State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2023

Name of Facility (as licensed) Farmington Care Center, LLC		
Address (No. & Street, City, State, Zip Code) 20 Scott Swamp Road, Farmington, CT 06032		
Type of Facility ☐ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	☑ (Specify)	☑ Other
Report for Year Beginning 10/1/2022	Report for Year Ending 8/30/2023	

License Numbers:	CCNH / RHNS	(Specify)	Other	Medicare Provider
	2288			07-5251

Medicaid Provider Numbers:	CCNH / RHNS	(Specify)	Other
	10447		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	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 Farmington Care Center, LLC [facility name], for the cost report period beginning October 1, 2022 and ending August 30, 2023, 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 accordanc with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Jessica DeRing			Printed Name (Owner) Chris Wright	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

Table of Contents

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1A Rev. 3/2023

State of Connecticut
Department of Social Services
55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Farmington Care Center, LLC	Period Covered:		From 10/1/2022	To 8/30/2023
Address of Facility 20 Scott Swamp Road, Farmington, CT 06032				
Report Prepared By iCare Management, LLC	Phone Number 860-570-2140		Date 2/15/2024	

Item		Total	CCNH / RHNS	(Specify)	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-2 Rev. 3/2023

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-677-7707	8/30/2023	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Farmington Care Center, LLC	20 Scott Swamp Road, Farmington, CT 06032

License Numbers:	CCNH / RHNS	(Specify)	Other	Medicare Provider No.
	2288			07-5251

Type of Facility (Check appropriate box(es))

☐ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined ☑ (Specify) ☑ Other

Type of Ownership (Check appropriate box)

○ Proprietorship ◉ LLC ○ Partnership ○ Profit Corp. ○ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Jessica DeRing	1580

Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name	License No.:

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3 Rev. 10/2005

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
Farmington Care Center, LLC	20 Scott Swamp Road, Farmington, CT 06032	CT

Name of Partners/Members	Business Address	Title	% Owned
Executive Advisors, LLC	341 Bidwell St. Manchester, CT 06040	Member	47.5
Apex Advisors LLC	341 Bidwell St. Manchester, CT 06040	Member	47.5
Christopher Wright	341 Bidwell St. Manchester, CT 06040	Member	5

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3A Rev. 10/2005

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	3A	37

If this facility is owned or operated as a corporation, provide the following information:

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

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Names of Stockholders Owning at Least 10% of Shares			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

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

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⊙ No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? ⊙ Yes ○ No

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
See Attached.		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-5 Rev. 9/2002

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	5	37

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (*See listing page 13*)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

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

1. In the preparation of this Report, were all costs allocated as required? ⊙ Yes ○ No If "No," explain fully why such allocation was not made.

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

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-6 Rev. 3/2023

General Information and Questionnaire
Other Lines of Business

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	6	37

Square footage of entire facility.	0

Outpatient Therapy

Does the Facility provide outpatient therapy services?	No

If yes, please complete the following:

	Square footage of therapy space.

Meals on Wheels

Does the facility provide Meals on Wheels?	No

If yes, please complete the following:

	Square footage of kitchen	
	Number of meals served per week	
No	Are meals included in meals served on page 18 of the Annual Report?	
No	Are direct costs included in the Annual Report?	
	If yes, please state where costs are reported.	
No	Are drivers for the program included in the facility's payroll?	
	If yes, please complete the following:	
		Amount Reported
		Annual Report page and line
	Please state the salary amounts of specific cooks and/or dietary aides	
	Please state where the cooks and/or dietary aides are reported in the Annual Report	

Apartments, Independent Living, Assisted Living

Does the facility have apartments, independent living, and/or assisted living?	No

If yes, please complete the following:

	Square footage of apartments
	Square footage of independent living
	Square footage of assisted living
	Please identify the services provided:

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 3/2023

General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Cent	2288	8/30/2023	7	37

Child Day Care

Does the Facility provide Child Day Care?	No

If yes, please complete the following:

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

Adult Day Care

Does the Facility provide Adult Day Care?	No

If yes, please complete the following:

	Square footage of adult day care space.
	Please state where it is located in relation to the facility.
	Average number of daily participants.
	Number of meals per day provided to adult day care.
	Nature of services provided:

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 3/2023

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	8	37

	Total All Levels	Total CCNH / RHNS Level	Total (Specify)	Total Other	Period 10/1 Thru 6/30 Total	Period 10/1 Thru 6/30 CCNH / RHNS	Period 10/1 Thru 6/30 (Specify)	Period 10/1 Thru 6/30 Other	Period 7/1 Thru 9/30 Total	Period 7/1 Thru 9/30 CCNH / RHNS	Period 7/1 Thru 9/30 (Specify)	Period 7/1 Thru 9/30 Other
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	105	105			105	105						
B. On last day of THIS report period	105	105							105	105		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	77	77			77	77						
B. As of midnight of THIS report period	73	73							73	73		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,765	2,765			2,436	2,436			329	329		
B. Medicaid (Conn.)	23,084	23,084			18,654	18,654			4,430	4,430		
C. Medicaid (other states)												
D. Private Pay	1,523	1,523			1,238	1,238			285	285		
E. State SSI for RCH												
F. Other (Specify) Insurance	269	269			269	269						
G. Total Care Days During Period (3A thru F)	27,641	27,641			22,597	22,597			5,044	5,044		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	27,641	27,641			22,597	22,597			5,044	5,044		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-9 Rev. 3/2023

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	9	37

4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH / RHNS	(Specify)	Other	Lost			Gained			CCNH / RHNS	(Specify)	Other	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				

5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.

Change in Resident Days	CCNH / RHNS	(Specify)	Other
1st change			
2nd change			
3rd change			
4th change			

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	Other	R.C.H.	ICF-MR
No. of Residents	2	66		5				
Per Diem Rate								
a. One bed rm.	508.00	######		514.00				
b. Two bed rms.								
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	(Specify)	Outpatient	Other
A. Medicare - Part B	5,118	5,118			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	1,249	1,249			
2. Restorative Treatments	3,316	3,316			
C. Other	7,772	7,772			
D. ***Total Physical Therapy Treatments***	17,455	17,455			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	138	138			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	147	147			
2. Restorative Treatments	266	266			
C. Other	397	397			
D. ***Total Speech Therapy Treatments***	948	948			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	3,720	3,720			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	914	914			
2. Restorative Treatments	2,648	2,648			
C. Other	6,733	6,733			
D. ***Total Occupational Therapy Treatments***	14,015	14,015			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-10 Rev. 3/2023

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	Other	Adjustment	Hours
A. Salaries and Wages*									
1. Operators/Owners (Complete also Sec. I of Schedule A1)									
2. Administrator(s) (Complete also Sec. III of Schedule A1)	110,092		1,491						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	187,143		8,589						
5. Dietary Service									
a. Head Dietitian	28,720		617						
b. Food Service Supervisor	55,728		1,885						
c. Dietary Workers	256,444		14,196						
6. Housekeeping Service									
a. Head Housekeeper									
b. Other Housekeeping Workers									
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance									
b. Other Maintenance Workers									
8. Laundry Service									
a. Supervisor									
b. Other Laundry Workers									
9. Barber and Beautician Services									
10. Protective Services									
11. Accounting Services									
a. Head Accountant									
b. Other Accountants									
12. Professional Care of Residents									
a. Directors and Assistant Director of Nurses	203,808		3,002						
b. RN									
1. Direct Care	363,727		5,976						
2. Administrative**	131,389		2,811						
c. LPN									
1. Direct Care	387,432		11,626						
2. Administrative**	81,475		2,051						
d. Aides and Attendants	1,194,979		55,604						
e. Physical Therapists									
f. Speech Therapists									
g. Occupational Therapists									
h. Recreation Workers	115,016		5,059						
i. Physicians									
1. Medical Director									
2. Utilization Review									
3. Resident Care***									
4. Other (Specify)									
j. Dentists									
k. Pharmacists									
l. Podiatrists									
m. Social Workers/Case Management	61,290		1,993						
n. Marketing									
o. Other (Specify)									
See Attached Schedule	35,472		1,549						
A-13. Total Salary Expenditures	3,212,714		116,450						

* 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 in the Adjustment column.

Schedule of Other Salaries and Wages (Page 10)

	CCNH / RHNS			(Specify)			Other		
Position	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**
UNIT SECRETARIES SALARIES	$ 34,020		1,485				$ -		-
MEDICAL RECORDS SALARIES	$ 1,452		64				$ -		-
CENTRAL SUPPLY SALARIES	$ -		-				$ -		-
RESPIRATORY THERAPY SALARIES	$ -		-				$ -		-
PLANT SECURITY SALARIES	$ -		-				$ -		-
MEDICAL RECORDS SALARIES SPCL	$ -		-				$ -		-
Total	$ 35,472	$ -	1,549	$ -	$ -	-	$ -	$ -	-

Schedule of Other Fees (Page 13)

	CCNH / RHNS			(Specify)			Other		
Service	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**
MEDICAL RECORDS CONTRACT SERVICE	$ 17,426		Storage				$ -		Storage
ADMISSIONS C/S LABOR	$ 40,436		630				$ -		-
CENTRAL SUPPLY CONTRACT SERVICE	$ 13,460		526				$ -		-
ADMINISTRATIVE CONTRACT SERVICE LABOR	$ 149,194		2,497				$ -		-
RESPIRATORY THERAPY CONTRACT SERVICES	$ 19,496		314				$ -		-
PHYSICAL THERAPY C/S MEDICIAD	$ -		-				$ -		-
SPEECH THERAPY C/S Medicaid	$ -		-				$ -		-
OCCUPATIONAL THERAPY C/S MEDICIAD	$ -	-	-				$ -		-
Total	$ 240,011	$ -	3,967	$ -	$ -	-	$ -	$ -	-

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-11 Rev. 10/2005

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	11	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	(Specify)	Other							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	(Specify)	Other							
Section III - Administrators* **										
Heather Rodriguez	38,797			Administrator		513	same as empl			
Francis Fritz	60,141			Administrator		817	same as empl			
Jennifer Johnson	11,154			Administrator		160	same as empl			
Section IV - Assistant Administrators										

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

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-13 Rev. 3/2023

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	13	37

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	Other	Adjustment	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)									
1. Dietitian									
2. Dentist									
3. Pharmacist	18,454		182						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	292,234		5,598						
b. Other									
6. Social Worker	6,813		139						
7. Recreation Worker	16,139		43 Hours +C						
8. Physicians									
a. Medical Director (entire facility)	33,858		340						
b. Utilization Review (Title 18 and 19 only) monthly meeting									
c. Resident Care**									
d. Administrative Services facility									
1. Infection Control Committee (Quarterly meetings)									
2. Pharmaceutical Committee (Quarterly meetings)									
3. Staff Development Committee (Once annually)									
e. Other (Specify)									
Physician Care Contract Services	7,893		55						
9. Speech Therapist									
a. Resident Care	28,379		544						
b. Other									
10. Occupational Therapist									
a. Resident Care	222,952		4,271						
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	408,155		4,001						
2. Administrative***	103,494		1,175						
b. LPN									
1. Direct Care	808,980		12,563						
2. Administrative***									
c. Aides	347,643		9,710						
d. Other									
12. Other (Specify)									
See Attached Schedule	240,011		3,967						
B-13 Total Fees Paid in Lieu of Salaries	2,535,005		42,545						

* 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 in the Adjustment column.

*** 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Tocuhpoints Therapy	Therapy for residents, also Therapy for Workers comp for staff	⊙	○	Common Ownership
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Shared Employees	⊙	○	Common Ownership
Pharm Scripts	Pharmacy Contract	○	⊙	
Guardian Consulting Srv	Pharmacy Consulting	○	⊙	
Healthdrive Physician Services	Audiology, Dental and Podiatry	○	⊙	
HHCMG Specialists	Medical Director	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
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		○	⊙	

* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15 Rev. 3/2023

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended					Page	of
Farmington Care Center, LLC	2288	8/30/2023					15	37

Item		Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	$	87,894	87,894					
2. Disability Insurance	$							
3. Unemployment Insurance	$							
4. Social Security (F.I.C.A.)	$	275,221	275,221					
5. Health Insurance	$	482,859	482,859					
6. Life Insurance (employees only) (not-owners and not-operators)	$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	156,539	156,539					
8. Uniform Allowance	$							
9. Other (*Specify*) See Attached Schedule	$	15,604	15,604					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$							
c. Bad Debts*	$	831,516	831,516					
d. Accounting and Auditing	$	18,074	18,074					
e. Legal (*Services should be fully described on Page 15b)*	$	18,050	18,050					
f. Insurance on Lives of Owners and Operators (*Specify*)*	$							
g. Office Supplies	$	15,932	15,932					
h. Telephone and Cellular Phones								
1. Telephone & Pagers	$	45,197	45,197					
2. Cellular Phones	$	851	851					
i. Appraisal (*Specify purpose and attach copy*)*	$							
j. Corporation Business Taxes (*franchise tax*)	$	(8)	(8)					
k. Other Taxes (*Not related to property - See Page 22)*								
1. Income*	$							
2. Other (*Specify*) See Attached Schedule	$							
3. Resident Day User Fee	$	517,870	517,870					
Subtotal	$	2,465,600	2,465,600					

* Facility should self-disallow the expense in the Adjustment column.

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
UNION TRAINING	$ 15,604				$ -	
Total	$ 15,604	$ -	$ -	$ -	$ -	$ -

Schedule of Other Taxes

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Total	$ -	$ -	$ -	$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15b Rev. 3/2023

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	15b	37

The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

Is the accounting basis for this period the same as for the previous period? ⊙ Yes ○ No — If "No," explain.

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Plante & Moran, PLLC	PO Box 307 3000 Town Center, Suite 100 Southfield, MI 48075
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Taxes, financial statements, accounting support	$ 18,074
2		$
3		$
4		$
		Charge for Services Provided $ 18,074

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

⊙ Yes ○ No 15D

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Senir Care Valuation LLC, Alix,Yale Ristas LLP	
2 Robinson & Cole, LLP	
3 Various others (American Arbitration , Various Arbitration, Murtha Cullina)	
4	
5	

Address (*No. & Street, City, State, Zip Code*)

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	Lease and contract issues, general legal advice, Labor Law	$ 1,261
2	General legal advice, union funds advice, employment law	$ 813
3	Employment Arbitrations, healthcare law & Conservatorships	$ 15,976
4		$
5	Collections	$ (0)
		Charge for Services Provided $ 18,050

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

⊙ Yes ○ No 15E

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-16 Rev. 3/2023

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

Name of Facility	License No.	Report for Year Ended					Page	of
Farmington Care Center, LLC	2288	8/30/2023					16	37

Item		Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Subtotals Brought Forward:		2,465,600	2,465,600					
l. Travel and Entertainment								
1. Resident Travel and Entertainment	$							
2. Holiday Parties for Staff	$	1,055	1,055					
3. Gifts to Staff and Residents	$	236	236					
4. Employee Travel	$	36	36					
5. Education Expenses Related to Seminars and Conventions	$	621	621					
6. Automobile Expense (*not purchase or depreciation*)	$							
7. Other (*Specify*)	$	701	701					
See Attached Schedule								
m. Other Administrative and General Expenses								
1. Advertising Help Wanted (*all such expenses*)	$	35,411	35,411					
2. Advertising Telephone Directory (*all such expenses*)***	$							
3. Advertising Other (*Specify*)***	$	8,958	8,958					
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	$	661	661					
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	6,549	6,549					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$							
9. Subscriptions	$	1,137	1,137					
10. Contributions***	$	2,500	2,500					
See Attached Schedule								
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	122,146	122,146					
12. Administrative Management Services**	$	287,944	287,944					
13. Other (*Specify*)	$	25,189	25,189					
See Attached Schedule								
C-14 Total Administrative & General Expenditures	$	2,958,743	2,958,743					

* 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 expensein the Adjustment column.

Schedule of Other Travel and Entertainment

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
MEALS	$ 701				$ -	
Total Other Travel and Entertainment	$ 701	$ -	$ -	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
COMMUNICATIONS SPECIAL EVENTS	$ 8,958				$ -	
Total Other Advertising	$ 8,958	$ -	$ -	$ -	$ -	$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
ALTCFM						
CAHCF Dues	$ 6,549				$ -	
OTHER DUES						
Total Dues	$ 6,549	$ -	$ -	$ -	$ -	$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
CONTRIBUTIONS	$ 2,500				$ -	
Total Contributions	$ 2,500	$ -	$ -	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
SOCIAL SERVICE SUPPLIES	$ -				$ -	
SOC SVC MINOR EQUIPMENT	$ -				$ -	
ADMINISTRATIVE MINOR EQUIPMENT	$ 3,652				$ -	
EMPLOYEE RELATIONS	$ (1,159)				$ -	
EMPLOYEE RELATIONS-OTHER	$ 52				$ -	
PERMITS & LICENSES	$ 3,197				$ -	
VOLUNTEER EXPENSE	$ -				$ -	
BANK FEES	$ 7,859				$ -	
CMS REVISIT USER FEES	$ -				$ -	
PENALTIES	$ -				$ -	
LATE FEES	$ 1,557				$ -	
INTERNET EXPENSES	$ 10,032				$ -	
Rounding	$ -					
Total Other Administrative and General	$ 25,189	$ -	$ -	$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Farmington Care Center, LLC	License No. 2288	Report for Year Ended 8/30/2023	Page 17 | of 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
iCare Management, LLC/iCare Health Management, LLC	287,944	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	92,002	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	22,795	MANAGEMENT FEES- INDIRECT CARE	Pg 20 k

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-18 Rev. 3/2023

C. Expenditures Other Than Salaries (cont'd) - Dietary Basis for Allocation of Costs (See Note on Page 5)

Name of Facility	License No.	Report for Year Ended					Page	of
Farmington Care Center, LLC	2288	8/30/2023					18	37

Item		Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	$	202,727	202,727					
2. Non-Food Supplies	$	33,745	33,745					
3. Other (*Specify*)_____ DIETARY SUPPLEMENTS	$	10,098	10,098					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	227	227					
c. Other (*Specify*)_____ DIETARY MINOR EQUIPMENT	$	2,057	2,057					
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	248,854	248,854					

		Total	CCNH / RHNS	(Specify)	Other
2E.	Dietary Questionnaire				
F.	Resident Meals: Total no. of meals served per day:*				

G.	Is cost of employee meals included in 2D?	○ Yes	⊙ No	
H.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	○ Yes	⊙ No	If yes, specify cost.
K.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	○ Yes	⊙ No	If yes, specify cost.
N.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-19 Rev. 3/2023

C. Expenditures Other Than Salaries (cont'd) - Laundry Basis for Allocation of Costs (See Note on Page 5)

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	19	37

Item		Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
3. Laundry								
a. In-House Processing*								
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.							
	Amt. $							
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.							
	Amt. $							
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.							
	Amt. $							
4. Repair and/or purchase of linens.***	Lbs.							
	Amt. $							
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	292,611	292,611					
c. Other (*Specify*) LAUNDRY MINOR EQUIPMENT	$							
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	292,611	292,611					

3E.	Laundry Questionnaire			
F.	Is cost of employee laundry included in 3D?	○ Yes	⊙ No	If yes, specify cost.
G.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
H.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)		
I.	Is Cost of laundry provided to persons other than employees or residents included in 3D?	○ Yes	⊙ No	If yes, specify cost.
J.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
K.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)		

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3D.

*** Pounds of Laundry only required for multi-level facilities.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-20 Rev. 3/2023

C. Expenditures Other Than Salaries (cont'd) - Housekeeping and Resident Care Basis for Allocation of Costs (See Note on Page 5)

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	20	37

Item		Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
4. Housekeeping	Sq. Ft. Serviced by Personnel							
a. In-House Care								
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt. $	14,397	14,397					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel							
	Amt. $	247,225	247,225					
C. Other (*Specify*) $								
HOUSEKEEPING MINOR EQUIPMENT								
4D. ***Total Housekeeping Expenditures*** (4a + b + c) $		261,622	261,622					
5. Resident Care (Supplies)**								
a. Prescription Drugs***								
1. Own Pharmacy $								
2. Purchased from $		210,711	210,711					
PHARMACY								
b. Medicine Cabinet Drugs $		6,967	6,967					
c. Medical and Therapeutic Supplies $		67,046	67,046					
d. Ambulance/Limousine*** $		333	333					
e. Oxygen								
1. For Emergency Use $		1,392	1,392					
2. Other*** $								
f. X-rays and Related Radiological Procedures*** $		5,199	5,199					
g. Dental (*Not dentists who should be included under salaries or fees)* $								
h. Laboratory*** $		46,068	46,068					
i. Recreation $								
j. Direct Management Services* $		92,002	92,002					
k. Indirect Management Services* $		22,795	22,795					
l. Cable TV $								
m. Other (Specify)**** $		79,031	79,031					
See Attached Schedule								
n. Physical Therapy Expense $								
o. Speech Therapy Expense $								
5P. ***Total Resident Care Expenditures*** (5a - 5o) $		531,545	531,545					

* 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 in the Adjustment column.

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

Schedule of Other Resident Care

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
NURSING ADMIN SUPPLIES	$ -				$ -	
NURSING MINOR EQUIP	$ 2,500				$ -	
MEDICAL RECORDS SUPPLIES	$ (2,053)				$ -	
MEDICAL RECORDS MINOR EQUIPMENT	$ -				$ -	
NON-COVERED PPS DR. VISITS	$ -				$ -	
RESIDENT CARE SUPPLIES	$ 47				$ -	
CENTRAL SUPPLY MINOR EQUIPMENT	$ 9,979				$ -	
PERSONAL CARE SUPPLIES	$ -				$ -	
INCONTINENCY SUPPLIES	$ -				$ -	
VACCINE RESIDENTS	$ 6,727				$ -	
PATIENT SPECIAL NEEDS	$ 428				$ -	
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	$ 32,098				$ -	
EQUIPMENT RENTAL: AIDS UNIT	$ -				$ -	
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	$ 9,006				$ -	
PEN THERAPY FOOD NOT BILLABLE TO PART B	$ 3,220				$ -	
HI LOW BED RENTAL & MATTRESSES	$ -				$ -	
IV THERAPY SUPPLIES	$ 14,657				$ -	
IV THERAPY CONTRACT SERVICE	$ -				$ -	
MEDICAL WASTE CONTRACT SERVICE	$ 660				$ -	
ACTIVITIES SUPPLIES	$ 1,761				$ -	
ACTIVITIES MINOR EQUIPMENT	$ -				$ -	
ADMISSIONS SUPPLIES	$ -				$ -	
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS						
STRIKE COSTS NON REIMBURSABLE	$ -				$ -	
COVID NON REIMBURSABLE	$ -				$ -	
Total Other Resident Care	$ 79,031	$ -	$ -	$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 3/2023

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH / RHNS	(Specify)	Other	Pg	Line
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	○	⊙	VENDOR	Housekeeping Services	247,225			20	4b
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	○	⊙	VENDOR	Laundry Services	292,611			19	3b
Eagle Elevator		○	⊙	VENDOR	Elevator Contract	5,726			22	6F
Brightview Landscapes LLC		○	⊙	VENDOR	Landscaping	8,186			22	6F
Lazer Scapes LLC		○	⊙	VENDOR	Snow Removal	11,500			22	6F
CWPM LLC		○	⊙	VENDOR	Trash removal	37,684			22	6F
Facility Complaince		○	⊙	VENDOR	Plant Contract Services	62,351			22	6F
American HealthTech	P.O. Box 9001006, Louisville, KY 40290	○	⊙	VENDOR	Software Maintenance Contract	24,297			16	M11
Automatic Data Processing		○	⊙	VENDOR	Payroll Services	27,564			16	M11
National Datacare Corp		○	⊙	VENDOR	Resident Trust Software	3,570			16	M11
Prime Care Technologuy services		○	⊙	VENDOR	Computer Consulting Services	41,802			16	M11
Priotiry Express		○	⊙	VENDOR	Courier Services	2,206			16	M11
Point Right Inc		○	⊙	VENDOR	Nursing Software	4,703			16	M11
		○	⊙	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).

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22 Rev. 3/2023

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

Name of Facility	License No.	Report for Year Ended					Page	of
Farmington Care Center, LLC	2288	8/30/2023					22	37
Item		Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	$	35,377	35,377					
b. Heat	$	39,805	39,805					
c. Light & Power	$	56,135	56,135					
d. Water	$	45,050	45,050					
e. Equipment Lease (*Provide detail on page 22b*)	$	16,361	16,361					
f. Other (*itemize*)	$	153,306	153,306					
See Attached Schedule								
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	346,034	346,034					
7. Depreciation (*complete schedule page 23**)								
a. Land Improvements	$							
b. Building & Building Improvements	$							
c. Non-Movable Equipment	$							
d. Movable Equipment	$	36,377	36,377					
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	36,377	36,377					
8. Amortization (*Complete att. Schedule Page 24**)								
a. Organization Expense	$							
b. Mortgage Expense	$							
c. Leasehold Improvements	$	50,265	50,265					
d. Other (*Specify*)	$							
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	50,265	50,265					
9. Rental payments on leased real property less real estate taxes included in item 10b	$	405,575	405,575					
10. Property Taxes								
a. Real estate taxes paid by owner	$							
b. Real estate taxes paid by lessor	$	59,486	59,486					
c. Personal property taxes	$	6,750	6,750					
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	558,454	558,454					

* Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 2

Schedule of Other Repairs and Maintenance

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
PLANT SUPPLIES	$ 7,966				$ -	
PLANT CONTRACT SERVICE LABOR	$ -				$ -	
ELEVATOR CONTRACT SERVICE	$ 5,726				$ -	
FIRE/SPRINKLER CONTRACT SERVICE	$ 7,823				$ -	
LANDSCAPING CONTRACT SERVICE	$ 8,186				$ -	
SNOW REMOVAL CONTRACT SERVICE	$ 11,500				$ -	
TRASH REMOVAL CONTRACT SERVICE	$ 37,684				$ -	
PLANT (POOL) CONTRACT SERVICES OTHER	$ 62,351				$ -	
SECURITY CONTRACT SERVICE	$ -				$ -	
PLANT CONTRACT SERVICE OTHER	$ 6,728				$ -	
PLANT MINOR EQUIPMENT	$ 4,771				$ -	
RENT AUTO	$ -				$ -	
RENT EQUIPMENT	$ 571				$ -	
RENT OTHER	$ -				$ -	
Total Other Repairs and Maintenance	$ 153,306	$ -	$ -	$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22b Rev. 3/2023

General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	22b	37

Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
ADP, Inc., One ADP Drive MS-100, Augusta, GA 30909	○	⊙	Time Clocks and Payroll Punch Equip	06/01/10	automatic renewals	7,802	7,802
GE Capital C/O Ricoh USA, P.O.Box 41564, Philadelphai, PA 19101	○	⊙	Copier	03/04/14	48 Months	7,793	7,793
Pitney Bowes	○	⊙	Postage Rental		Month to month	812	812
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
						Total ***	16,407

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

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
** Attach copies of newly acquired leases.
*** Amount should agree to Page 22, Line 6e.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-23 Rev. 10/2022

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	1,160		1,160	1,161				
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					1,205,323		1,205,323	1,079,589			35,168	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative					7,418						759	
d. Standard Resident					15,463						558	
e. Specialized Resident												
Total Acquired during this report period					22,881						1,316	
D-3. Subtotal												36,484
E. ***Total Depreciation***												36,484

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Land Improvements		$ -		$ -	*
Deletions:					
Total deletions for Land Improvements		$ -		$ -	**

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

****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Building Improvements		$ -		$ -	*
Deletions:					
Total deletions for Building Improvements		$ -		$ -	**

***Ties to Page 23, Line B3**

****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report perio

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Non-Movable Equipmen		$ -		$ -	*
Deletions:					
Total deletions for Non-Movable Equipmen		$ -		$ -	**

***Ties to Page 23, Line C3**

****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report perio

Acquisition Date	Description of Item	Pick One Movable Category	Cost	Useful Life	Depreciation	
Additions:						
1/27/2023	Beds, Head/Foot: Direct Supply	Standard Resident	$ 9,204	60	$ 1,074	
8/9/2022	Washer Repair: Daniels Equipment	Standard Resident	$ 2,713	120	$ 271	
3/15/2023	Power Lift: Direct Supply	Standard Resident	$ 3,899	120	$ 162	
3/6/2023	Slings for lifts: Direct Supply	Standard Resident	$ 2,542	36	$ 353	
6/30/2023	Ice Machine: Proline	Standard Resident	$ (2,896)		$ (1,303)	
3/23/2023	Laptops: Primecare	Administrative	$ 4,158	36	$ 578	
6/20/2023	Laptops: Primecare	Administrative	$ 3,260	36	$ 181	
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
Total additions for Movable Equipmen			$ 22,881		$ 1,316	*
Deletions:						
Total deletions for Movable Equipmen			$ -		$ -	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report perio

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/14/2022	Dishwasher: HPC	$ 19,140	120	$ 1,595	
9/22/2022	Roof repair: F.J. Dahill Co.	$ 3,651	120	$ 335	
8/31/2022	Roof Repair: Quisenberry Arcari Malik, LLC	$ 6,001	120	$ 550	
3/20/2023	Boiler Repairs: Saucier	$ 4,696	240	$ 98	
5/31/2023	Roof Repair: Quisenberry Arcari Malik, LLC	$ 12,036	120	$ 301	
3/21/2023	Roof repair: F.J. Dahill Co.	$ 3,561	120	$ 148	
8/16/2023	Fire/sprinkler repair: Facility Compliance	$ 4,438	300	-	
Total additions for Leasehold Improvemen		$ 53,523		$ 3,027	*
Deletions:					
Total deletions for Leasehold Improvemen		$ -		$ -	**

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

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

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period				1,580,579	1,239,952			47,238	
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)				53,523				3,027	
C-4. Subtotal									50,265
D. ***Total Amortization***									50,265

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-25 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ○ Yes ⊙ No

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

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

Description	Total
1. Date Land Purchased	12/01/03
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	12/01/03
4. Date of Initial Licensure	12/01/03
5. Total Licensed Bed Capacity	105
6. Square Footage	29,450
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
Summit Farmington, LLC	20 Scott Swamp Rd, Farmington, CT	08/09/17	15 year with 2	285,954

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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-26 Rev. 3/2023

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	26	37

Item	Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage $							
Name of Lender / Rate							
Address of Lender							
2. Second Mortgage $							
Name of Lender / Rate							
Address of Lender							
3. Third Mortgage $							
Name of Lender / Rate							
Address of Lender							
4. Fourth Mortgage $							
Name of Lender / Rate							
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount $							
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expense							
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $							

(*Carry Subtotals forward to next page*)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-27 Rev. 3/2023

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	27	37

Item	Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Subtotals Brought Forward:							
12. C. Movable Equipment 1. Automotive Equipment $							
A. Item / Rate / Amount Lender Address of Lender							
2. Other (*Specify*) $							
A. Item / Rate / Amount Lender Address of Lender							
B. Item / Rate / Amount Lender Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $							
12. D. Other Interest Expense (*Specify*) $ INTEREST	165,754	165,754					
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	165,754	165,754					
14. Insurance							
a. Insurance on Property (buildings only) $	10,260	10,260					
b. Insurance on Automobiles $							
c. Insurance other than Property (as specified above)							
1. Umbrella (*Blanket Coverage*) $	66,885	66,885					
2. Fire and Extended Coverage $							
3. Other (*Specify*) $ Other insurance, crime	9,208	9,208					
14d. ***Total Insurance Expenditures (14a + b + c)*** $	86,353	86,353					
15. ***Total All Expenditures (A-13 thru C-14)*** $	11,197,687	11,197,687					

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-30 Rev. 3/2023

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	30	37

Item		Total	CCNH / RHNS	(Specify)	Other
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	6,846,452	6,846,452		
b. Medicaid Room and Board Contractual Allowance **	$				
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,597,162	1,597,162		
b. Medicare Room and Board Contractual Allowance **	$				
4. a. Private-Pay Residents and Other	$	891,500	891,500		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	133,251	133,251		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(132,851)	(132,851)		
c. Prescription Drugs - Non-Medicare	$	83,505	83,505		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(83,505)	(83,505)		
2. a. Medical Supplies - Medicare	$	6,563	6,563		
b. Medical Supplies - Medicare Contractual Allowance **	$	(6,563)	(6,563)		
c. Medical Supplies - Non-Medicare	$	3,209	3,209		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(3,209)	(3,209)		
3. a. Physical Therapy - Medicare	$	306,337	306,337		
b. Physical Therapy - Medicare Contractual Allowance **	$	(219,737)	(219,737)		
c. Physical Therapy - Non-Medicare	$	187,992	187,992		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(187,992)	(187,992)		
4. a. Speech Therapy - Medicare	$	27,928	27,928		
b. Speech Therapy - Medicare Contractual Allowance **	$	(21,551)	(21,551)		
c. Speech Therapy - Non-Medicare	$	37,322	37,322		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(37,322)	(37,322)		
5. a. Occupational Therapy - Medicare	$	268,437	268,437		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(205,881)	(205,881)		
c. Occupational Therapy - Non-Medicare	$	161,577	161,577		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(148,356)	(148,356)		
6. a. Other *(Specify)* - Medicare	$	(161,025)	(161,025)		
b. Other *(Specify)* - Non-Medicare	$	152,515	152,515		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	9,495,758	9,495,758		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	(68)	(68)		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	6,055	6,055		
V. Total Other Revenue (1 thru 8)	$	5,987	5,987		
VI. Total All Revenue (III +V)	$	9,501,745	9,501,745		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	Other
	Lab Medicare	$ 24,735		
	Lab Medicare CA	$ (24,735)		
	Oxygen Medicare	$ 798		
	Oxygen Medicare CA	$ (798)		
	Equipment rental	$ 6,368		
	Equipment rental CA	$ (6,368)		
	Pen Therapy	$ -		
	Pen Therapy CA	$ -		
	Therapy Beds Medicare	$ -		
	Therapy Beds Medicare CA	$ -		
	Radiology Medicare	$ 3,946		
	Radiology Medicare CA	$ (3,946)		
	IV Therapy	$ 39,187		
	IV Therapy CA	$ (39,187)		
	Medical Transportation	$ -		
	Medical Transportation CA	$ -		
	Glucose testing	$ -		
	Glucose testing CA	$ -		
	Outpatient therapy Medicare	$ -		
	MEDICAID COVID REVENUE	$ -		
	CRF MEDICAID REVENUE	$ -		
	MEDICAID WAGE & ENHANCEMENT RESERVE	$ (161,025)		
Total Other Resident Revenue - Medicare		$ (161,025)	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	Other
	Lab	14,859		
	Lab CA	(14,859)		
	Oxygen	$ 1,256		$ -
	Oxygen CA	$ (1,256)		$ -
	Equipment rental	$ 7,642		
	Equipment rental CA	$ (7,642)		
	Pen Therapy	$ -		
	Pen Therapy CA	$ -		
	Therapy Beds	$ -		
	Therapy Beds CA	$ -		
	Radiology	$ 63		
	Radiology CA	$ (63)		
	Medical Transportation	$ -		
	Medical Transportation CA	$ -		
	Glucose Testing	$ -		
	Glucose Testing CA	$ -		
	IV therapy	$ 5,411		$ -
	IV therapy CA	$ (5,411)		$ -
	Flu shot revenue	$ 1,748		
	Outpatient therapy	$ -		
	prior period revenue	$ 78,560		
	Optum B	$ 211,689		
	Optum B CA	$ (133,964)		
	C/A VBP	$ (5,495)		
	rounding	$ (22)		
Total Other Resident Revenue		$ 152,515	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	Other
	INTEREST INCOME		$ (68)		
Total Interest Income			$ (68)	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	Other
	MEALS	$ -		
	TELEVISION INCOME	$ -		
	OTHER INCOME: DMHAS OPERATING REVENUE	$ -		
	OTHER INCOME: DMHAS ORGANIZATIONAL REV	$ -		
	OTHER INCOME: DEFERRED REVENUE	$ 2,795		
	MEDICARE COVID STIMULUS REVENUE	$ -		
	CONCESSIONS / VENDING INCOME	$ -		
	RESIDENT LATE FEE REVENUE	$ -		
	RESIDENT ATTORNEY FEE REVENUE	$ -		
	TELEPHONE INCOME	$ -		
	OTHER INCOME	$ -		
	OPTUM DIVIDENDS REVENUE	$ 3,260		
	OPTUM OUTLIERS	$ -		
	HHS GENERAL FUND REVENUE	$ -		
	HHS INFECTION CONTROL REVENUE	$ -		
	CARES ACT REVENUE	$ -		
	EMPLOYEE TESTING REVENUE	$ -		
	COVID ECHO TRAINING REVENUE	$ -		
Total Other Revenue		$ 6,055	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-31 Rev. 6/95

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 52,214
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 4,794,611
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 13,696
5. Prepaid Expenses				$ 107,779
a. Prepaid Insurance		70,600		
b. Prepaid Property Taxes		33,738		
c. Prepaid Expenses Other		3,441		
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ (3,250,608)
Due From (to) Related Parties		(608,437)		
Other Owners reserves		(2,642,171)		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,717,693
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost	1,160		$ (1)
	Accum. Depreciation	1,161	Net	
4. Leasehold Improvements	*Historical Cost	1,634,102		$ 343,885
	Accum. Depreciation	1,290,217	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	1,228,205		$ 112,132
	Accum. Depreciation	1,116,073	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
Construction in Progress				
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 456,016

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			$ -

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

Page Ref	Line Ref	Description	
Total Other Current Assets (Itemize)			$ -

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

Page Ref	Line Ref	Description	
Total Other Other Fixed Assets (Itemize)			$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-32 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	32	37

Account				Amount
			Total Brought Forward:	$ 2,173,709
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$ 175,436
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$ 80,480
Patient Trust Funds		54,525		
Long Term Deposit - primecare		25,955		
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 2,588,915
RIGHT TO USE ASSET		3,013,370		
ACCUM RIGHT TO USE ASSET		(424,455)		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 2,844,832
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 5,018,541

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-33 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 1,271,621
2. Notes Payable (*itemize*)				$ 520,657
Working Capital Line of Credit	520,657			
See Schedule				
3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 43,438
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$
7. Medicare Final Settlement Payable				$
8. Medicare Current Financing Payable				$
9. Mortgage Payable (*Current Portion*)				$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
11. Accrued Income Taxes*				$
12. Other Current Liabilities (*itemize*)				$ 6,748,461
Related Party Payables	6,432,485			
Accrued Expenses	(88,401)			
Accrued Resident User Fees	389,648			
Accrued Workers Comp Expense	14,730	See Schedule		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 8,584,177

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

(Carry Total forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	34	37

Account	Amount
Total Brought Forward:	8,584,177
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ 54,525
Patient Trust Funds	54,525	
See Schedule		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 54,525
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 8,638,703

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-35 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$ 25,000
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (1,949,220)
	6. Gain or Loss for Period 10/1/2022 thru 8/30/2023	$ (1,695,942)
	7. Total Net Worth	$ (3,620,162)
C.	***Total Reserves and Net Worth***	$ (3,620,162)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 5,018,541

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-36 Rev. 6/95

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	36	37

Account	Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2022	$
B. Total Revenue (*From Statement of Revenue Page 30*)	$ 9,501,745
C. Total Expenditures (*From Statement of Expenditures Page 27*)	$ 11,197,687
D. Net Income or Deficit	$ (1,695,942)
E. Balance	$ (1,695,942)
F. Additions	
1. Additional Capital Contributed (*itemize*)	
2. Other (*itemize*)	
F-3. Total Additions	$
G. Deductions	
1. Drawings of Owners/Operators/Partners (*Specify*)	$

Name and Address (*No., City, State, Zip*)	Title	Amount

2. Other Withdrawings *(Specify)*	$
Purpose	Amount
3. Total Deductions	$
H. ***Balance at End of Period*** 08/30/23	$ (1,695,942)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-37 Rev. 9/2002

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	8/30/2023	37	37

Check appropriate category

☐ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	☑ (Specify)	☑ Other

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
iCare Management, LLC

Addres Address	Phone Number
341 Bidwell Street, Manchester, CT 06040	860-570-2140

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Kartik Patel	860-570-2140

Contact Email Address
kpatel@icarehn.com