State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2021

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 only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021	

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	10447		

For Department Use Only

Sequence Number Assigned	Signed and Notarized	Date Received	Sequence Number Assigned	Signed and Notarized	Date Received

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	9/30/2021	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, 2020 and ending September 30, 2021, 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) Heather Rodriguez			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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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 10/1/2020	To 9/30/2021
Address of Facility 20 Scott Swamp Road, Farmington, CT 06032				
Report Prepared By iCare Management, LLC	Phone Number 860-570-2140		Date 2/15/2022	

Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid $				
2. Laundry wages paid $				
3. Housekeeping wages paid $				
4. Nursing wages paid $				
5. All other wages paid $				
6. ***Total Wages Paid*** $				
7. Total salaries paid $				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report) $				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-677-7707	9/30/2021	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

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

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

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.:
Heather Rodriguez	001691

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
Farmington Care Center, LLC	2288	9/30/2021	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

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	9/30/2021	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
Farmington Care Center, LLC	2288	9/30/2021	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
Farmington Care Center, LLC	2288	9/30/2021	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
Farmington Care Center, LLC	2288	9/30/2021	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
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	9/30/2021	6	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	8,312	8,312
GE Capital C/O Ricoh USA, P.O.Box 41564, Philadelphai, PA 19101	○	⊙	Copier	03/04/14	48 Months	7,793	7,793
Quadient Leasing USA Inc	○	⊙	Postage Meter Rental		Monthly	921	921
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
						Total ***	17,025

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.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	9/30/2021	7	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 O'Connor, Davies LLP	100 Great Meadow Road, Ste 401, Wethersfield, CT 06109
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Taxes, financial statements, accounting support	$ 8,483
2		$
3		$
4		$
		Charge for Services Provided $ 8,483

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
⊙ Yes ○ No 15D

Legal Services Information

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

Address (*No. & Street, City, State, Zip Code*)
1 341 Bidwell Street, Manchester CT
2 32 Main Street, Avon, CT
3 280 Trumbull St, Hartford, CT
4
5 32 Main Street, Avon, CT & 341 Bidwell Street, Manchester CT

Services Provided by This Firm (*describe fully*)

1	Lease and contract issues, general legal advice, Labor Law	$ 910
2	Lease and contract issues, general legal advice, union funds advice	$
3	Employment law, arbitrations, contract negotiations	$ 5,006
4	Employment Arbitrations, healthcare law & Conservatorships	$ 1,486
5	Collections	$ 0
		Charge for Services Provided $ 7,402

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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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	9/30/2021	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
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	85	85			85	85						
B. As of midnight of THIS report period	84	84							84	84		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,831	4,831			3,573	3,573			1,258	1,258		
B. Medicaid (Conn.)	22,780	22,780			17,171	17,171			5,609	5,609		
C. Medicaid (other states)												
D. Private Pay	1,690	1,690			1,243	1,243			447	447		
E. State SSI for RCH												
F. Other (Specify) Insurance	478	478			355	355			123	123		
G. Total Care Days During Period (3A thru F)	29,779	29,779			22,342	22,342			7,437	7,437		
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)**	29,779	29,779			22,342	22,342			7,437	7,437		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	17	62				5		
Per Diem Rate								
a. One bed rm.	556.00	292.00				419.00		
b. Two bed rms.								
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	5,607	5,607		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	708	708		
2. Restorative Treatments	1,380	1,380		
C. Other	9,788	9,788		
D. ***Total Physical Therapy Treatments***	17,483	17,483		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	280	280		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	57	57		
2. Restorative Treatments	72	72		
C. Other	616	616		
D. ***Total Speech Therapy Treatments***	1,025	1,025		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	3,598	3,598		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	458	458		
2. Restorative Treatments	1,269	1,269		
C. Other	8,767	8,767		
D. ***Total Occupational Therapy Treatments***	14,092	14,092		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	9/30/2021	10	37

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	134,640	2,077				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	151,425	5,667				
5. Dietary Service						
a. Head Dietitian	358	21				
b. Food Service Supervisor	54,474	2,056				
c. Dietary Workers	290,097	14,428				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	28,613	1,538				
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	160,861	3,150				
b. RN						
1. Direct Care	475,810	10,526				
2. Administrative**	214,849	5,637				
c. LPN						
1. Direct Care	1,037,526	31,616				
2. Administrative**						
d. Aides and Attendants	1,332,424	65,364				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	117,381	5,695				
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	57,317	2,108				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	55,161	2,829				
A-13. Total Salary Expenditures	4,110,936	152,712				

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
UNIT SECRETARIES SALARIES	$ 41,214	2,014			$ -	-
MEDICAL RECORDS SALARIES	$ 13,947	815			$ -	-
CENTRAL SUPPLY SALARIES	$ -	-			$ -	-
RESPIRATORY THERAPY SALARIES	$ -	-			$ -	-
PLANT SECURITY SALARIES	$ -	-			$ -	-
MEDICAL RECORDS SALARIES SPCL	$ -	-			$ -	-
Total	$ 55,161	2,829	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
MEDICAL RECORDS CONTRACT SERVICE	$ 11,454	-			$ -	-
ADMISSIONS C/S LABOR	$ 32,550	691			$ -	-
CENTRAL SUPPLY CONTRACT SERVICE	$ 12,559	624			$ -	-
ADMINISTRATIVE CONTRACT SERVICE LABOR	$ 140,304	3,548			$ -	-
RESPIRATORY THERAPY CONTRACT SERVICES	$ 21,822	421			$ -	-
PHYSICAL THERAPY C/S MEDICIAD	$ -	-			$ -	-
SPEECH THERAPY C/S Medicaid	$ -	-			$ -	-
OCCUPATIONAL THERAPY C/S MEDICIAD	$ -	-			$ -	-
Total	$ 218,690	5,283	$ -	-	$ -	-

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

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

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	9/30/2021	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
John Zazzaro	125,282			same as employees less union funds	Administrator	1,925	A2			
Healther Rodriguez	9,357			same as employees less union funds	Administrator	152	A2			
				same as employees less union funds	Administrator		A2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	9/30/2021	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist	4,915	208				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	280,105	5,366				
b. Other						
6. Social Worker	6,580	88				
7. Recreation Worker	16,088	20+Cable				20+Cable
8. Physicians						
a. Medical Director (entire facility)	38,400	544				
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	14,449	103				
9. Speech Therapist						
a. Resident Care	35,313	676				
b. Other						
10. Occupational Therapist						
a. Resident Care	220,799	4,230				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	128,644	1,527				
2. Administrative***	124,286	2,045				
b. LPN						
1. Direct Care	88,651	1,137				
2. Administrative***						
c. Aides	70,089	1,865				
d. Other						
12. Other (Specify)						
See Attached Schedule	218,690	5,283				
B-13 Total Fees Paid in Lieu of Salaries	1,247,010	23,072				

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

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

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

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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
Farmington Care Center, LLC	2288	9/30/2021	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Tocuhpoints Therapy	Therapy	⊙	○	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.

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	9/30/2021	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	116,588	116,588		
2. Disability Insurance	$				
3. Unemployment Insurance	$				
4. Social Security (F.I.C.A.)	$	341,487	341,487		
5. Health Insurance	$	785,872	785,872		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	241,158	241,158		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	29,299	29,299		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	168,204	168,204		
d. Accounting and Auditing	$	8,483	8,483		
e. Legal (*Services should be fully described on Page 7)*	$	7,402	7,402		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	19,389	19,389		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	27,294	27,294		
2. Cellular Phones	$	584	584		
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	$	526,760	526,760		
Subtotal	$	2,272,520	2,272,520		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
UNION TRAINING	$ 29,299		$ -
Total	$ 29,299	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Total	$ -	$ -	$ -

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CSP-16 Rev. 9/2002

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	9/30/2021	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,272,520	2,272,520		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	178	178		
5. Education Expenses Related to Seminars and Conventions	$	823	823		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$	994	994		
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	57,746	57,746		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	5,409	5,409		
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	$	1,984	1,984		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	7,165	7,165		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	1,502	1,502		
10. Contributions***	$	1,438	1,438		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	137,545	137,545		
12. Administrative Management Services**	$	323,113	323,113		
13. Other (*Specify*)	$	13,168	13,168		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,823,585	2,823,585		

* Do not include Subscriptions, which should go in item 9.

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
MEALS	$ 994		$ -
Total Other Travel and Entertainment	$ 994	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
COMMUNICATIONS SPECIAL EVENTS	$ 5,409		$ -
Total Other Advertising	$ 5,409	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
ALTCFM			
CAHCF Dues	$ 7,165		$ -
OTHER DUES			
Total Dues	$ 7,165	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
CONTRIBUTIONS	$ 1,438		$ -
Total Contributions	$ 1,438	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
SOCIAL SERVICE SUPPLIES	$ -		$ -
SOC SVC MINOR EQUIPMENT	$ -		$ -
ADMINISTRATIVE MINOR EQUIPMENT	$ 3,027		$ -
EMPLOYEE RELATIONS	$ 23		$ -
EMPLOYEE RELATIONS-OTHER	$ -		$ -
PERMITS & LICENSES	$ 2,699		$ -
VOLUNTEER EXPENSE	$ -		$ -
BANK FEES	$ 3,853		$ -
CMS REVISIT USER FEES	$ -		$ -
PENALTIES	$ -		$ -
LATE FEES	$ 631		$ -
INTERNET EXPENSES	$ 2,934		$ -
Rounding			
Total Other Administrative and General	$ 13,168	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Farmington Care Center, LLC	License No. 2288	Report for Year Ended 9/30/2021	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	323,113	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	133,937	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	33,222	MANAGEMENT FEES- INDIRECT CARE	Pg 20 j

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

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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
Farmington Care Center, LLC	2288	9/30/2021	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	192,291	192,291		
2. Non-Food Supplies	$	16,324	16,324		
3. Other (*Specify*)_____ DIETARY SUPPLEMENTS	$	15,447	15,447		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	25,659	25,659		
c. Other (*Specify*)_____ DIETARY MINOR EQUIPMENT	$	2,844	2,844		
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	252,565	252,565		

2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F. Resident Meals:	Total no. of meals served per day:*	245	245		

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
Farmington Care Center, LLC	2288	9/30/2021	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $				
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)*	$	274,538	274,538		
c. Other (*Specify*) LAUNDRY MINOR EQUIPMENT	$				
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	274,538	274,538		

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
Farmington Care Center, LLC	2288	9/30/2021	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	17,237	17,237		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	272,187	272,187		
C. Other (*Specify*) HOUSEKEEPING MINOR EQUIPMENT		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	289,425	289,425		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from PHARMACY		$	217,686	217,686		
b. Medicine Cabinet Drugs		$	(1,109)	(1,109)		
c. Medical and Therapeutic Supplies		$	121,582	121,582		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$	1,610	1,610		
2. Other***		$				
f. X-rays and Related Radiological Procedures***		$	12,975	12,975		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	40,073	40,073		
i. Recreation		$				
j. Direct Management Services*		$	133,937	133,937		
k. Indirect Management Services*		$	33,222	33,222		
l. Other (Specify)**** See Attached Schedule		$	136,061	136,061		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	696,037	696,037		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
NURSING ADMIN SUPPLIES	$ 5,583		$ -
NURSING MINOR EQUIP	$ 3,332		$ -
MEDICAL RECORDS SUPPLIES	$ (35)		$ -
MEDICAL RECORDS MINOR EQUIPMENT	$ -		$ -
NON-COVERED PPS DR. VISITS	$ 29		$ -
RESIDENT CARE SUPPLIES	$ 40		$ -
CENTRAL SUPPLY MINOR EQUIPMENT	$ 14,595		$ -
PERSONAL CARE SUPPLIES	$ 248		$ -
INCONTINENCY SUPPLIES	$ -		$ -
VACCINE RESIDENTS	$ 2,009		$ -
PATIENT SPECIAL NEEDS	$ 400		$ -
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	$ 40,517		$ -
EQUIPMENT RENTAL: AIDS UNIT	$ -		$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	$ 8,475		$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	$ -		$ -
HI LOW BED RENTAL & MATTRESSES	$ -		$ -
IV THERAPY SUPPLIES	$ 19,327		$ -
IV THERAPY CONTRACT SERVICE	$ -		$ -
MEDICAL WASTE CONTRACT SERVICE	$ 851		$ -
ACTIVITIES SUPPLIES	$ 851		$ -
ACTIVITIES MINOR EQUIPMENT	$ -		$ -
ADMISSIONS SUPPLIES	$ -		$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	$ 1,761		$ -
STRIKE COSTS NON REIMBURSABLE	$ 38,078		$ -
COVID NON REIMBURSABLE	$ -		$ -
Total Other Resident Care	$ 136,061	$ -	$ -

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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
Farmington Care Center, LLC	2288	9/30/2021	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	○	⊙	VENDOR	Housekeeping Services	265,818			20	4b
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	○	⊙	VENDOR	Laundry Services	274,538			19	3b
Eagle Elevator		○	⊙	VENDOR	Elevator Contract	5,444			22	6F
Brightview Landscapes LLC/Lazer Scapes LLC		○	⊙	VENDOR	Snow Removal/Landscaping	17,643			22	6F
CWPM LLC		○	⊙	VENDOR	Trash removal	38,853			22	6F
American HealthTech		○	⊙	VENDOR	Software Maintenance Contract	22,135			16	M11
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	○	⊙	VENDOR	Payroll Services	21,597			16	M11
National Datacare Corp		○	⊙	VENDOR	Resident Trust Software	3,206			16	M11
Prime Care Technologuy services		○	⊙	VENDOR	Computer Consulting Services	36,585			16	M11
Priotiry Express		○	⊙	VENDOR	Courier Services	2,174			16	M11
Point Right Inc		○	⊙	VENDOR	Nursing Software	4,697			16	M11
		○	⊙	VENDOR					22	6F
		○	⊙	VENDOR						
		○	⊙	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
Farmington Care Center, LLC	2288	9/30/2021	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	28,978	28,978		
b. Heat	$	20,137	20,137		
c. Light & Power	$	50,161	50,161		
d. Water	$	41,303	41,303		
e. Equipment Lease (*Provide detail on page 6*)	$	17,025	17,025		
f. Other (*itemize*)	$	88,451	88,451		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	246,056	246,056		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	232	232		
c. Non-Movable Equipment	$				
d. Movable Equipment	$	41,085	41,085		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	41,317	41,317		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	58,666	58,666		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	58,666	58,666		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	269,896	269,896		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	63,313	63,313		
c. Personal property taxes	$	6,579	6,579		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	439,770	439,770		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
PLANT SUPPLIES	$ 8,419		$ -
PLANT CONTRACT SERVICE LABOR	$ 956		$ -
ELEVATOR CONTRACT SERVICE	$ 5,444		$ -
FIRE/SPRINKLER CONTRACT SERVICE	$ 7,236		$ -
LANDSCAPING CONTRACT SERVICE	$ 8,943		$ -
SNOW REMOVAL CONTRACT SERVICE	$ 8,699		$ -
TRASH REMOVAL CONTRACT SERVICE	$ 38,853		$ -
HVAC CONTRACT SERVICE	$ -		$ -
SECURITY CONTRACT SERVICE	$ -		$ -
PLANT CONTRACT SERVICE OTHER	$ 3,650		$ -
PLANT MINOR EQUIPMENT	$ 4,527		$ -
RENT AUTO	$ -		$ -
RENT EQUIPMENT	$ 1,724		$ -
RENT OTHER	$ -		$ -
Total Other Repairs and Maintenance	$ 88,451	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	9/30/2021	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	1,161		1,161	890			232	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								232
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					1,113,438		1,113,438	995,230			34,946	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					54,501						6,139	
D-3. Subtotal												41,085
E. ***Total Depreciation***												41,317

Schedule of Land Improvements Acquired during this report period

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

***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 Improvement		$ -		$ -	*
Deletions:					
Total deletions for Building Improvement		$ -		$ -	**

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

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

Schedule of Non-Movable Equipment Acquired during this report peri

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 peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/19/2020	Commercial Washe: Daniels Equipment Co	$ 10,314	120	$ 945	
11/9/2020	Marttresses: Direct Supply	$ 3,428	60	$ 571	
2/26/2021	Bladder scanner: Direct Supply	$ 6,078	96	$ 443	
1/7/2021	Washer set up/wiring: Daniels Equip & Precision Electric	$ 12,834	120	$ 856	
3/15/2021	Washer motor/hardware: Daniels Equip	$ 2,693	120	$ 135	
6/12/2020	Mattresses: Medline	$ 5,681	60	$ 1,420	
5/10/2021	Liko Slings: Hil-Rom	$ 4,770	60	$ 318	
3/31/2021	IT Upgrade project: Phase 1 Primecare	$ 8,704	36	$ 1,451	
Total additions for Movable Equipmen		$ 54,501		$ 6,139	*
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 peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/28/2020	Hot water boiler valve & Taco Pump: Saucier	$ 2,808	180	$ 172	
2/24/2021	Hot water heater: Saucier	$ 15,215	120	$ 888	
3/4/2021	Gas lines: Saucier	$ 14,945	360	$ 249	
1/2/2021	Gas lines: Saucier	$ 7,954	360	$ 177	
10/23/2020	Fire Sprinkler Repair: Facilities Comp	$ 5,627	300	$ 206	
3/15/2021	Fire Sprinkler: Facilities Comp	$ 14,215	300	$ 284	
9/24/2021	Fire Sprinkler: Facilities Comp	$ 10,516	300	-	
Total additions for Leasehold Improvemen		$ 71,280		$ 1,976	*
Deletions:					
Total deletions for Leasehold Improvemen		$ -		$ -	**

***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
Farmington Care Center, LLC	2288	9/30/2021	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				1,497,913	1,130,213			56,690	
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)				71,280				1,976	
C-4. Subtotal									58,666
D. ***Total Amortization***									58,666

* 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
Farmington Care Center, LLC	2288	9/30/2021	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 years with	303,079
			year extensio	

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
Farmington Care Center, LLC	2288	9/30/2021	26 | 37

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

(*Carry Subtotals forward to next page*)

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CSP-27 Rev. 6/95

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	9/30/2021	27	37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				
12. C. Movable Equipment				
1. Automotive Equipment $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*) $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
B. Item / Rate / Amount				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $				
12. D. Other Interest Expense (*Specify*) $	8,328	8,328		
INTEREST				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	8,328	8,328		
14. Insurance				
a. Insurance on Property (buildings only) $	10,485	10,485		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	77,986	77,986		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $	10,315	10,315		
Other insurance, crime				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	98,786	98,786		
15. ***Total All Expenditures (A-13 thru C-14)*** $	10,487,036	10,487,036		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Farmington Care Center, LLC	2288	9/30/2021	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	C	Bad Debts $	168,204	168,204		
10.			Accounting $				
10a.			Legal $				
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.	16	m3	Unallowable Advertising * $	5,409	5,409		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	631	631		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $				
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	174,244	174,244		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Salaries Adjustment			$ -	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Fees Adjustments			$ -	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16a		PENALTIES	$ -		$ -
16a		LATE FEES	$ 631		$ -
16a		PRIOR PERIOD EXPENSES			
		rounding			
		Provider User Fee for Medicare days	$ -		$ -
Total Other A&G Adjustments			$ 631	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	9/30/2021	29	37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	174,244	174,244		
Page 20 - Resident Care Supplies***								
27.			Prescription Drugs	$				
28.	20	5d	Ambulance/Limousine	$				
29.	20	5f	X-rays, etc	$	12,975	12,975		
30.	20	5h	Laboratory	$	40,073	40,073		
31.			Medical Supplies	$				
32.			Oxygen (non emergency)	$				
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	12	12		
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$				
36.			Depreciation on Unallowable Motor Vehicles	$				
37.			Unallowable Property and Real Estate Taxes	$				
38.			Rental of Building Space or Rooms	$				
39.			Other - See Attached Schedule	$				
Page 27 - Insurance								
40.			Mortgage Insurance	$				
41.			Property Insurance	$				
Other - Miscellaneous								
42.			Other - Indirect	$	(0)	(0)		
43.			Interest Income on Account Rec.	$				
44.			Other - Miscellaneous Administrative	$				
45.			Management Fees Direct	$				
46.			Management Fees Indirect	$				
47.			Other - Direct	$				
Not For Profit Providers Only								
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	$				
49.	***Total Amount of Decrease (Items 1 - 48)***			$	227,304	227,304		

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

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5J	Non Covered PPS Visits	29.32		-
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	(6)		
13	B9A	ST- Resident Care (for outpatent therapy - see schedule)	(6)		
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)	(6)		
Total Other Ancillary Costs			$ 12	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Property Adjustments			$ -	$ -	$ -

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	4A1	Housekeeping Supplies (for Outpatient Therapy - see schedule)	$ (0)		
20	4B	Housekeeping purchased services (for Outpatient Therapy see schedule)	$ (0)		
22	6B	Heat (for outpatient Therapy see schedule)	$ (0)		
22	6C	Light and Power (for outpatient therapy see schedule)	$ (0)		
22	6D	water (for outpatient therapy see schedule)	$ (0)		
22	6A	Repair&Maint (for outpatient therapy see schedule)	$ (0)		
Total Other Adjustments			$ (0)	$ -	$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Adjustments			$ -	$ -	$ -

Schedule of Other - Direct Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Adjustments			$ -	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Farmington Care Center, LLC	2288	9/30/2021	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	6,025,140	6,025,140		
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)*	$	2,577,520	2,577,520		
b. Medicare Room and Board Contractual Allowance **	$				
4. a. Private-Pay Residents and Other	$	890,183	890,183		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	189,330	189,330		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(189,330)	(189,330)		
c. Prescription Drugs - Non-Medicare	$	33,725	33,725		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(33,725)	(33,725)		
2. a. Medical Supplies - Medicare	$	2,083	2,083		
b. Medical Supplies - Medicare Contractual Allowance **	$	(2,083)	(2,083)		
c. Medical Supplies - Non-Medicare	$	480	480		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(480)	(480)		
3. a. Physical Therapy - Medicare	$	461,985	461,985		
b. Physical Therapy - Medicare Contractual Allowance **	$	(334,562)	(334,562)		
c. Physical Therapy - Non-Medicare	$	109,327	109,327		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(109,327)	(109,327)		
4. a. Speech Therapy - Medicare	$	61,020	61,020		
b. Speech Therapy - Medicare Contractual Allowance **	$	(46,449)	(46,449)		
c. Speech Therapy - Non-Medicare	$	16,504	16,504		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(16,504)	(16,504)		
5. a. Occupational Therapy - Medicare	$	401,767	401,767		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(316,597)	(316,597)		
c. Occupational Therapy - Non-Medicare	$	97,222	97,222		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(91,120)	(91,120)		
6. a. Other *(Specify)* - Medicare	$	318,774	318,774		
b. Other *(Specify)* - Non-Medicare	$	105,434	105,434		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	10,150,317	10,150,317		
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)*	$	374	374		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	1,835,381	1,835,381		
V. Total Other Revenue (1 thru 8)	$	1,835,755	1,835,755		
VI. Total All Revenue (III +V)	$	11,986,072	11,986,072		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Lab Medicare	$ 31,249		
	Lab Medicare CA	$ (31,249)		
	Oxygen Medicare	$ 26		
	Oxygen Medicare CA	$ (26)		
	Equipment rental	$ 5,981		
	Equipment rental CA	$ (5,981)		
	Pen Therapy	$ -		
	Pen Therapy CA	$ -		
	Therapy Beds Medicare	$ -		
	Therapy Beds Medicare CA	$ -		
	Radiology Medicare	$ 13,745		
	Radiology Medicare CA	$ (13,745)		
	IV Therapy	$ 36,361		
	IV Therapy CA	$ (36,361)		
	Medical Transportation	$ -		
	Medical Transportation CA	$ -		
	Glucose testing	$ -		
	Glucose testing CA	$ -		
	Outpatient therapy Medicare	$ (365)		
	MEDICAID COVID REVENUE	$ 177,705		
	CRF MEDICAID REVENUE	$ 141,434		
Total Other Resident Revenue - Medicare		$ 318,774	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Lab	5,918		
	Lab CA	(5,918)		
	Oxygen	$ 569		$ -
	Oxygen CA	$ (569)		$ -
	Equipment rental	$ 2,777		
	Equipment rental CA	$ (2,777)		
	Pen Therapy	$ -		
	Pen Therapy CA	$ -		
	Therapy Beds	$ -		
	Therapy Beds CA	$ -		
	Radiology	$ 1,532		
	Radiology CA	$ (1,532)		
	Medical Transportation	$ -		
	Medical Transportation CA	$ -		
	Glucose Testing	$ -		
	Glucose Testing CA	$ -		
	IV therapy	$ 14,766		$ -
	IV therapy CA	$ (14,766)		$ -
	Flu shot revenue	$ 87		
	Outpatient therapy	$ (1,430)		
	prior period revenue	$ 48,659		
	Optum B	$ 159,449		
	Optum B CA	$ (83,849)		
	C/A VBP	$ (17,481)		
	rounding	$ (1)		
Total Other Resident Revenue		$ 105,434	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	INTEREST INCOME		$ 374		
Total Interest Income			$ 374	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	MEALS	$ -		
	TELEVISION INCOME	$ -		
	OTHER INCOME: DMHAS OPERATING REVENUE	$ -		
	OTHER INCOME: DMHAS ORGANIZATIONAL REV	$ -		
	OTHER INCOME: DEFERRED REVENUE	$ 3,059		
	MEDICARE COVID STIMULUS REVENUE	$ -		
	CONCESSIONS / VENDING INCOME	$ -		
	RESIDENT LATE FEE REVENUE	$ -		
	RESIDENT ATTORNEY FEE REVENUE	$ -		
	TELEPHONE INCOME	$ -		
	OTHER INCOME	$ 609		
	OPTUM DIVIDENDS REVENUE	$ 20,095		
	OPTUM OUTLIERS	$ -		
	HHS GENERAL FUND REVENUE	$ -		
	HHS INFECTION CONTROL REVENUE	$ 890,618		
	CARES ACT REVENUE	$ 915,000		
	EMPLOYEE TESTING REVENUE	$ -		
	COVID ECHO TRAINING REVENUE	$ 6,000		
Total Other Revenue		$ 1,835,381	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	9/30/2021	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 44,727
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 3,332,147
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 107,253
a. Prepaid Insurance		55,875		
b. Prepaid Property Taxes		29,964		
c. Prepaid Expenses Other		21,414		
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ (1,996,814)
Due From (to) Related Parties		(323,750)		
Other Owners reserves		(1,673,063)		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,487,312
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost	1,161		$ 39
	Accum. Depreciation	1,122	Net	
4. Leasehold Improvements	*Historical Cost	1,569,192		$ 380,313
	Accum. Depreciation	1,188,879	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	1,167,939		$ 131,625
	Accum. Depreciation	1,036,314	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)				$ 511,977

* 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
Farmington Care Center, LLC	2288	9/30/2021	32	37

Account				Amount
			Total Brought Forward:	$ 1,999,289
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$ 352,831
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$ 74,334
Patient Trust Funds		71,779		
Long Term Deposit - primecare		2,555		
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 427,165
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 2,426,454

* 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
Farmington Care Center, LLC	2288	9/30/2021	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 539,038
	2. Notes Payable (*itemize*)				$ 50,427
	Working Capital Line of Credit	50,427			
	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*)				$ 356,085
	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*)				$ 1,491,895
	Related Party Payables	1,355,496			
	Accrued Expenses	17,214			
	Accrued Resident User Fees	130,429			
	Accrued Workers Comp Expense	(11,245) See Schedule			
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 2,437,444

* 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
Farmington Care Center, LLC	2288	9/30/2021	34	37

Account	Amount
Total Brought Forward:	2,437,444
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*)		$ 71,779
Patient Trust Funds	71,779	
See Schedule		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 71,779
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 2,509,223

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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	9/30/2021	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	$ (1,606,804)
	6. Gain or Loss for Period 10/1/2020 thru 9/30/2021	$ 1,499,036
	7. Total Net Worth	$ (82,768)
C.	***Total Reserves and Net Worth***	$ (82,768)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 2,426,454

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	9/30/2021	36	37

Account	Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2020	$
B. Total Revenue (*From Statement of Revenue Page 30*)	$ 11,986,072
C. Total Expenditures (*From Statement of Expenditures Page 27*)	$ 10,487,036
D. Net Income or Deficit	$ 1,499,036
E. Balance	$ 1,499,036
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***	09/30/21	$ 1,499,036

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2288	9/30/2021	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)

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