meals: Total no. of meals served per day:* 468 468 H. Is cost of employee meals included in 2E? O Yes O No I. Did you receive revenue from employees? O Yes O No I. Did you receive revenue from employees? O Yes O No Is cost of meals provided to persons other K. than employees or residents (i.e., Board O Yes O No Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes O No If yes, specify cost. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks N. at mouthly staff meetings board meetings) O Yes O Yes O No If yes, specify amt.	chased Services (by contract other	(by contract other		\$	6,272	l	6,236	36				
c. Other (Specify) \$ 4,540	n through Management Services)	۷	ement Services)										
DIETARY MINOR EQUIPMENT 2D. Total Dietary Expenditures (2a + b + c + d) \$ 406,773 404,427 2,345 2F. Dietary Questionnaire	mplete Schedule C-2 att. Page 21)	(C-2 att. Page 21)										
2D. Total Dietary Expenditures (2a + b + c + d) \$ 406,773 404,427 2,345 2F. Dietary Questionnaire					9	4,540	<u> </u>	4,514	26	<u>.</u>			
2F. Dietary Questionnaire G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes O No I. Did you receive revenue from employees? O Yes No If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other K. than employees or residents (i.e., Board O Yes O No Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks N. at monthly staff meetings board meetings) O Yes O No If yes, specify at monthly staff meetings board meetings)	DIETARY MINOR EQUIPMENT		NOR EQUIPMENT										
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H. Is cost of employee meals included in 2E? O Yes	•	-							RHNS		О	ther	
I. Did you receive revenue from employees? O Yes	int Meals: Total no. of meals served per day)	o. of meals served per da	ay	*	468	<u> </u>	468		Ĺ			
I. Did you receive revenue from employees? O Yes o No amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other K. than employees or residents (i.e., Board O Yes o No Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes o No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks N. at monthly staff meetings board meetings) O Yes o No If yes, specify If yes, specify	of employee meals included in 2E?		Is included in 2E? C)	Yes	•	No)					
Is cost of meals provided to persons other K. than employees or residents (i.e., Board O Yes O No Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks N. at monthly staff meetings, board meetings) O Yes O No If yes, specify If yes, specify	ou receive revenue from employees?	r	from employees?)	Yes	•	No)					
K. than employees or residents (i.e., Board O Yes O No Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks N. at monthly staff meetings, board meetings) O Yes O No If yes, specify	is the revenue received reported in the Cost		ceived reported in the Co	st	Report	? (Page/Line I	tem)					
Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks N. at monthly staff meetings, board meetings) O Yes O No If yes, specify	of meals provided to persons other	,	d to persons other						If you appoint				
L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks N. at monthly staff meetings, board meetings) O Yes O No)	Yes	•	No)					
Is cost of food (other than meals, e.g., snacks Note at monthly staff meetings board meetings) O Ves O No)	Yes	•	No)					
Is cost of food (other than meals, e.g., snacks Note at monthly staff meetings board meetings) O Ves O No	is the revenue received reported in the Cost	L	ceived reported in the Co	ost	Report	? (Page/Line I	tem	1)					
IN at monthly start meetings, hoard meetings) (1) Yes (9) No		•			A.				If you anaif				
provided to employees included in 2E?)	Yes	•	No	0	cost.				
O. Is any revenue collected from employees? O Yes O No If yes, specify amt.	revenue collected from employees?	5	from employees?	>	Yes	•	No	O					
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)	is the revenue received reported in the Cost	ι	ceived reported in the Co	st	t Repor	? (Page/Line I	tem	1)					

^{*} 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)

	e of Facility den Care Center, LLC	License	No. 153-C	Report for Y 9/30/2018	ear Ended	Page of 19 37
IVICII	den Care Center, ELC		133-0	7/30/2010		17 37
!	Item		Total	CCNH	RHNS	Other
3.	Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies,	Lbs.				
	gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	944	938	5	
	Employee items including uniforms, gowns, etc. washed, ironed and/or	Lbs.				
	processed.***	Amt. \$				
	3. Personal clothing of residents	Lbs.				
	washed, ironed, and/or processed.***	Amt. \$				
	4. Repair and/or purchase of linens.***	Lbs.				
	b. Purchased Services (by contract other	Amt. \$		406,670	2,358	
	than through Management Services) (Complete Schedule C-2 att. Page 21)					
	c. Other (<i>Specify</i>) LAUNDRY MINOR EQUIPMENT	\$		856	5	
3D.	Total Laundry Expenditures (3a + b + c)	\$	410,833	408,465	2,369	<u> </u>
3F. G.	Laundry Questionnaire Is cost of employee laundry included in 3E? C	Yes	•	No	If yes, specify cost.	
H.	Did you receive revenue from employees?	Yes	•	No	If yes, specify amt.	***************************************
Ī.	Where is the revenue received reported in the Cost	Report?		(Page/Line		
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	Yes	•	No	If yes, specify cost.	
K.) Yes	•	No	If yes, specify amt.	
L.	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 3E.

^{***} 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)

Nan	e of Facility	License No.	Rep	ort for Year E	nded	Page	of
Mer	den Care Center, LLC	2153-C		9/30/2018	·	20	37
	Item			Total	CCNH	RHNS	Other
4.	Housekeeping	Sq. Ft. Serviced					
l ''	a. In-House Care	by Personnel					
	1. Supplies - Cleaning (Mops,	Amt.	\$	33,119	32,928	191	
	pails, brooms, etc.)	1	_	,	,		
	b. Purchased Services (by contract other	Sq. Ft. Serviced					
	than through Management Services)	by Personnel					
	(Complete Schedule C-2 att.	Amt.	\$	449,759	447,165	2,593	
	Page 21)			·			
	C. Other (Specify)		\$				
	HOUSEKEEPING MINOR EQUI	PMENT					
4D.	Total Housekeeping Expenditures (4a +	b+c)	\$	482,878	480,094	2,784	
5.	Resident Care (Supplies)**						
	a. Prescription Drugs***						
	1. Own Pharmacy		\$				
	2. Purchased from		\$	232,133	230,795	1,338	
	OMNICARE PHARMACY						
	b. Medicine Cabinet Drugs		\$	9,798	9,741	56	
	c. Medical and Therapeutic Supplies		\$	102,446	102,446		
	d. Ambulance/Limousine***		\$				
	e. Oxygen						
	1. For Emergency Use		\$	5,054	5,054		
	2. Other***		\$				
	f. X-rays and Related Radiological		\$	6,013	6,013		
	Procedures***						
	g. Dental (Not dentists who should be inc	luded under	\$				
	salaries or fees)						
	h. Laboratory***		\$	· · · · · · · · · · · · · · · · · · ·	13,862		
	i. Recreation		\$				
	j. Direct Management Services*		\$				
	k. Indirect Management Services*		\$				
	1. Other (Specify)****		\$	306,050	304,685	1,365	
	See Attached Schedule						
5M.	Total Resident Care Expenditures (5a - 5	5j)	\$	675,357	672,597	2,760	<u> </u>

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	Other
NURSING ADMIN SUPPLIES	\$ 132	\$ 1	
NURSING MINOR EQUIP	\$ 5,118	\$ 31	
MEDICAL RECORDS SUPPLIES	\$ 10	\$ 0	
MEDICAL RECORDS MINOR EQUIPMENT	\$ -	\$ -	
MANAGEMENT ALLOCATIONS - DIRECT	\$ 179,876	\$ 1,043	
NON-COVERED PPS DR. VISITS	\$ 9,506	\$ -	
RESIDENT CARE SUPPLIES	\$ 350	\$ -	
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 11,059	\$ -	
PERSONAL CARE SUPPLIES	\$ 3,464	\$ 21	
INCONTINENCY SUPPLIES	\$ 8,641	\$ 52	
VACCINE RESIDENTS	\$ 4,028	\$ 24	
PATIENT SPECIAL NEEDS	\$ 11	\$ 0	
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	\$ 21,581	\$ -	
EQUIPMENT RENTAL: AIDS UNIT	\$ -	\$ -	
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ 298	\$ -	
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ 31	\$ -	
HI LOW BED RENTAL & MATTRESSES	\$ -	\$ -	
IV THERAPY SUPPLIES	\$ 26,502	\$ -	
IV THERAPY CONTRACT SERVICE	\$ -	\$ -	
MEDICAL WASTE CONTRACT SERVICE	\$ 376	\$ 2	
CHAPERONE/COMPANION CONTRACT SERVICES	\$ 591	\$ 4	
ACTIVITIES SUPPLIES	\$ 6,596		
ACTIVITIES MINOR EQUIPMENT	\$ -	\$ -	
MANAGEMENT ALLOCATION - INDIRECT	\$ 24,652	\$ 148	
ADMISSIONS SUPPLIES	\$ -	\$ -	
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$ 1,865	\$ -	
STRIKE COSTS NON REIMBURSABLE	\$ -	\$ -	
Total Other Resident Care	\$ 304,685	\$ 1,365	\$ -

Annual Report of Long-Term Care Facility CSP-21 Rev. 10/2001 State of Connecticut

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

Name of Facility Meriden Care Center, LLC	And and applications of the state of the sta			License No. 2153-C	Report for Year Ended 9/30/2018		**************************************		Page 21	of 37
		Related ** to Owners,	to Owners,			L	Total Cost/I	Total Cost/Page Ref.***	*	
		Character	0.00000							
Name of Individual or Company	Address	Yes	Š	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHINS	Other	Pg	Line
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	0	•	VENDOR	Housekeeping Services	449,759			20	4b
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	0	0	VENDOR	Laundry Services	409,028			19	35
Eagle Elevator		0	0	VENDOR	Elevator Contract	9,189			22	6F
Bioserve, Inc.		0	0	VENDOR	Medical Waste	378			22	6F
Brightview Landscaping/Amaya Landscaping		0	•	VENDOR	Snow Removal/Landscaping	24,473			22	6F
CWPM		0	•	VENDOR	Trash removal	45,151			22	6F
American HealthTech		0	•	VENDOR	Software Maintenance Contract	11,590			16	MII
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	0	0	VENDOR	Payroll Services	47,572			16	M11
National Datacare Corp		0	0	VENDOR	Resident Trust Software	4,132			16	M11
Prime Care Technologuy services		0	•	VENDOR	Computer Consulting Services	27,956			16	16 M11
Priotiry Express		0	0	VENDOR	Courier Services	3,572			16	M11
Point Right Inc		0	0	VENDOR	Nursing Software	4,680			16	MII
Aron Security Inc		0	0	VENDOR	Security Contract Services				22	22 6F
		0	•	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 Ye	ear Ended		Page	of
Meriden Care Center, LLC	2153-C	9/30/2018			22	37
Item		Total	CCNH	RHNS	Ot	her
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	;	\$ 46,953	46,673	280		
b. Heat		\$ 28,483	28,313	170		
c. Light & Power		\$ 138,802	137,973	829		
d. Water		\$ 125,584	124,834	750		
e. Equipment Lease (Provide detail on p	page 6)	\$ 42,819	42,563	256		
f. Other (itemize)		\$ 115,340	114,651	689		
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a	- 6f)	\$ 497,981	495,007	2,974		
7. Depreciation (complete schedule page 23	(*)					
a. Land Improvements		\$				
b. Building & Building Improvements	,	\$ 23,223	23,084	139		
c. Non-Movable Equipment		\$				
d. Movable Equipment		\$ 47,582	47,298	284		
*7e. Total Depreciation Costs (7a + b + c + c	d) (i	\$ 70,805	70,382	423		
8. Amortization (Complete att. Schedule Pa	ge 24*)					
a. Organization Expense		\$ 		***		
b. Mortgage Expense		\$ 		***************************************		
c. Leasehold Improvements		\$ 48,671	48,380	291		
d. Other (Specify)		\$ 				
*8e. Total Amortization Costs (8a+b+c+c	d)	\$ 48,671	48,380	291		
9. Rental payments on leased real property l	ess					
real estate taxes included in item 10b		\$ 554,162	550,852	3,310		
10. Property Taxes						
a. Real estate taxes paid by owner		\$				
b. Real estate taxes paid by lessor		\$ 147,912	147,029	883		
c. Personal property taxes		\$ 8,754	8,701	52		
11. Total Property Expenses (7e + 8e + 9 +	10)	\$ 830,303	825,344	4,959		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	Other
PLANT SUPPLIES	\$ 7,526	\$ 45	
PLANT CONTRACT SERVICE LABOR	\$ -	\$ -	
ELEVATOR CONTRACT SERVICE	\$ 9,134	\$ 55	
FIRE/SPRINKLER CONTRACT SERVICE	\$ 5,713	\$ 34	
LANDSCAPING CONTRACT SERVICE	\$ 10,198	\$ 61	
SNOW REMOVAL CONTRACT SERVICE	\$ 14,129	\$ 85	
TRASH REMOVAL CONTRACT SERVICE	\$ 44,881	\$ 270	
HVAC CONTRACT SERVICE	\$ -	\$ -	
SECURITY CONTRACT SERVICE	\$ 2,040	\$ 12	
PLANT CONTRACT SERVICE OTHER	\$ 8,987	\$ 54	
PLANT MINOR EQUIPMENT	\$ 12,043	\$ 72	
RENT AUTO	\$ -	\$ -	
RENT EQUIPMENT	\$ -	\$ -	
RENT OTHER	\$ -	\$ -	
Total Other Repairs and Maintenance	\$ 114,651	\$ 689	\$ -

State of Connecticut

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

7.1. II.O F.4.										
[Name of Facility			License No.			Report for Year Ended	'nded		Page	jo
Meriden Care Center, LLC			2153-C	ပ္		9/30/2018			23	37
			Historical Cost	Tess		Accumulated Depreciation to	Method of			
			Exclusive of	Salvage	Cost to Be	Beginning of	Computing	Useful	Depreciation	
Property Item			Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
A. Land Improvements										
 Acquired prior to this report period 						· · · · · · · · · · · · · · · · · · ·				
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	th schedule)									
A.4. Subtotal										
B. Building and Building Improvements										
 Acquired prior to this report period 			416,163		416,163	54,125			23,223	
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	h schedule)									
B-4. Subtotal										23,223
C. Non-Movable Equipment										
1. Acquired prior to this report period										
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	h schedule)									
C-4. Subtotal										
	Is a mileage	4	Historical			Accumulated				
	maintained?	Acquisition	Cost	Less		Depreciation to	Method of			
1			Exclusive of	Salvage	Cost to Be	Beginning of	Computing	Useful	Depreciation	.
A Madelan marry	Yes No	Month Year	Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
D. Movable Equipment										
1. Motor Vehicles (Specify name, model										
and year of each vehicle)										
a. Van Repair: Hillside Automotive Celx	×									
ę.										
C.										
d.										
2. Movable Equipment										
a. Acquired prior to this report period			717,234		717,234	578,760			41,256	
b. Disposals (attach schedule)										
c. Acquired during this report period									i e	
(attach schedule)			95,270						6,327	
D-3. Subtotal										47,582
E. Total Depreciation	-									70.805

Useful

Useful

Schedule of Land Improvements Acquired during this report period

Description of Hem	Cost	Life	Depreciation
Description of tem	Cost		2 Sp. Semeron
		5-0000000000000000000000000000000000000	
Land Improvements	\$ -		\$ ~
Land Improvements	\$		\$ -
		Land Improvements S	Land Improvements S

^{*}Ties to Page 23, Line A3

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
Total additions for	Building Improvements	\$		\$ -
Deletions:				
				0.000
		200 100 100 100 100 100 100 100 100 100		
Total deletions for I	Building Improvements	\$ -	24 (340) 450 (351)	\$

^{*}Ties to Page 23, Line B3

Schedule of Non-Movable Equipment Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
1.0000000000000000000000000000000000000				
Total additions for	r Non-Movable Equipment	\$ -		S
Deletions:				
-0. (30 00 100 kg) 1.30				
Total deletions for	Non-Movable Equipment	\$ -		\$. ~ ·

^{*}Ties to Page 23, Line C3

^{**}Ties to Page 23, Line A2

^{**}Ties to Page 23, Line B2

^{**}Ties to Page 23, Line C2

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:	Description of Ren	Cust	Life	Depreciation
10/5/2017	Generator Repair: Weld Power Generator Inc	\$ 2,647	60	\$ 485
11/2/2017	Panacea Mattresses (2)	\$ 4,511	60	\$ 752
12/16/2017	Bedspreads & Bed: Medline	\$ 8,985	60	\$ 1,348
2/1/2018	Unimac Dryer & Parts: Daniels Equip, Proline	\$ 11,013	120	\$ 642
3/19/2018	Resident Room Furniture; Medline	\$ 9,829	180	\$ 328
1/1/2018	Dining Room Upgrade: Various Vendors	\$ 2,195	120	\$ 165
5/2/2018	Bed; Medline	\$ 14,357	60	\$ 957
7/4/2018	Bed: Medline	\$ 14,357	60	\$ 479
9/27/2018	Mattress: Medline	\$ 9,116	60	÷
6/20/2018	Electric Steamer: HPC Food & MC Electrical Cont.	\$ 6,168	120	\$ 154
4/27/2018	Bariatric Chaus: Medline	\$ 4,698	120	\$ 196
6/1/2018	Laptop & Wiring: Various Vendor	\$ 7,394	36	\$ 822
Total additions fo	r Movable Equipment	\$ 95,270		\$ 6,327
Deletions:				
Total deletions for	Movable Equipment	\$		\$ -

^{*}Ties to Page 23, Line D2c

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:	Description of Item	Cost	Lite	Depreciation
10/24/2017	Lobby Renovations; Shalom, Sahar	\$ 29.778	120	\$ 2,730
11/10/2017	Lobby Renovations: Shalom, Sahar	\$ 3,200	120	William ratio a section of
11/10/2017	Lobby Renovations: Shalom, Sahar	s 700	120	\$ 58
1/30/2017	Kitchen Upgrade: Various Vendors	\$ 15,959	120	1.00 (100 (200 (200 (200 (200 (200 (200 (2
1/4/2018	2 Heaters, Material & labor: E, Haberli Electric	\$ 2,872	120	\$ 191
10/17/2017	Literay Safety Edge: Eagle Elevator	\$ 4,216	120	\$ 386
1/4/2018	Rewiring for Reception and lobby remodl: E. Haberli Electric	\$ 4,891	120	\$ 326
4/30/2018	Catch Basin Kitchen; Sahar, Shalom	\$ 2,500	180	\$ 73
5/18/2018	Gas Furnace- Dietary: Climatech Mechancical	\$ 11,645	180	\$ 273
1/27/2018	Outside Sig: Write Way Sings & Designs	\$ 2,587	120	\$ 108
5/22/2018	Kitchen AC New Wiring; MC Electrical Contracting	\$ 3,729	180	\$ 87
6/6/2018	Walkin Freezer Upgrade: Climatech Mechanical Srv	\$ 4,274	180	\$ 75
1/1/2018	Dining Room Upgrade; Various Vendors	\$ 5,796	180	\$ 298
6/1/2018	Laptop & Wiring: Various Vendor	\$ 1,239	180	\$ 29
7/25/2018	Fence: Hartford Fence Co	\$ 9,622	180	\$ 114
9/1/2018	AC Replaced: Climatech Mech & Mc Electrical	\$ 23,275	180	\$ 139
9/4/2018	Installed Fire Door: Sahar Shalom	\$ 3,835	180	
8/9/2018	Hot Water Heather; Climatech Mechanical SRv	\$ 14,623	180	\$ 87
Total additions for	r Leasehold Improvement	\$ 144,740		\$ 6,571
Deletions:				
			100	
Total deletions for	Leaschold Improvement	(S		\$

^{*}Ties to Page 24, Line C3

^{**}Ties to Page 23, Line D2b

^{**}Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility CSP-24 Rev. 10/2006 State of Connecticut

Amortization Schedule*

Nam	Name of Facility		License No.		Report for Year Ended	r Ended		Page	of
Mer	Menden Care Center, LLC		2153-C	3-C	9/30/2018			24	37
					Accumulated				
		Date of			Amort. to				
		Acquisition			Beginning of	Basis for			
			Length of	Cost to Be	Year's	Computing	Rate	Rate Amortization	
	Item	Month Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
Ą	Organization Expense								
	1								
	2.								
	Š								
A-4	A-4. Subtotal								
М	Mortgage Expense								
	1.								
	2.								
	3.								
B-4 .	Subtotal								
ن	Leasehold Improvements and Other								
	1. Acquired prior to this report period			547,328	330,762			42,099	
	2. Disposals (attach schedule)								
	3. Acquired during this report period								
	(attach schedule)			144,740				6,571	
C-4	. Subtotal								48,671
D.	Total Amortization								48,671
]	* Straight-line method mist he used								

* 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	License No.	Report for Year En	ded		Page of
Meriden Care Center, LLC	2153-C	9/30/2018			25 37
11. Property Questionnaire					
Part A					
Is the property either owned by th	e Facility	**	_		If "Yes," complete Part B.
or leased from a Related Party?*	, 0	Yes	0	1330	If "No," complete Part C.
*If any owner or operator of this faci	lity is related by family, ma	arriage, ownership, ability	to control or		
business association to any person or	organization from whom b	uildings are leased, then i	t is considered a		
related party transaction. Description		Total			
Date Land Purchased		12/01/03			
Date Structure Completed		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
3. If NOT Original Owner, Date	e of Purchase	12/01/03			
4. Date of Initial Licensure		12/01/03			
5. Total Licensed Bed Capacity		159			
6. Square Footage					
7. Acquisition Cost					
a. Land b. Building					
Part B - Owner and Related Pa	wtios	1st Mortgage	2nd Mortgage	2rd Mortgage	4th Mortgage
1. Financing	rties	1st Wortgage	Ziid Mortgage	31d Mortgage	4th Mortgage
a. Type of Financing (e.g., fi	xed, variable)				
b. Date Mortgage Obtained					
c. Interest Rate for the Cost	Year				
d. Term of Mortgage (numbe					
e. Amount of Principal Borro					
f. Principal balance outstand					
Complete if Mortgage was I					
During Current Cost Ye					
g. Type of Financing (e.g., financing) h. Date of Refinancing	xed, variable)				
i. New Interest Rate					
j. Term of Mortgage (number	er of years)				
k. Amount of Principal Borro					
Principal Outstanding on	Note Paid-Off				
Part C - Arms-Length Leas	 				
Name and Address of Lesso					Annual Amount of Lease
Summit Meriden, LLC	33 Roy St	reet, Meriden, CT	08/09/17	15 years with 2	\$598,500 yr 1
				year extension	

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 L	icense No.		Report for Yea	r Ended		Page	of
Meriden Care Center, LLC	2153-C		9/30/2018			26	37
Item			Total	CCNH	RHNS	Ot	her
12. Interest							
A. Building, Land Improvemen	nt & Non-Movable						
Equipment 1. First Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
Second Mortgage		\$					
Name of Lender		Rate					
Twine of Lordon		Tate					
Address of Lender							
		4					
3. Third Mortgage Name of Lender		\$					
Name of Lender		Rate					
Address of Lender	······································						
4. Fourth Mortgage		\$	700000000000000000000000000000000000000				000000000000000000000000000000000000000
Name of Lender		Rate					
Address of Lender							
Actions of Donto							
B. CHEFA Loan Information							
1. Original Loan Amount		\$					
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expens	e						······································
12 B7. Total Building Interest Expen							
12 2. 1 Total Distributed Theorem	(111 111 130)			. C. 1-4-4-1-	forward to n		`

(Carry Subtotals forward to next page)

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

Name of Facility	License No. 2153-C		Report for Ye 9/30/2018	ear Ended		Page 27	of 37
Meriden Care Center, LLC	2133-C		9/30/2018			21	31
Ite	m		Total	CCNH	RHNS	Oth	er
The state of the s		ught Forward:	1 Otal	CCIVII	1(1111)	Otti	
12. C. Movable Equipment	D GOVOVAID E-10	1 02 17 10 11					
1. Automotive Equipmen	nt	\$					
A. Item	Rate	Amount					
Lender		.!	,				
Address of Lender							
2. Other (Specify)		\$					
A. Item	Rate	Amount					

Lender							
Address of Lender							
Address of Lender							
B. Item	Rate	Amount					
Lender	_						
A I I CT			_				
Address of Lender							
12. C. 3. Total Movable Equip	ment Interest	d)					
Expense (C1 + 2) 12. D. Other Interest Expense (A)	Specify)	<u> </u>		10,747	65		
INTEREST	specify j	Φ	10,612	10,747	03		
IIIIIIIIIIII							
13. Total All Interest Expense (12B7 + 12C3 + 12D	9) \$	10,812	10,747	65		
14. Insurance		-					
a. Insurance on Property (b		\$		8,763	53		
b. Insurance on Automobile		hava					
c. Insurance other than Pro 1. Umbrella (<i>Blanket C</i>		bove) \$	53,412	53,093	319		
2. Fire and Extended Co		\$	33,712	23,073	317		
3. Other (Specify)		<u> </u>		5,561	33		
Other insurance, crim	ne						
14d. Total Insurance Expenditur		\$		67,416	405		
15. Total All Expenditures (A-1	3 thru C-14)	\$	14,470,322	14,389,759	80,563		

D. Adjustments to Statement of Expenditures

	of Fa		II C	Lic	cense No.	Report for Ye 9/30/2018	ar Ended	Page 28	of 37
ivieric	en Ca	re Ce	nter, LLC		2153-C	7/30/2018	<u> </u>	<u> </u>	1 3/
. .	_				Total				
	Page		.		Amount of	000.00	DIDIG .		v/1
	No.		Item Description		Decrease	CCNH	RHNS	C	ther
Page	10 - S	·	es and Wages						
1.			Outpatient Service Costs	\$					
2.			Salaries not related to Resident Care	\$				-	
3,			Occupational Therapy	\$				ļ	
4.			Other - See attached Schedule	\$					*******************
	13 - I	rofes	sional Fees						
5.			Resident Care Physicians **	\$					
6,			Occupational Therapy	\$					
7.			Other - See attached Schedule	\$					
Page	s 15 &	16 -	Administrative and General						
8.			Discriminatory Benefits	\$					
9,			Bad Debts	\$	(126,605)	(125,875)	(730)		
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	\$				110001000	*************
16.			Travel for purposes of attending						
			conferences or seminars outside the						
			continental U.S. Other out-of-state						
			travel in excess of one representative	\$		***************************************	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	T	*************
17.			Automobile Expense (e.g. personal use)	\$					
18.			Unallowable Advertising *	\$		16,204	94		
19.			Income Tax / Corporate Business Tax	\$					
20.			Fund Raising / Contributions	\$					
21.			Unallowable Management Fees	\$					
22.			Barber and Beauty	\$	<u> </u>	 			
23.	<u> </u>		Other - See attached Schedule	\$		45,107	270		
	18 - 1	Dietar	y Expenditures		1				
24.			Meals to employees, guests and others						
A-7.			who are not residents	\$:			*************	100000000000000000000000000000000000000
Daga	10 1	auruz	lry Expenditures	- 4	<u> </u>				
25.	17-1	Juunu	Laundry services to employees, guests		l l				
23.			and others who are not residents	\$				S#2000000000000000000000000000000000000	
D	20 1	II.		1	<u>' </u>				
	20-1	10USE	Ekeeping Expenditures		-			1	
26.		1	Housekeeping services to employees, guests	đ	,		1	40000000	
	<u> </u>		and others who are not residents	<u>\$</u>		(615/1	(366)		
			Subtotal (Items 1 - 26)	1 3	<u> </u>	(64,564)		<u></u>	

^{*} All except "Help Wanted".

⁽Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	Other
				7 (8) (0) (4) (3)	
. V 10 V					
Total Other	r Salaries A	Adjustment	\$	\$.	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref Description	CCNH	RHNS	Other
	(6)		Maria (1880-1980)	
50.00.000				
Total Othe	r Fees Adjustments	\$ -	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref Description	CCNH	RHNS	Other
16a	PENALTIES	\$ -	\$ -	
16a	LATE FEES	\$ 5,425	\$ 31	
16a	PRIOR PERIOD EXPENSES			
	rounding	\$.		
	Provider User Fee for Medicare days	\$ 39,682	\$ 238	
Total Othe	r A&G Adjustments	\$ 45,107	\$ 270	s -

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

Name	e of Fa	cility	D. Adjustments to Statemen			Report for Y		Page		of
			nter, LLC	1.710	2153-C	9/30/2018	cai Lilaca	29	3′	
IVICIR		i CC	iller, LLC	<u> </u>	Total	7/30/2010				
Itam	Page	Lina			Amount of					
No.	1 - 1	No.	Item Description		Decrease	CCNH	RHNS		Other	
140.	140.	110.	Subtotals Brought Forward	•	(64,930)	(64,564)	(366)	<u>'</u>	Other	
Daga	20 E	Pasida	nt Care Supplies***	49	(04,930)	(04,304)	(300)			
27.	20 - N		Prescription Drugs	\$					-	
28.			Ambulance/Limousine	<u>φ</u>						
29.			X-rays, etc	 \$	6,013	6,013				
30.			Laboratory	\$	13,862	13,862				
31.			Medical Supplies	<u>э</u> \$	13,862	13,602				
31.				\$						
			Oxygen (non emergency)	<u>\$</u>						—
33.			Occupational Therapy	- <u>\$</u>	0.506	0.506				
34.		M	Other - See Attached Schedule	Ф	9,506	9,506				
	22 - 1		enance and Property							
35.			Excess Movable Equipment Depreciation	eth.				625.5		
<u> </u>			See Attached Schedule	\$						S.CO.
36.			Depreciation on Unallowable	•				900000000	kiberii 21	
			Motor Vehicles	\$						
37.			Unallowable Property and Real	•						
			Estate Taxes	\$						
38.			Rental of Building Space or Rooms	\$						
39.			Other - See Attached Schedule	\$						
	27 - I								250.000	
40.			Mortgage Insurance	\$						
41.			Property Insurance	\$						
	r - Mis	scellar								195010
42.			Other - Indirect	\$						
43.			Interest Income on Account Rec.	\$	1					
44.			Other - Miscellaneous Administrative	\$						
45.			Management Fees Direct	\$						
46.			Management Fees Indirect	\$	I					
47.			Other - Direct	\$						
Not .	For Pr	ofit P	roviders Only		750 Carlon San Carlon					
48.			Building/Non Movable Eq. Depreciation							
			Unallowable Building Interest -					80.00	15 (B. 6)	
			See Attached Schedule	\$						
49,	Total	Amoi	unt of Decrease (Items 1 - 48)	\$	(35,548)	(35,182)	(366)			

^{***} Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Other
20	5J		9,505.54		1
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	ė.		
13	B9A	ST- Resident Care (for outpatent therapy - see schedule)	÷		
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)			
(2000)					
Total Othe	r Ancillary	y Costs	\$ 9,506	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Other
	6.000 0.000				
	80 (S. 19.19)				
Total Exce	ss Movabl	e Equipment Depreciation	\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
6.100.000					
	3. 22.3.				
2000000	900 900 000 900				
0.000					
Total Othe	r Propert	y Adjustments	\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	Other
20	4A1	Houskeeping Supplies (for Outpatient Therapy - see schedule)	\$ -		
20	4B	Housekeeping purchased services (for Outpatient Therapy see schedule)	\$ -		
22	6B	Heat (for outpatient Therapy see schedule)	S -		
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 Othe	r Adjustm	ents .	\$ -	\$	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Other
	88 88 88				
100000				er omkom reduc	
Total Unal	lowable Bu	allding Interest	\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility Lice	nse No.		Report for Y	ear Ended		Page		of
	153-C		9/30/2018			30		37
	William III							
Iten			Total	CCNH	RHNS		Other	
I. Resident Room, Board & Routine Car	e Revenue							
1. a. Medicaid Residents (CT only)		\$	12,030,807	11,964,187	66,620			
 b. Medicaid Room and Board Contri 	actual Allowance **	\$						
2. a. Medicaid (All other states)		\$						
b. Other States Room and Board Co	ntractual Allowance **	\$						
3. a. Medicare Residents (all inclusive)	\$	871,438	871,438				
 b. Medicare Room and Board Contr 	actual Allowance **	\$						
4. a. Private-Pay Residents and Other		\$	1,777,060	1,777,060				
 b. Private-Pay Room and Board Con 	tractual Allowance **	\$,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ionskova a
II. Other Resident Revenue								
1. a. Prescription Drugs - Medicare		\$	61,023	61,023				
b. Prescription Drugs - Medicare Co	ontractual Allowance **	\$	(61,023)	(61,023)				
c. Prescription Drugs - Non-Medica	re	\$	180,648	180,648				
d. Prescription Drugs - Non-Medica	re Contractual Allowance **	\$	(180,648)	(180,648)				
2. a. Medical Supplies - Medicare		\$						
b. Medical Supplies - Medicare Cor	ntractual Allowance **	\$						
c. Medical Supplies - Non-Medicare	······································	\$						
d. Medical Supplies - Non-Medicar		\$						
3. a. Physical Therapy - Medicare		\$	172,410	172,410				
b. Physical Therapy - Medicare Con	tractual Allowance **	\$	(111,942)	(111,942)				
c. Physical Therapy - Non-Medicare		\$	108,418	108,418				
d. Physical Therapy - Non-Medicare		\$	(108,418)	(108,418)				
4. a. Speech Therapy - Medicare		\$	42,801	42,801				
b. Speech Therapy - Medicare Cont	ractual Allowance **	\$	(21,217)	(21,217)				
c. Speech Therapy - Non-Medicare		\$	27,203	27,203				
d. Speech Therapy - Non-Medicare	Contractual Allowance **	\$	(27,203)	(27,203)				
5. a. Occupational Therapy - Medicar		\$	229,898	229,898				
b. Occupational Therapy - Medicar		\$	(122,673)	(122,673)				
c. Occupational Therapy - Non-Me		\$	160,893	160,893				
d. Occupational Therapy - Non-Me		\$	(74,999)	(74,999)				
6. a. Other (Specify) - Medicare		\$						
b. Other (Specify) - Non-Medicare		\$	37,237	37,237	-			
III. Total Resident Revenue (Section I. th	aru Section II.)	\$	14,991,712	14,925,092	66,620			
IV. Other Revenue*								
Meals sold to guests, employees & c	others	\$				800000000	(10000000000000000000000000000000000000	2000000
2. Rental of rooms to non-residents	Juli 13	\$						
3. Telephone		<u> </u>				1		
Rental of Television and Cable Serv	icae	<u> </u>				<u> </u>		
5. Interest Income (Specify)	ICO	\$	12	12		 		
6. Private Duty Nurses' Fees	L. C. LI HAVELLAND THE CONTROL OF TH	 \$	12	1		 		
	ne	<u> </u>						
7. Barber, Coffee, Beauty and Gift sho8. Other (Specify)	ho	\$	288	288		1		
V. Total Other Revenue (1 thru 8)		\$		300		 		
			300			\vdash		
VI. Total All Revenue (Ⅲ+V)		\$	14,992,011	14,925,392	66,620	<u> </u>		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	Other
11 (5) (6)	Lab Medicare	\$ 5,199	400000	langer (standard)
	Lab, Medicare CA	\$ (5.199)	4 8000000	egan enders
	Oxygen Medicare	\$ 25	WY STANK	SA PORTOR
	Oxygen Medicare CA	\$ (25)		
1.00	Equipment rental	\$ 572		20011000000-14
W 3000	Equipment rental CA	\$ (572)		(50,000,000,000,000)
	Pen Therapy	\$		AND YOU
	Pen Therapy CA	\$		
Contraction	Therapy Beds Medicare	\$	\$600 PERM	genetije, /
nga ba	Therupy Beds Medicare CA	\$	Stricture Stricts	
	Radiology Medicare	\$ 2,355		
	Radiology Medicare CA	\$ (2,355)		
	[V Therapy	\$ 3,863		bethenisk?
\$45.65	IV Therapy, CA	\$ (3,863)		\$150 METER 1855
5,000	Medical Transportation	\$	PER PROPERTY.	78.33
	Medical Transportation CA	\$		ZOYACESE
	Glucose testing	\$	10000000	20,000
S. 17 (1997)	Glucose testing CA	\$ -	V000100 (444)	11114/1980
19000000	Outpalient therapy Medicure	S	ji booljak Herv	
14723		Principles 14		Salid James C
Total Oth	or Resident Revenue - Medicare	\$	\$	Ş

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CENH	RHNS	Other
	Lib	9,312.87		gay ayr ép.
0.000	Leb CA	(9,312.87)		
1000100.0	Öxygen	\$ 364	04/04/04/04/05/05/05/05/05/05/05/05/05/05/05/05/05/	\$
03913-00	Oxygen CA	\$ (364)		\$
400,000	Equipment rental	\$ 14,125		500000000000000000000000000000000000000
	Equipment rental CA	\$ (14,125)		
	Pen Therapy	:		
1,5494,53	Рен Пістіру СА	\$	A 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	
430K	Theropy Beds		25 2 3 4 4	elebrication (
	Therspy Beds CA	\$	16-11-6	N. 14. 1
4000	Radiology	\$ 4315		
19, 417	Radiology CA	\$ (4,315)		23.5(4).743
(s.e.	Medical Transportation	\$ 8,557	1970 (19.11)	De Bygne Kin
10000	Medical Transportation CA	\$ (8,557)		54.03.050
	Glucgse Tesling	anni markini sekalika		600000000000000000000000000000000000000
	Glucose Testing CA	\$	A Table	4,000,000
100	IV lberapy	\$ 14,826	2019/80% (EV)	\$
100,88	IV therapy CA	\$ (14,826)	pire Parket	\$ -
violes.	Flu shot revenue	\$ (2,587)	7.50	1.7874.338
	Oppulent therapy	\$	(% \0000 0) 1 566	CONT.
rijejove	prior period revenue	\$ 39,824		properties of
150.000	Option B	\$	100000000000000000000000000000000000000	100000000000000000000000000000000000000
0.00	Optum B CA	\$	0.5000	
			0.0000000000000000000000000000000000000	
13700	rewiding	S 0		\$90,00000
				100000000000000000000000000000000000000
Total Oth	ier Resident Revenue	\$ 37,237.	\$ -	2

Interest Income

Account

Page Ref Acces	ent.	Balance	CCNH	RHNS	Other
ENTE	REST INCOME	810000000000000000000000000000000000000	\$ 12	dikat Kiri	
251 600 600					200.00
				Police Process	2012
					diferiorients (
Total Interest Inc	come		5 12	\$ +	S

Schedule of Other Revenue

Page Ref	Description	CONH	RHNS	Other
	MEALS	\$ -		
Section.	TELEVISION INCOME	\$		
110000	CONCESSIONS / VENDING INCOME	\$ 288		
1100	RESIDENT LATE FEE REVENUE	\$	C'rydria.	way day
138086	RESIDENT ATTORNEY FEE REVENUE	\$	1 (1440) (440)	13-4-11-00
1179,000	TELEPHONE INCOME	\$	87 Year Air	144,4474
	OTHER INCOME	\$	TE HERWICH	
1000	OPTUM DIVIDENDS REVENUE	\$	19803880	Tribulando
2420.00		Japan Kalanda	gi gir farçışi görleşi	34,000,000,00
1 1 1 1 1 1 1 1			0.00	a vedada,
			Note that	
275.30.25		SARAY SERVE	100000000000000000000000000000000000000	yarı i dalatı
Total Oth	er Rayanna	\$ 288	\$.	\$

G. Balance Sheet

Name	of	Facility	License No.	Rep	ort for Year Ended	Page		of
Merid	en	Care Center, LLC	2153-C	9/3()/2018	31		37
			Account			A	mount	
Assets	<u>s</u>							
Α, (Cu	rrent Assets						
	1.	Cash (on hand and in banks)			\$	()	217,171)
,	2.	Resident Accounts Receivab	le (Less Allowance 1	for Bad	Debts)	\$	2,3	328,264
,	3.	Other Accounts Receivable (Excluding Owners of	r Relate	ed Parties)	\$		
4	4	Inventories				\$		
,	5.	Prepaid Expenses				\$	(950,323
		a. Prepaid Insurance			948,757			
		b. Prepaid Property Taxes						
		c. Prepaid Expenses Other			1,565			
		d. See Schedule						
	6.	Interest Receivable				\$		
	7.	Medicare Final Settlement R	eceivable			\$		
	8.	Other Current Assets (itemize	e)			\$	(464,804)
		Due From (to) Related Parties			50,970			
		Other Owners reserves			(515,774)			
		See Schedule						
A-9.	To	tal Current Assets (Lines A1	thru 8)			\$	2,	596,612
В.	Fix	ted Assets						
	1.	Land				\$ 		
	2.	Land Improvements	*Historical Cost			\$		
		*	Accum. Deprecia	tion	Net			
	3,	Buildings	*Historical Cost		416,163	\$	•	338,816
		0	Accum. Deprecia	tion	77,347 Net			
	4.	Leasehold Improvements	*Historical Cost		692,068	\$		312,635
		*	Accum. Deprecia	tion	379,433 Net			
	5.	Non-Movable Equipment	*Historical Cost			\$		
			Accum, Deprecia	tion	Net			
	6.	Movable Equipment	*Historical Cost		812,504	\$ l		186,161
		• •	Accum. Deprecia	tion	626,342 Net			
	7.	Motor Vehicles	*Historical Cost			\$		
			Accum. Deprecia	tion	Net			
	8.	Minor Equipment-Not Depr				\$		
	9.	Other Fixed Assets (itemize))			\$ 		30,255
		Construction in Progress			30,255			
		See Schedule						
B-10.		Total Fixed Assets (Lines E	31 thru 9)			\$ 3		867,867

^{*} 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
Merio	den	Care Center, LLC	2153-C	9/30/2018	32 37
			Account	m . 15 1.5 1	Amount
		1 13 17	1 10 77 ' 75	Total Brought Forward:	\$ 3,464,479
C.		asehold or like property record	led for Equity Purposes		Ф
		Land	*****		\$
	2.	Land Improvements	*Historical Cost	NT	φ.
	~	D.311	Accum. Depreciation *Historical Cost	Net	\$
	Э.	Buildings		Net	\$
	1	Non-Movable Equipment	Accum. Depreciation *Historical Cost	INGL	Φ
	4.	Non-Movable Equipment	Accum, Depreciation	Net	\$
	5	Movable Equipment	*Historical Cost	ı ıncı	Ψ
	J.	Wovable Equipment	Accum, Depreciation	Net	\$
<u> </u>	6	Motor Vehicles	*Historical Cost	1108	Ψ
	U.	Wiotor Vemeres	Accum. Depreciation	Net	\$
	7	Minor Equipment-Not Depre		1100	\$
C-8		tal Leasehold or Like Proper			\$
D.		estment and Other Assets	wes (of the 7)		Ψ
		Deferred Deposits			\$
		Escrow Deposits	, , , , , , , , , , , , , , , , , , , ,		\$ 314,675
		Organization Expense	*Historical Cost		
			Accum, Depreciation	Net	\$
	4.	Goodwill (Purchased Only)	<u> </u>		\$
	5.	Investments Related to Resid	lent Care (itemize)		\$ 81,147
		Patient Trust Funds	,	78,592	
		Long Term Deposit - prim	necare	2,555	
	6.	Loans to Owners or Related	Parties (itemize)		\$
		Name and Address	Amount	Loan Date	
	7.	Other Assets (itemize)			\$
<u> </u>		See Schedule			
		tal Investments and Other As			\$ 395,823
D-9.	To	tal All Assets (Lines A9 + B1	(0 + C8 + D8)		\$ 3,860,302

^{*} 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 F	Ended	Page	of
Meriden Care	e Cen	ter, LLC	2153-C	9/30/2018		33	37
			Account			An	nount
Liabilities							
A.	Cu	rrent Liabilities					
	1.	Trade Accounts Payable			\$		413,802
1	2.	Notes Payable (itemize)			\$	***************************************	91,920
		Working Capital Line of Cr	edit	91,920)		
		n n 1 1 1					
		See Schedule	1/0 / !:	\ (\); \			
	3.	Loans Payable for Equipme					
_		Name of Lender	Purpose	Amount	Date Due		
	4.	Accrued Payroll (Exclusive	of Owners and/or S	Stockholders only)	\$		445,106
	5.	Accrued Payroll (Owners a	nd/or Stockholders	only)	\$		
	6.	Accrued Payroll Taxes Pay	able		\$		
	7.	Medicare Final Settlement	Payable		\$		
	8.	Medicare Current Financing	g Payable		\$		
	9.	Mortgage Payable (Curren	t Portion)		\$		
	10	. Interest Payable (Exclusive	of Owner and/or Re	elated Parties)	\$		
	11	. Accrued Income Taxes*			\$	1	
	12	. Other Current Liabilities (i.	temize)		\$	 	2,381,849
		Related Party Payables	1,276,	020			
		Accrued Expenses	75,	540			
		Accrued Resident User Fees	290,	979			
		Accrued Workers Comp Expense		310 See Schedule			
A-13	, To	tal Current Liabilities (Lin	es A1 thru 12)		\$)	3,332,677

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year	Ended	Page	of
Meriden Care Center, LLC	2153-C	9/30/2018		34	37
	Account			An	nount
		Total Broug	ht Forward:		3,332,677
Liabilities (cont'd)					
B. Long-Term Liabilities					
Loans Payable-Equipment (\$		
Name of Lender	Purpose	Amount	Date Due		

2. Mortgages Payable			\$		
Loans from Owners or Rela	ated Parties (itemize)	\$		
Name and Address of Lender	Amount	Loan D)ate		
4. Other Long-Term Liabilitie	es (itemize)		\$		78,592
Patient Trust Funds		78,592			
See Schedule					
B-5. Total Long-Term Liabilities (\$		78,592
C. Total All Liabilities (Lines A-	13 + B- 5))	3,411,269

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

Nan	ne of Facility	License No.	Report for Ye	ear Ended	Page	of
Mer	riden Care Center, LLC	2153-C	9/30/2018		35	37
		Account			Ar	nount
A.	Reserves					
	1. Reserve for value of leased	land			\$	
	2. Reserve for depreciation va	lue of leased buildin	gs and appurten	ances		
	to be amortized				\$	
	3. Reserve for depreciation va	lue of leased person	al property (Equ	ity)	\$	
	4. Reserve for leasehold real p	properties on which	fair rental value i	s 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		•	A A A A A A A A A A A A A A A A A A A	\$	(97,657)
	6. Gain or Loss for Period	10/1/20	017 thru	9/30/2018	\$	521,689
	7. Total Net Worth				\$	449,033
C.	Total Reserves and Net Worth	i e			\$	449,033
D.	Total Liabilities, Reserves, an	d Net Worth			\$	3,860,302

H. Changes in Total Net Worth

Name of Facility		License No.	Report for Year	Ended	Page	of		
Meriden Care Center, LLC		2153-C 9/30/2018			36	37		
	Account					Amount \$		
A. Balance at End of Prior Period as shown on Report of 09/30/2017								
B. Total Revenue (From Statement of Revenue Page 30)					\\$ \$	14,992,011		
	C. Total Expenditures (From Statement of Expenditures Page 27)					14,470,322		
	D. Net Income or Deficit					521,689		
<u>E.</u>	Balance					521,689		
F.	Additions 1. Additional Capital Contributed (itemize)							
2. Other (itemize)								
F-3.	otal Additions				\$			
G.	Deductions							
1. Drawings of Owners/Operators/Partners (Specify)					\$			
	Name and Address (No., City	, State, Zip)	Title	Amount	\$			
	2. Other Withdrawings (Specify)							
	Purpose	Purpose Amount		ount	_			
					\$			
	3. Total Deductions							
H. Balance at End of Period 09/30/18					\$	521,689		

I. Preparer's/Reviewer's Certification

Name of Facility		License No.	Report for Year Ended	Page	of					
Meriden Care Center, LLC		2153-C	9/30/2018	37	37					
		Check appropriate category								
☑	Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)	☑ Other	☑ Other						
		Preparer/Reviewer Certifica	ation							
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	Date Signed						
Printe	d Name of Preparer									
iCare	Management, LLC									
Addre	es Address	Phone Number	Phone Number							
341 B	idwell Street, Manchester, CT 06040	860-570-2140	860-570-2140							
Annu	al Report Contact	Phone Number	Phone Number							
Annu	al Report Contact Email Address									