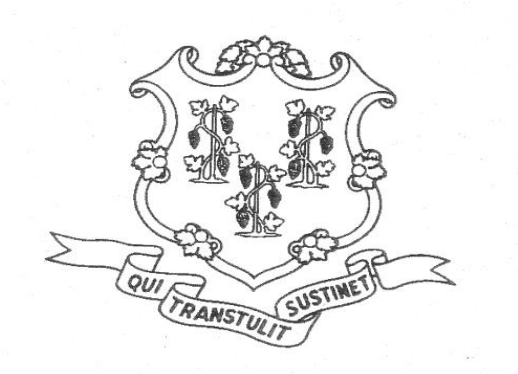
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2023

Name of Facility (as licensed) Meriden Care Center, LLC	
Address (No. & Street, City, State, Zip Code) 33 Roy St. Meriden, CT 06450	
Type of Facility ☐ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined ☑ (Specify) ☑ Other	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

License Numbers:	CCNH / RHNS	(Specify)	Other	Medicare Provider
	2448			07-5337

Medicaid Provider Numbers:	CCNH / RHNS	(Specify)	Other
	10660		

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CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	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 Meriden Care Center, LLC [facility name], for the cost report period beginning October 1, 2022 and ending September 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 accordance with applicable instructions.

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

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

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

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Meriden Care Center, LLC	Period Covered:		From 10/1/2022	To 9/30/2023
Address of Facility 33 Roy St. Meriden, CT 06450				
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.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-237-8457	9/30/2023	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Meriden Care Center, LLC	33 Roy St. Meriden, CT 06450

License Numbers:	CCNH / RHNS	(Specify)	Other	Medicare Provider No.
	2448			07-5337

Type of Facility (Check appropriate box(es))

☐ 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.:
Raymond Hackling	000853

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
Meriden Care Center, LLC	33 Roy St. Meriden, CT 06450	CT

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

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	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			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	3B	37

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	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.

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	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.

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General Information and Questionnaire
Other Lines of Business

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	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:

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General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center,	2448	9/30/2023	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:

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	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	159	159			159	159						
B. On last day of THIS report period	158	158							158	158		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	149	149			149	149						
B. As of midnight of THIS report period	149	149							149	149		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,165	1,165			796	796			369	369		
B. Medicaid (Conn.)	48,950	48,950			36,775	36,775			12,175	12,175		
C. Medicaid (other states)												
D. Private Pay	44	44			44	44						
E. State SSI for RCH												
F. Other (Specify) Insurance	4,111	4,111			2,976	2,976			1,135	1,135		
G. Total Care Days During Period (3A thru F)	54,270	54,270			40,591	40,591			13,679	13,679		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	54,270	54,270			40,591	40,591			13,679	13,679		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	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)				
5/1/2023	X			(1)									

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	3	132		14				
Per Diem Rate								
a. One bed rm.	530.00	######		360.00				
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	1,185	1,185			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	802	802			
2. Restorative Treatments	2,033	2,033			
C. Other	2,821	2,821			
D. ***Total Physical Therapy Treatments***	6,841	6,841			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	328	328			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	230	230			
2. Restorative Treatments	175	175			
C. Other	342	342			
D. ***Total Speech Therapy Treatments***	1,075	1,075			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	1,090	1,090			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	996	996			
2. Restorative Treatments	1,717	1,717			
C. Other	2,810	2,810			
D. ***Total Occupational Therapy Treatments***	6,613	6,613			

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	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)	197,239		2,086						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	377,393		13,877						
5. Dietary Service									
a. Head Dietitian	19,640		422						
b. Food Service Supervisor	59,642		1,721						
c. Dietary Workers	585,942		28,054						
6. Housekeeping Service									
a. Head Housekeeper									
b. Other Housekeeping Workers									
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance	69,593		2,022						
b. Other Maintenance Workers	50,007		2,215						
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	283,349		4,053						
b. RN									
1. Direct Care	598,262		8,697						
2. Administrative**	16,427		408						
c. LPN									
1. Direct Care	1,620,414		44,115						
2. Administrative**	120,829		2,943						
d. Aides and Attendants	2,340,651		102,346						
e. Physical Therapists									
f. Speech Therapists									
g. Occupational Therapists									
h. Recreation Workers	175,663		8,302						
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	178,913		4,014						
n. Marketing									
o. Other (Specify)									
See Attached Schedule	71,596		3,408						
A-13. Total Salary Expenditures	6,765,561		228,682						

* 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	$ 44,069		2,207				$ -		-
MEDICAL RECORDS SALARIES	$ -		-				$ -		-
CENTRAL SUPPLY SALARIES	$ 27,528		1,201				$ -		-
RESPIRATORY THERAPY SALARIES	$ -		-				$ -		-
PLANT SECURITY SALARIES	$ -		-				$ -		-
MEDICAL RECORDS SALARIES SPCL	$ -		-				$ -		-
Total	$ 71,596	$ -	3,408	$ -	$ -	-	$ -	$ -	-

Schedule of Other Fees (Page 13)

	CCNH / RHNS			(Specify)			Other		
Service	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**
MEDICAL RECORDS CONTRACT SERVICE	$ 10,907		Storage				$ -		Storage
ADMISSIONS C/S LABOR	$ 67,398		1,245				$ -		-
CENTRAL SUPPLY CONTRACT SERVICE	$ 7,802		201				$ -		-
ADMINISTRATIVE CONTRACT SERVICE LABOR	$ 61,923		1,458				$ -		-
RESPIRATORY THERAPY CONTRACT SERVICES	$ 1,212		-				$ -		-
PHYSICAL THERAPY C/S MEDICIAD	$ -		-				$ -		-
SPEECH THERAPY C/S Medicaid	$ -		-				$ -		-
OCCUPATIONAL THERAPY C/S MEDICIAD	$ -	-	-				$ -		-
Total	$ 149,242	$ -	2,904	$ -	$ -	-	$ -	$ -	-

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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
Meriden Care Center, LLC	2448	9/30/2023	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.

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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
Meriden Care Center, LLC	2448	9/30/2023	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* **										
Raymond Hackling	197,239			Administrator		2,086	same as empl			
				Administrator			same as empl			
				Administrator			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.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	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	28,416		239						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	116,699		2,236						
b. Other									
6. Social Worker	13,475		176						
7. Recreation Worker	13,755		8 Hours +Ca						
8. Physicians									
a. Medical Director (entire facility)	36,000		204						
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			29						
9. Speech Therapist									
a. Resident Care	34,336		658						
b. Other									
10. Occupational Therapist									
a. Resident Care	122,670		2,350						
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	216,586		2,036						
2. Administrative***	131,378		2,311						
b. LPN									
1. Direct Care	344,040		4,930						
2. Administrative***									
c. Aides	414,649		11,696						
d. Other									
12. Other (Specify)									
See Attached Schedule	149,242		2,904						
B-13 Total Fees Paid in Lieu of Salaries	1,621,245		29,768						

* 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.

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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
Meriden Care Center, LLC	2448	9/30/2023	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	○	⊙	
IPC Hospitalists	Medical Director	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	15	37

Item		Total Including Adjustment	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	$	280,527	280,527					
2. Disability Insurance	$							
3. Unemployment Insurance	$							
4. Social Security (F.I.C.A.)	$	566,298	566,298					
5. Health Insurance	$	1,141,729	1,141,729					
6. Life Insurance (employees only) (not-owners and not-operators)	$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	396,884	396,884					
8. Uniform Allowance	$							
9. Other (*Specify*) See Attached Schedule	$	41,300	41,300					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$							
c. Bad Debts*	$	223,935	223,935					
d. Accounting and Auditing	$	35,463	35,463					
e. Legal (*Services should be fully described on Page 15b)*	$	38,268	38,268					
f. Insurance on Lives of Owners and Operators (*Specify*)*	$							
g. Office Supplies	$	16,594	16,594					
h. Telephone and Cellular Phones								
1. Telephone & Pagers	$	38,885	38,885					
2. Cellular Phones	$	1,576	1,576					
i. Appraisal (*Specify purpose and attach copy*)*	$							
j. Corporation Business Taxes (*franchise tax*)	$							
k. Other Taxes (*Not related to property - See Page 22)*								
1. Income*	$							
2. Other (*Specify*) See Attached Schedule	$							
3. Resident Day User Fee	$	1,118,833	1,118,833					
Subtotal	$	3,900,292	3,900,292					

* 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	$ 41,300				$ -	
Total	$ 41,300	$ -	$ -	$ -	$ -	$ -

Schedule of Other Taxes

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	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	$ 35,463
2		$
3		$
4		$
		Charge for Services Provided: $ 35,463

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	
2 Robinson & Cole, LLP & Other Legal Firm	
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	$
2	General legal advice, union funds advice, employment law	$ 36,026
3	Employment Arbitrations, healthcare law & Conservatorships	$ 2,242
4		$
5	Collections	$ (0)
		Charge for Services Provided: $ 38,268

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

⊙ Yes ○ No 15E

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

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	16	37

Item		Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Subtotals Brought Forward:		3,900,292	3,900,292					
l. Travel and Entertainment								
1. Resident Travel and Entertainment	$							
2. Holiday Parties for Staff	$	318	318					
3. Gifts to Staff and Residents	$	153	153					
4. Employee Travel	$	425	425					
5. Education Expenses Related to Seminars and Conventions	$	632	632					
6. Automobile Expense (*not purchase or depreciation*)	$							
7. Other (*Specify*)	$	595	595					
See Attached Schedule								
m. Other Administrative and General Expenses								
1. Advertising Help Wanted (*all such expenses*)	$	41,489	41,489					
2. Advertising Telephone Directory (*all such expenses*)***	$							
3. Advertising Other (*Specify*)***	$	20,538	20,538					
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	$	6,300	6,300					
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	10,769	10,769					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$							
9. Subscriptions	$	896	896					
10. Contributions***	$	200	200					
See Attached Schedule								
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	153,258	153,258					
12. Administrative Management Services**	$	514,511	514,511					
13. Other (*Specify*) See Attached Schedule	$	90,320	90,320					
C-14 Total Administrative & General Expenditures	$	4,740,696	4,740,696					

* 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	$ 595				$ -	
Total Other Travel and Entertainment	$ 595	$ -	$ -	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
COMMUNICATIONS SPECIAL EVENTS	$ 20,538				$ -	
Total Other Advertising	$ 20,538	$ -	$ -	$ -	$ -	$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
ALTCFM						
CAHCF Dues	$ 10,769				$ -	
OTHER DUES						
Total Dues	$ 10,769	$ -	$ -	$ -	$ -	$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
CONTRIBUTIONS	$ 200				$ -	
Total Contributions	$ 200	$ -	$ -	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
SOCIAL SERVICE SUPPLIES	$ -				$ -	
SOC SVC MINOR EQUIPMENT	$ -				$ -	
ADMINISTRATIVE MINOR EQUIPMENT	$ 3,047				$ -	
EMPLOYEE RELATIONS	$ 2,036				$ -	
EMPLOYEE RELATIONS-OTHER	$ 43				$ -	
PERMITS & LICENSES	$ 2,467				$ -	
VOLUNTEER EXPENSE	$ -				$ -	
BANK FEES	$ 6,499				$ -	
CMS REVISIT USER FEES	$ -				$ -	
PENALTIES	$ 62,741				$ -	
LATE FEES	$ 1,847				$ -	
INTERNET EXPENSES	$ 11,639				$ -	
Rounding	$ -					
Total Other Administrative and General	$ 90,320	$ -	$ -	$ -	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	17	37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
iCare Management, LLC/iCare Health Management, LLC	514,511	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	165,264	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	40,947	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.**

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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
Meriden Care Center, LLC	2448	9/30/2023	18	37

Item		Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	$	404,126	404,126					
2. Non-Food Supplies	$	58,887	58,887					
3. Other (*Specify*) DIETARY SUPPLEMENTS	$	16,692	16,692					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	35,612	35,612					
c. Other (*Specify*) DIETARY MINOR EQUIPMENT	$	11,025	11,025					
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	526,341	526,341					

2E. Dietary Questionnaire	Total	CCNH / RHNS	(Specify)	Other
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.

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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
Meriden Care Center, LLC	2448	9/30/2023	19	37

Item		Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
3. Laundry								
a. In-House Processing*	Lbs.							
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	591	591					
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)*	$	467,106	467,106					
c. Other (*Specify*) LAUNDRY MINOR EQUIPMENT	$	187	187					
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	467,883	467,883					

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.

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

Name of Facility	License No.	Report for Year Ended					Page	of
Meriden Care Center, LLC	2448	9/30/2023					20	37

Item			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.	$	35,007	35,007					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel								
	Amt.	$	515,704	515,704					
C. Other (*Specify*) HOUSEKEEPING MINOR EQUIPMENT		$							
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	550,711	550,711					
5. Resident Care (Supplies)**									
a. Prescription Drugs***									
1. Own Pharmacy		$							
2. Purchased from PHARMACY		$	167,456	167,456					
b. Medicine Cabinet Drugs		$	8,213	8,213					
c. Medical and Therapeutic Supplies		$	129,972	129,972					
d. Ambulance/Limousine***		$	3,776	3,776					
e. Oxygen									
1. For Emergency Use		$	4,838	4,838					
2. Other***		$							
f. X-rays and Related Radiological Procedures***		$	1,045	1,045					
g. Dental (*Not dentists who should be included under salaries or fees*)		$							
h. Laboratory***		$	36,274	36,274					
i. Recreation		$							
j. Direct Management Services*		$	165,264	165,264					
k. Indirect Management Services*		$	40,947	40,947					
l. Cable TV		$							
m. Other (Specify)**** See Attached Schedule		$	141,436	141,436					
n. Physical Therapy Expense		$							
o. Speech Therapy Expense		$							
5P. ***Total Resident Care Expenditures*** (5a - 5o)		$	699,222	699,222					

* 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	$ 2,134				$ -	
MEDICAL RECORDS SUPPLIES	$ 302				$ -	
MEDICAL RECORDS MINOR EQUIPMENT	$ -				$ -	
NON-COVERED PPS DR. VISITS	$ 43,372				$ -	
RESIDENT CARE SUPPLIES	$ 116				$ -	
CENTRAL SUPPLY MINOR EQUIPMENT	$ 17,660				$ -	
PERSONAL CARE SUPPLIES	$ 697				$ -	
INCONTINENCY SUPPLIES	$ 262				$ -	
VACCINE RESIDENTS	$ 5,088				$ -	
PATIENT SPECIAL NEEDS	$ 309				$ -	
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	$ 30,310				$ -	
EQUIPMENT RENTAL: AIDS UNIT	$ -				$ -	
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	$ 969				$ -	
PEN THERAPY FOOD NOT BILLABLE TO PART B	$ 8,299				$ -	
HI LOW BED RENTAL & MATTRESSES	$ -				$ -	
IV THERAPY SUPPLIES	$ 12,934				$ -	
IV THERAPY CONTRACT SERVICE	$ -				$ -	
MEDICAL WASTE CONTRACT SERVICE	$ 771				$ -	
ACTIVITIES SUPPLIES	$ 18,214				$ -	
ACTIVITIES MINOR EQUIPMENT	$ -				$ -	
ADMISSIONS SUPPLIES	$ -				$ -	
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS						
STRIKE COSTS NON REIMBURSABLE	$ -				$ -	
COVID NON REIMBURSABLE	$ -				$ -	
Total Other Resident Care	$ 141,436	$ -	$ -	$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	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	515,704			20	4b
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	○	⊙	VENDOR	Laundry Services	467,106			19	3b
Eagle Elevator		○	⊙	VENDOR	Elevator Contract	10,516			22	6F
Brightview Landscapes LLC		○	⊙	VENDOR	Landscaping	8,992			22	6F
Amaya Landscaping LLC		○	⊙	VENDOR	Snow Removal	24,248			22	6F
CWPM LLC		○	⊙	VENDOR	Trash removal	44,238			22	6F
Facility Complaince		○	⊙	VENDOR	Plant Contract Services				22	6F
American HealthTech	P.O. Box 9001006, Louisville, KY 40290	○	⊙	VENDOR	Software Maintenance Contract	19,291			16	M11
Automatic Data Processing		○	⊙	VENDOR	Payroll Services	55,226			16	M11
National Datacare Corp		○	⊙	VENDOR	Resident Trust Software	4,668			16	M11
Prime Care Technologuy services		○	⊙	VENDOR	Computer Consulting Services	44,523			16	M11
Priotiry Express		○	⊙	VENDOR	Courier Services	3,637			16	M11
Point Right Inc		○	⊙	VENDOR	Nursing Software	5,149			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).

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

Name of Facility	License No.	Report for Year Ended					Page	of
Meriden Care Center, LLC	2448	9/30/2023					22	37
Item		Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	$	39,636	39,636					
b. Heat	$	49,486	49,486					
c. Light & Power	$	139,004	139,004					
d. Water	$	97,998	97,998					
e. Equipment Lease (*Provide detail on page 22b*)	$	34,511	34,511					
f. Other (*itemize*)	$	125,789	125,789					
See Attached Schedule								
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	486,424	486,424					
7. Depreciation (*complete schedule page 23**)								
a. Land Improvements	$							
b. Building & Building Improvements	$	22,904	22,904					
c. Non-Movable Equipment	$							
d. Movable Equipment	$	59,607	59,607					
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	82,511	82,511					
8. Amortization (*Complete att. Schedule Page 24**)								
a. Organization Expense	$							
b. Mortgage Expense	$							
c. Leasehold Improvements	$	72,937	72,937					
d. Other (*Specify*)	$							
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	72,937	72,937					
9. Rental payments on leased real property less real estate taxes included in item 10b	$	923,078	923,078					
10. Property Taxes								
a. Real estate taxes paid by owner	$							
b. Real estate taxes paid by lessor	$	29,813	29,813					
c. Personal property taxes	$	4,804	4,804					
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,113,143	1,113,143					

* 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	Adjustment	(Specify)	Adjustment	Other	Adjustment
PLANT SUPPLIES	$ 13,407				$ -	
PLANT CONTRACT SERVICE LABOR	$ -				$ -	
ELEVATOR CONTRACT SERVICE	$ 10,516				$ -	
FIRE/SPRINKLER CONTRACT SERVICE	$ 7,598				$ -	
LANDSCAPING CONTRACT SERVICE	$ 8,992				$ -	
SNOW REMOVAL CONTRACT SERVICE	$ 24,248				$ -	
TRASH REMOVAL CONTRACT SERVICE	$ 44,238				$ -	
PLANT (POOL) CONTRACT SERVICES OTHER	$ -				$ -	
SECURITY CONTRACT SERVICE	$ -				$ -	
PLANT CONTRACT SERVICE OTHER	$ 6,043				$ -	
PLANT MINOR EQUIPMENT	$ 10,747				$ -	
RENT AUTO	$ -				$ -	
RENT EQUIPMENT	$ -				$ -	
RENT OTHER	$ -				$ -	
Total Other Repairs and Maintenance	$ 125,789	$ -	$ -	$ -	$ -	$ -

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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
Meriden Care Center, LLC	2448	9/30/2023	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	9,178	9,178
Quadient Leasing USA Inc PO Box 123682, Dept 3682, Dallas, TX 75312-3682	○	⊙	Postage Meter Rental		Monthly	727	727
Xerox Financial Services LLC, PO Box 202882, Dallas, TX 75320-2882	○	⊙	Copier	10/08/20	automatic renewals	24,606	24,606
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total ***** 34,511

* 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.

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	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	416,163		416,163	169,999			22,904	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								22,904
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					1,076,249		1,076,249	893,725			55,737	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative					6,607						365	
d. Standard Resident					48,563						3,505	
e. Specialized Resident												
Total Acquired during this report period					55,170						3,870	
D-3. Subtotal												59,607
E. ***Total Depreciation***												82,511

Schedule of Land Improvements Acquired during this report period

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

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

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

Schedule of Building Improvements Acquired during this report period

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

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

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

Schedule of Non-Movable Equipment Acquired during this report period

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

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One Movable Category	Cost	Useful Life	Depreciation	
Additions:						
10/27/2022	Ice Cube Machine: Direct Supply	Standard Resident	$ 4,220	120	$ 387	
11/14/2022	Bedside Cabinet: HD Supply	Standard Resident	$ 4,058	180	$ 225	
1/13/2023	Heat Pumps: Direct Supply	Standard Resident	$ 3,903	120	$ 260	
1/23/2023	Bedside Cabinets: HD Supply	Standard Resident	$ 6,885	180	$ 306	
2/21/2023	Mattresses: Direct Supply	Standard Resident	$ 850	60	$ 99	
2/21/2023	Beds: Direct supply	Standard Resident	$ 9,155	60	$ 1,068	
3/21/2023	Mattresses: Direct Supply	Standard Resident	$ 3,149	60	$ 315	
4/6/2023	Mattresses: Direct Supply	Standard Resident	$ 4,524	60	$ 377	
4/30/2023	Wound Vac: H&R Healthcare	Standard Resident	$ 4,688	60	$ 391	
6/28/2023	Dishwasher Repairs: HPC	Standard Resident	$ 3,066	120	$ 77	
9/18/2023	Ice Machine Replacement: Direct Supply & Mark's Appliance	Standard Resident	$ 4,065	120	-	
6/19/2023	Laptop Purchase: Primecare	Administrative	$ 3,260	36	$ 272	
8/16/2023	Laptop Purchase: Primecare	Administrative	$ 3,348	36	$ 93	
		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 Equipment			$ 55,170		$ 3,870	*
Deletions:						
Total deletions for Movable Equipment			$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/20/2022	Doors: Target 10	$ 21,759	240	$ 997	
1/27/2023	STEAMER/OVEN: HPC & E. Haberli	$ 16,884	120	$ 1,126	
1/9/2023	Legionella: Supplies: Chem Aqua	$ 6,678	120	$ 445	
12/23/2022	Outlets/electrical: E Haberli Electric	$ 4,546	120	$ 341	
11/11/2022	Legionella: Testing & Supplies Chem-Aqua	$ 5,081	120	$ 423	
9/15/2022	Legionella: Materials Chem-Aqua	$ 15,664	120	$ 1,566	
10/20/2022	Install steel double doors: Target 10	$ 26,970	240	$ 1,236	
5/1/2023	Sidewalk Repairs: Target 10	$ 17,548	180	$ 390	
4/24/2023	Legionella: Testing Chem-Aqua	$ 3,254	120	$ 136	
6/8/2023	Cabinets: HD Supply	$ 4,225	180	$ 70	
8/11/2023	Driveway Repairs: Target 10	$ 6,913	120	$ 58	
9/16/2022	Kitchen Exhaust Fan: Climatech	$ 6,284	240	$ 314	
7/10/2023	Legionella: Testing & Supplies Chem-Aqua	$ 8,409	120	$ 140	
3/24/2021	Elevator repair: Excel Elevator & Escalator	$ 2,513	240	$ 304	
10/14/2022	Elevator repair: Excel Elevator & Escalator	$ 4,170	240	$ 191	
8/1/2023	Elevator repair: Excel Elevator & Escalator	$ 3,940	240	$ 16	
Total additions for Leasehold Improvement		$ 154,838		$ 7,754	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	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				1,140,306	579,669			65,183	
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)				154,838				7,754	
C-4. Subtotal									72,937
D. ***Total Amortization***									72,937

* 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.

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

Name of Facility	License No.	Report for Year Ended	Page of
Meriden Care Center, LLC	2448	9/30/2023	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	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	158
6. Square Footage	65,790
7. Acquisition Cost	
a. Land	
b. Building	

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

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

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
Summit Meriden, LLC	33 Roy Street, Meriden, CT	08/09/17	15 year with 2	632,313

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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	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*)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	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	1,453	1,453					
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	1,453	1,453					
14. Insurance							
a. Insurance on Property (buildings only) $	11,993	11,993					
b. Insurance on Automobiles $							
c. Insurance other than Property (as specified above)							
1. Umbrella (*Blanket Coverage*) $	109,524	109,524					
2. Fire and Extended Coverage $							
3. Other (*Specify*) $ Other insurance, crime	16,186	16,186					
14d. ***Total Insurance Expenditures (14a + b + c)*** $	137,704	137,704					
15. ***Total All Expenditures (A-13 thru C-14)*** $	17,110,382	17,110,382					

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Meriden Care Center, LLC	2448	9/30/2023	30 | 37

Item		Total	CCNH / RHNS	(Specify)	Other
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	14,688,364	14,688,364		
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)*	$	941,235	941,235		
b. Medicare Room and Board Contractual Allowance **	$				
4. a. Private-Pay Residents and Other	$	1,532,092	1,532,092		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	55,629	55,629		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(55,379)	(55,379)		
c. Prescription Drugs - Non-Medicare	$	301,362	301,362		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(301,362)	(301,362)		
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	59,282	59,282		
b. Physical Therapy - Medicare Contractual Allowance **	$	(44,002)	(44,002)		
c. Physical Therapy - Non-Medicare	$	143,907	143,907		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(143,907)	(143,907)		
4. a. Speech Therapy - Medicare	$	10,372	10,372		
b. Speech Therapy - Medicare Contractual Allowance **	$	(7,230)	(7,230)		
c. Speech Therapy - Non-Medicare	$	42,390	42,390		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(42,390)	(42,390)		
5. a. Occupational Therapy - Medicare	$	65,134	65,134		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(43,549)	(43,549)		
c. Occupational Therapy - Non-Medicare	$	142,997	142,997		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	19,342	19,342		
6. a. Other *(Specify)* - Medicare	$	(401,279)	(401,279)		
b. Other *(Specify)* - Non-Medicare	$	102,400	102,400		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	17,065,407	17,065,407		
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)*	$	37,273	37,273		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	65,350	65,350		
V. Total Other Revenue (1 thru 8)	$	102,623	102,623		
VI. Total All Revenue (III +V)	$	17,168,030	17,168,030		

* *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	$ 3,207		
	Lab Medicare CA	$ (3,207)		
	Oxygen Medicare	$ -		
	Oxygen Medicare CA	$ -		
	Equipment rental	$ 1,030		
	Equipment rental CA	$ (1,030)		
	Pen Therapy	$ -		
	Pen Therapy CA	$ -		
	Therapy Beds Medicare	$ -		
	Therapy Beds Medicare CA	$ -		
	Radiology Medicare	$ 126		
	Radiology Medicare CA	$ (126)		
	IV Therapy	$ -		
	IV Therapy CA	$ -		
	Medical Transportation	$ -		
	Medical Transportation CA	$ -		
	Glucose testing	$ -		
	Glucose testing CA	$ -		
	Outpatient therapy Medicare	$ -		
	MEDICAID COVID REVENUE	$ -		
	CRF MEDICAID REVENUE	$ -		
	MEDICAID WAGE & ENHANCEMENT RESERVE	$ (401,279)		
Total Other Resident Revenue - Medicare		$ (401,279)	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	Other
	Lab	28,576		
	Lab CA	(28,576)		
	Oxygen	$ -		$ -
	Oxygen CA	$ -		$ -
	Equipment rental	$ 14,725		
	Equipment rental CA	$ (14,725)		
	Pen Therapy	$ -		
	Pen Therapy CA	$ -		
	Therapy Beds	$ -		
	Therapy Beds CA	$ -		
	Radiology	$ 919		
	Radiology CA	$ (919)		
	Medical Transportation	$ 24,140		
	Medical Transportation CA	$ (24,140)		
	Glucose Testing	$ -		
	Glucose Testing CA	$ -		
	IV therapy	$ -		$ -
	IV therapy CA	$ -		$ -
	Flu shot revenue	$ 3,442		
	Outpatient therapy	$ -		
	prior period revenue	$ (79,142)		
	Optum B	$ 249,330		
	Optum B CA	$ (71,230)		
	C/A VBP	$ -		
	rounding	$ 0		
Total Other Resident Revenue		$ 102,400	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	Other
	INTEREST INCOME		$ 37,273		
Total Interest Income			$ 37,273	$ -	$ -

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	$ 30,000		
	MEDICARE COVID STIMULUS REVENUE	$ -		
	CONCESSIONS / VENDING INCOME	$ -		
	RESIDENT LATE FEE REVENUE	$ -		
	RESIDENT ATTORNEY FEE REVENUE	$ -		
	TELEPHONE INCOME	$ -		
	OTHER INCOME	$ -		
	OPTUM DIVIDENDS REVENUE	$ 35,350		
	OPTUM OUTLIERS	$ -		
	HHS GENERAL FUND REVENUE	$ -		
	HHS INFECTION CONTROL REVENUE	$ -		
	CARES ACT REVENUE	$ -		
	EMPLOYEE TESTING REVENUE	$ -		
	COVID ECHO TRAINING REVENUE	$ -		
Total Other Revenue		$ 65,350	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 751,867
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 3,713,809
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 26,405
5. Prepaid Expenses				$ 170,131
a. Prepaid Insurance		161,963		
b. Prepaid Property Taxes		3,024		
c. Prepaid Expenses Other		5,144		
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ (1,605,902)
Due From (to) Related Parties		(101,709)		
Other Owners reserves		(1,504,193)		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 3,056,309
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost	416,163		$ 223,260
	Accum. Depreciation	192,903	Net	
4. Leasehold Improvements	*Historical Cost	1,295,144		$ 642,538
	Accum. Depreciation	652,607	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	1,131,419		$ 178,087
	Accum. Depreciation	953,332	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)				$ 1,043,885

* 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)			$ -

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	32	37

Account				Amount
			Total Brought Forward:	$ 4,100,194
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				$ 512,091
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$ 113,446
Patient Trust Funds		101,591		
Long Term Deposit - primecare		11,855		
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 5,218,861
RIGHT TO USE ASSET		6,157,335		
ACCUM RIGHT TO USE ASSET		(938,474)		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 5,844,398
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 9,944,592

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 235,447
	2. Notes Payable (*itemize*)				$
	Working Capital Line of Credit				
	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*)				$ 469,749
	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*)				$ 6,738,344
	Related Party Payables 6,612,138				
	Accrued Expenses (45,264)				
	Accrued Resident User Fees				
	Accrued Workers Comp Expense 171,470 See Schedule				
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 7,443,540

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	34	37

Account	Amount
Total Brought Forward:	7,443,540
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*)		$ 101,591
Patient Trust Funds	101,591	
See Schedule		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 101,591
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 7,545,131

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

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	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	$ 2,316,813
	6. Gain or Loss for Period 10/1/2022 thru 9/30/2023	$ 57,648
	7. Total Net Worth	$ 2,399,461
C.	***Total Reserves and Net Worth***	$ 2,399,461
D.	***Total Liabilities, Reserves, and Net Worth***	$ 9,944,592

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	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*)			$ 17,168,030
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 17,110,382
D.	Net Income or Deficit			$ 57,648
E.	Balance			$ 57,648
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*** 09/30/23			$ 57,648

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2023	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. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
iCare Management, LLC

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