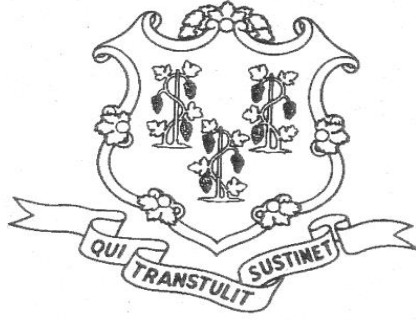


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2023

Name of Facility (as licensed) SecureCare Options, LLC	
Address (No. & Street, City, State, Zip Code) 60 West Street Rocky Hill CT	
Type of Facility Chronic and Convalescent <input type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input checked="" type="checkbox"/> (Specify) <input checked="" type="checkbox"/> Other	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

License Numbers:	CCNH / RHNS 2389	(Specify)	Other	Medicare Provider 07-5442
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Medicaid Provider Numbers:	CCNH / RHNS 8046363	(Specify)	Other
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General Information

Name of Facility (as licensed) SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2023	Page 1	of 37
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Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for SecureCare Options, 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) Melissa Schmitt			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 SecureCare Options, LLC		Period Covered:	From 10/1/2022	To 9/30/2023
Address of Facility 60 West Street Rocky Hill CT				
Report Prepared By Plante Moran, PLLC		Phone Number 248-223-3569	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.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-529-0880		Report for Year Ended 9/30/2023	Page 2	of 37
Name of Facility (as shown on license) SecureCare Options, LLC		Address (No. & Street, City, State, Zip) 60 West Street Rocky Hill CT		
License Numbers:	CCNH / RHNS 2389	(Specify)	Other	Medicare Provider No. 07-5442
Type of Facility (Check appropriate box(es)) Chronic and Convalescent <input type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input checked="" type="checkbox"/> (Specify) <input checked="" type="checkbox"/> Other				
Type of Ownership (Check appropriate box) <input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Melissa Schmitt		Nursing Home Administrator's License No.:	2182	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

General Information and Questionnaire
Partners/Members

Name of Facility SecureCare Options, LLC		License No. 2389	Report for Year Ended 9/30/2023	Page 3	of 37
Legal Name of Partnership/LLC SecureCare Options, LLC		Business Address 60 West Street Rocky Hill CT		State(s) and/or Town(s) in Which Registered CT	
Name of Partners/Members	Business Address	Title		% Owned	
Rocky Associates	245 South Benton St STE 100, Lakewood, CO 80226	Member		31.66	
UTG Investments, LLC	2500 17th St, STE 201 Denver CO 80211	Member		31.66	
LTC Associates, LLC	245 South Benton St STE 100, Lakewood, CO 80226	Member		31.66	
Vantage Capital, LLC	c/o iCare, 341 Bidwell St Manchester CT 06040	Member		5.02	

**General Information and Questionnaire
 Related Parties***

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2023	Page 4	of 37
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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	%**				
Bidwell Care Center, LLC	333 Bidwell St. Manchester, CT 06040	<input type="radio"/>	<input checked="" type="radio"/>		Shared Employees	Pg 13, B11a2; Pg 13, E	(5,829)	5,829
Chelsea Place Care Center, LLC	25 Lorraine St. Hartford, CT 06105	<input type="radio"/>	<input checked="" type="radio"/>		Shared Employees	Pg 13, B11a2; Pg 13, E	(12,744)	12,744
Chestnut Point Care Center, LLC	171 Main St. East Windsor, CT 06088	<input type="radio"/>	<input checked="" type="radio"/>		Shared Employees	Pg 13, B11a2; Pg 13, E	(44,733)	44,733
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Shared Employees	Pg 13, B11a2; Pg 13, E	(27,653)	27,653
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088	<input type="radio"/>	<input checked="" type="radio"/>		Shared Employees	Pg 13, B11a2; Pg 13, E	(7,658)	7,658
Meriden Care Center, LLC (Silver Springs)	33 Roy St. Meriden, CT 06450	<input type="radio"/>	<input checked="" type="radio"/>		Shared Employees	Pg 13, B11a2; Pg 13, E	(43,327)	43,327
Trinity Hill Care Center, LLC	151 Hillside Ave. Hartford, CT 06106	<input type="radio"/>	<input checked="" type="radio"/>		Shared Employees	Pg 13, B11a2; Pg 13, E	96,180	(96,180)
Westside Care Center, LLC	349 Bidwell St. Manchester, CT 06040	<input type="radio"/>	<input checked="" type="radio"/>		Shared Employees	Pg 13, B11a2; Pg 13, E	(10,909)	10,909
See Attached Schedule		<input type="radio"/>	<input checked="" type="radio"/>					

* Use additional sheets if necessary.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2023	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

General Information and Questionnaire
Other Lines of Business

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2023	Page 6	of 37
Square footage of entire facility.		43,827		
Outpatient Therapy				
Does the Facility provide outpatient therapy services?		No		
<i>If yes, please complete the following:</i>				
Square footage of therapy space.				
Meals on Wheels				
Does the facility provide Meals on Wheels?		No		
<i>If yes, please complete the following:</i>				
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?			
<i>If yes, please state where costs are reported.</i>				
No	Are drivers for the program included in the facility's payroll?			
<i>If yes, please complete the following:</i>				
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		
<i>If yes, please complete the following:</i>				
Square footage of apartments				
Square footage of independent living				
Square footage of assisted living				
Please identify the services provided:				

General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility SecureCare Options, I	License No. 2389	Report for Year Ended 9/30/2023	Page 7	of 37
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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:

Schedule of Resident Statistics

Name of Facility SecureCare Options, LLC			License No. 2389			Report for Year Ended 9/30/2023				Page 8		of 37	
	Total All Levels	Total CCNH / RHNS Level	Total (Specify)	Total Other	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH / RHNS	(Specify)	Other	Total	CCNH / RHNS	(Specify)	Other	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	95	95			95	95							
B. On last day of THIS report period	95	95							95	95			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	88	88			88	88							
B. As of midnight of THIS report period	95	95							95	95			
3. Total Number of Days Care Provided During Period													
A. Medicare	126	126			66	66			60	60			
B. Medicaid (Conn.)	32,013	32,013			24,092	24,092			7,921	7,921			
C. Medicaid (other states)													
D. Private Pay	539	539			254	254			285	285			
E. State SSI for RCH													
F. Other (Specify) DMHAS	1,273	1,273			905	905			368	368			
G. Total Care Days During Period (3A thru F)	33,951	33,951			25,317	25,317			8,634	8,634			
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)	33,951	33,951			25,317	25,317			8,634	8,634			

Schedule of Resident Statistics (Cont'd)

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2023	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? Yes No
 If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	Other	R.C.H.	ICF-MR
No. of Residents	1	90		4				
Per Diem Rate								
a. One bed rm.	675.00	454.00		660.00				
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	2,699	2,699			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	2,259	2,259			
2. Restorative Treatments	23	23			
C. Other	153	153			
D. Total Physical Therapy Treatments	5,134	5,134			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	360	360			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	302	302			
2. Restorative Treatments					
C. Other	18	18			
D. Total Speech Therapy Treatments	680	680			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	2,043	2,043			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	2,042	2,042			
2. Restorative Treatments					
C. Other	155	155			
D. Total Occupational Therapy Treatments	4,240	4,240			

Report of Expenditures - Salaries & Wages

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2023	Page 10	of 37
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Are time records maintained by all individuals receiving compensation? Yes No

Item	Total Cost and Hours									
	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)	147,934		2,341							
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)										
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	416,472		11,127							
5. Dietary Service										
a. Head Dietitian										
b. Food Service Supervisor										
c. Dietary Workers										
6. Housekeeping Service										
a. Head Housekeeper										
b. Other Housekeeping Workers										
7. Repairs & Maintenance Services										
a. Engineer or Chief of Maintenance	90,107		2,112							
b. Other Maintenance Workers			68							
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	310,260		4,490							
b. RN										
1. Direct Care	872,891		13,935							
2. Administrative**	371,783		7,587							
c. LPN										
1. Direct Care	1,067,305		29,373							
2. Administrative**	188,585		4,517							
d. Aides and Attendants	2,267,370		100,190							
e. Physical Therapists										
f. Speech Therapists										
g. Occupational Therapists										
h. Recreation Workers	282,863		9,596							
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	244,731		7,470							
n. Marketing										
o. Other (Specify) See Attached Schedule	169,804		6,625							
<i>A-13. Total Salary Expenditures</i>	6,430,106		199,430							

* 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)

Position	CCNH / RHNS			(Specify)			Other		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
UNIT SECRETARIES SALARIES	\$ 10,175		225				\$ -		-
MEDICAL RECORDS SALARIES	\$ 40,797		2,228				\$ -		-
CENTRAL SUPPLY SALARIES	\$ 62,335		2,086				\$ -		-
RESPIRATORY THERAPY SALARIES	\$ -		-				\$ -		-
PLANT SECURITY SALARIES	\$ 56,497		2,086				\$ -		-
MEDICAL RECORDS SALARIES SPCL	\$ -		-				\$ -		-
Total	\$ 169,804	\$ -	6,625	\$ -	\$ -	-	\$ -	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH / RHNS			(Specify)			Other		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$ 1,934		34				\$ -		-
ADMISSIONS C/S LABOR	\$ 40,292		745				\$ -		-
CENTRAL SUPPLY CONTRACT SERVICE	\$ (76,110)		(1,960)				\$ -		-
ADMINISTRATIVE CONTRACT SERVICE LABOR	\$ (77,000)		(180)				\$ -		-
RESPIRATORY THERAPY CONTRACT SERVICES	\$ 2,633		2				\$ -		-
PHYSICAL THERAPY C/S MEDICIAD	\$ -		-				\$ -		-
SPEECH THERAPY C/S Medicaid	\$ -		-				\$ -		-
OCCUPATIONAL THERAPY C/S MEDICIAD	\$ -	-	-				\$ -		-
Total	\$ (108,252)	\$ -	(1,359)	\$ -	\$ -	-	\$ -	\$ -	-

**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	
SecureCare Options, LLC				2389	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.

**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	
SecureCare Options, LLC				2389	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***										
Melissa Schmitt	123,846			same as employees less union funds	Administrator	2,038	A2			
Jessica DeRing	24,088			same as employees less union funds	Administrator	303	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.

Annual Report of Long-Term Care Facility

CSP-13 Rev. 3/2023

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended						Page	of
SecureCare Options, LLC	2389	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	15,904		168						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	114,284		2,189						
b. Other									
6. Social Worker	7,539		80						
7. Recreation Worker	25,387		119						
8. Physicians									
a. Medical Director (entire facility)	42,000		158						
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	12,770		23						
9. Speech Therapist									
a. Resident Care	26,784		513						
b. Other									
10. Occupational Therapist									
a. Resident Care	82,996		1,590						
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	34,398		303						
2. Administrative***	(88,597)		(1,699)						
b. LPN									
1. Direct Care	186,187		2,395						
2. Administrative***									
c. Aides	14,972		448						
d. Other									
12. Other (Specify) See Attached Schedule	(108,252)		(1,359)						
B-13 Total Fees Paid in Lieu of Salaries	366,372		4,929						

* 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.

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

Name of Facility SecureCare Options, LLC		License No. 2389		Report for Year Ended 9/30/2023		Page 14	of 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	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership			
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Shared Employees	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership			
Pharm Scripts	Pharmacy Contract	<input type="radio"/>	<input checked="" type="radio"/>				
Guardian Consulting Srv	Pharmacy Consulting	<input type="radio"/>	<input checked="" type="radio"/>				
Healthdrive Physician Services	Audiology, Dental and Podiatry	<input type="radio"/>	<input checked="" type="radio"/>				
Sterling Physicians	Med Dir	<input type="radio"/>	<input checked="" type="radio"/>				
Claris	Med Dir	<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended					Page	of
SecureCare Options, LLC	2389	9/30/2023					15	37
Item	Total Including Adjustment	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment	
I. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	\$ 85,235	85,235						
2. Disability Insurance	\$							
3. Unemployment Insurance	\$							
4. Social Security (F.I.C.A.)	\$ 518,301	518,301						
5. Health Insurance	\$ 998,977	998,977						
6. Life Insurance (employees only) (not-owners and not-operators)	\$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 352,050	352,050						
8. Uniform Allowance	\$							
9. Other (<i>Specify</i>) See Attached Schedule	\$ 30,117	30,117						
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$							
c. Bad Debts*	\$ 13	13						
d. Accounting and Auditing	\$ 25,831	25,831						
e. Legal (<i>Services should be fully described on Page 15b</i>)	\$ 2,078	2,078						
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$							
g. Office Supplies	\$ 45,162	45,162						
h. Telephone and Cellular Phones								
1. Telephone & Pagers	\$ 50,489	50,489						
2. Cellular Phones	\$ 2,238	2,238						
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$							
j. Corporation Business Taxes (<i>franchise tax</i>)	\$							
k. Other Taxes (<i>Not related to property - See Page 22</i>)								
1. Income*	\$							
2. Other (<i>Specify</i>) See Attached Schedule	\$							
3. Resident Day User Fee	\$ 711,080	711,080						
Subtotal	\$ 2,821,572	2,821,572						

* 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	\$ 30,117				\$ -	
Total	\$ 30,117	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Other Taxes

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

General Information and Questionnaire
Accounting Basis

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2023	Page 15b	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual Cash Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1 Taxes, financial statements, accounting support	\$ 25,831
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 25,831

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 1 iCare Health Management, LLC 2 Robinson & Cole, LLP 3 Various others (American Arbitration , Various Arbitration, Murtha Cullina) 4 5	Telephone Number 860-570-2140 860-275-8200
---	--

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

1 341 Bidwell Street, Manchester CT
 2 280 Trumbull St, Hartford, CT
 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	\$ 173
3 Employment Arbitrations, healthcare law & Conservatorships	\$ 1,905
4	\$
5 Collections	\$ (0)
	Charge for Services Provided
	\$ 2,078

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

Yes No 15E

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

Name of Facility	License No.	Report for Year Ended					Page	of
SecureCare Options, LLC	2389	9/30/2023					16	37
Item	Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment	
Subtotals Brought Forward:	2,821,572	2,821,572						
l. Travel and Entertainment								
1. Resident Travel and Entertainment	\$							
2. Holiday Parties for Staff	\$ 1,642	1,642						
3. Gifts to Staff and Residents	\$ 2,900	2,900						
4. Employee Travel	\$ 8,908	8,908						
5. Education Expenses Related to Seminars and Conventions	\$ 5,908	5,908						
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$							
7. Other (<i>Specify</i>) See Attached Schedule	\$ 920	920						
m. Other Administrative and General Expenses								
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 26,597	26,597						
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$							
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 6,476	6,476						
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	\$ 2,323	2,323						
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 6,483	6,483						
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$							
9. Subscriptions	\$ 452	452						
10. Contributions*** See Attached Schedule	\$ 200	200						
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 172,765	172,765						
12. Administrative Management Services**	\$ 579,756	579,756						
13. Other (<i>Specify</i>) See Attached Schedule	\$ 28,930	28,930						
C-14 Total Administrative & General Expenditures	\$ 3,665,833	3,665,833						

* 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 in the Adjustment column.

Schedule of Other Travel and Entertainment

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
MEALS	\$ 920				\$ -	
Total Other Travel and Entertainment	\$ 920	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
COMMUNICATIONS SPECIAL EVENTS	\$ 6,476				\$ -	
Total Other Advertising	\$ 6,476	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
ALTCFM						
CAHCF Dues	\$ 6,483				\$ -	
OTHER DUES						
Total Dues	\$ 6,483	\$ -	\$ -	\$ -	\$ -	\$ -

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	\$ 5,542				\$ -	
EMPLOYEE RELATIONS	\$ 630				\$ -	
EMPLOYEE RELATIONS-OTHER	\$ 2,630				\$ -	
PERMITS & LICENSES	\$ 2,499				\$ -	
VOLUNTEER EXPENSE	\$ -				\$ -	
BANK FEES	\$ 1,924				\$ -	
CMS REVISIT USER FEES	\$ -				\$ -	
PENALTIES	\$ -				\$ -	
LATE FEES	\$ 1,956				\$ -	
INTERNET EXPENSES	\$ 13,750				\$ -	
Rounding	\$ -					
Total Other Administrative and General	\$ 28,930	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2023	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
iCare Management, LLC/iCare Health Management, LLC	579,756	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	185,198	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	45,886	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.**

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
SecureCare Options, LLC		2389	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	\$ 7,625	7,625					
2. Non-Food Supplies	\$ 4,572	4,572					
3. Other (Specify) _____ DIETARY SUPPLEMENTS	\$ 360	360					
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 1,375,858	1,375,858					
c. Other (Specify) _____ DIETARY MINOR EQUIPMENT	\$ 10,704	10,704					
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 1,399,118	1,399,118					
2E. Dietary Questionnaire		Total	CCNH / RHNS	(Specify)	Other		
F. Resident Meals:	Total no. of meals served per day:*	279	279				
G. Is cost of employee meals included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No						
H. Did you receive revenue from employees?	<input type="radio"/> Yes <input checked="" type="radio"/> No	If yes, specify amt.					
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)							
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No	If yes, specify cost.					
K. Is any revenue collected from these people?	<input type="radio"/> Yes <input checked="" type="radio"/> No	If yes, specify amt.					
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)							
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No	If yes, specify cost.					
N. Is any revenue collected from employees?	<input type="radio"/> Yes <input checked="" type="radio"/> No	If yes, specify amt.					
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)							

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

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

Name of Facility		License No.	Report for Year Ended				Page	of
SecureCare Options, LLC		2389	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. \$	903	903				
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)		\$	294,710	294,710				
c. Other (Specify) LAUNDRY MINOR EQUIPMENT		\$	309	309				
3D. Total Laundry Expenditures (3a + b + c)		\$	295,922	295,922				
3E. Laundry Questionnaire								
F. Is cost of employee laundry included in 3D?		<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.				
G. Did you receive revenue from employees?		<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify amt.				
H. Where is the revenue received reported in the Cost Report? (Page/Line Item)								
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?		<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.				
J. Did you receive revenue from these people?		<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify amt.				
K. Where is the revenue received reported in the Cost Report? (Page/Line Item)								

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3D.

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

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

Name of Facility		License No.	Report for Year Ended				Page	of	
SecureCare Options, LLC		2389	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 (<i>Mops, pails, brooms, etc.</i>)	Amt.	\$ 13,804	13,804					
	b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel							
		Amt.	\$ 312,664	312,664					
	C. Other (<i>Specify</i>)								
	HOUSEKEEPING MINOR EQUIPMENT								
4D.	Total Housekeeping Expenditures (4a + b + c)		\$ 326,468	326,468					
5.	Resident Care (Supplies)**								
	a. Prescription Drugs***								
	1. Own Pharmacy		\$						
	2. Purchased from PHARMACY		\$ 44,210	44,210					
	b. Medicine Cabinet Drugs		\$ 26,426	26,426					
	c. Medical and Therapeutic Supplies		\$ 54,112	54,112					
	d. Ambulance/Limousine***		\$ 3,170	3,170					
	e. Oxygen								
	1. For Emergency Use		\$ 1,969	1,969					
	2. Other***		\$						
	f. X-rays and Related Radiological Procedures***		\$ 1,219	1,219					
	g. Dental (<i>Not dentists who should be included under salaries or fees</i>)		\$						
	h. Laboratory***		\$ 20,352	20,352					
	i. Recreation		\$						
	j. Direct Management Services*		\$ 185,198	185,198					
	k. Indirect Management Services*		\$ 45,886	45,886					
	l. Cable TV		\$						
	m. Other (Specify)**** See Attached Schedule		\$ 109,075	109,075					
	n. Physical Therapy Expense		\$						
	o. Speech Therapy Expense		\$						
5P.	Total Resident Care Expenditures (5a - 5o)		\$ 491,617	491,617					

* 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	\$ 1,085				\$ -	
NURSING MINOR EQUIP	\$ 3,399				\$ -	
MEDICAL RECORDS SUPPLIES	\$ (67)				\$ -	
MEDICAL RECORDS MINOR EQUIPMENT	\$ -				\$ -	
NON-COVERED PPS DR. VISITS	\$ 6,255				\$ -	
RESIDENT CARE SUPPLIES	\$ 1,829				\$ -	
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 10,896				\$ -	
PERSONAL CARE SUPPLIES	\$ 16,716				\$ -	
INCONTINENCY SUPPLIES	\$ 18,031				\$ -	
VACCINE RESIDENTS	\$ 6,588				\$ -	
PATIENT SPECIAL NEEDS	\$ 5,633				\$ -	
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	\$ 9,834				\$ -	
EQUIPMENT RENTAL: AIDS UNIT	\$ -				\$ -	
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ 348				\$ -	
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ 20,114				\$ -	
HI LOW BED RENTAL & MATTRESSES	\$ -				\$ -	
IV THERAPY SUPPLIES	\$ 1,436				\$ -	
IV THERAPY CONTRACT SERVICE	\$ -				\$ -	
MEDICAL WASTE CONTRACT SERVICE	\$ 1,100				\$ -	
ACTIVITIES SUPPLIES	\$ 5,879				\$ -	
ACTIVITIES MINOR EQUIPMENT	\$ -				\$ -	
ADMISSIONS SUPPLIES	\$ -				\$ -	
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS						
STRIKE COSTS NON REIMBURSABLE	\$ -				\$ -	
COVID NON REIMBURSABLE	\$ -				\$ -	
Total Other Resident Care	\$ 109,075	\$ -	\$ -	\$ -	\$ -	\$ -

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

Name of Facility SecureCare Options, LLC			License No. 2389	Report for Year Ended 9/30/2023	Page of 21 37					
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH / RHNS	(Specify)	Other	Pg	Line
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Housekeeping Services	312,664			20	4b
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Laundry Services	294,710			19	3b
Eagle Elevator		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Elevator Contract	893			22	6F
Brightview Landscapes LLC		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Landscaping	17,725			22	6F
Peter Marcue		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Snow Removal	8,496			22	6F
All Waste Inc		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Trash removal	33,344			22	6F
Facility Complainece		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Plant Contract Services	61,668			22	6F
American HealthTech	P.O. Box 9001006, Louisville, KY 40290	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Software Maintenance Contract	16,761			16	M11
Automatic Data Processing		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Payroll Services	48,660			16	M11
National Datacare Corp		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Resident Trust Software	4,680			16	M11
Prime Care Technology services		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Computer Consulting Services	61,376			16	M11
Priotiry Express		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Courier Services	2,186			16	M11
Us Security Associate		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Security Contract Servie	234,709			22	6F
Health Services Group		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Dieraty/Raw Food	1,375,858			18	a1,b

* List all contracted services over \$10,000. Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended					Page	of
SecureCare Options, LLC	2389	9/30/2023					22	37
Item		Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	\$	43,767	43,767					
b. Heat	\$	82,268	82,268					
c. Light & Power	\$	106,858	106,858					
d. Water	\$	44,386	44,386					
e. Equipment Lease (<i>Provide detail on page 22b</i>)	\$	12,400	12,400					
f. Other (<i>itemize</i>)	\$	393,786	393,786					
See Attached Schedule								
6g. Total Maint. & Operating Expense (6a - 6f)	\$	683,464	683,464					
7. Depreciation (<i>complete schedule page 23*</i>)								
a. Land Improvements	\$							
b. Building & Building Improvements	\$							
c. Non-Movable Equipment	\$							
d. Movable Equipment	\$	51,219	51,219					
*7e. Total Depreciation Costs (7a + b + c + d)	\$	51,219	51,219					
8. Amortization (<i>Complete att. Schedule Page 24*</i>)								
a. Organization Expense	\$							
b. Mortgage Expense	\$							
c. Leasehold Improvements	\$	73,408	73,408					
d. Other (<i>Specify</i>)	\$							
*8e. Total Amortization Costs (8a + b + c + d)	\$	73,408	73,408					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	488,675	488,675					
10. Property Taxes								
a. Real estate taxes paid by owner	\$							
b. Real estate taxes paid by lessor	\$	97,636	97,636					
c. Personal property taxes	\$	12,555	12,555					
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	723,493	723,493					

* 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	\$ 11,915				\$ -	
PLANT CONTRACT SERVICE LABOR	\$ -				\$ -	
ELEVATOR CONTRACT SERVICE	\$ 893				\$ -	
FIRE/SPRINKLER CONTRACT SERVICE	\$ 5,609				\$ -	
LANDSCAPING CONTRACT SERVICE	\$ 17,725				\$ -	
SNOW REMOVAL CONTRACT SERVICE	\$ 8,496				\$ -	
TRASH REMOVAL CONTRACT SERVICE	\$ 33,344				\$ -	
PLANT (POOL) CONTRACT SERVICES OTHER	\$ 61,668				\$ -	
SECURITY CONTRACT SERVICE	\$ 234,709				\$ -	
PLANT CONTRACT SERVICE OTHER	\$ 4,898				\$ -	
PLANT MINOR EQUIPMENT	\$ 11,474				\$ -	
RENT AUTO	\$ -				\$ -	
RENT EQUIPMENT	\$ 3,055				\$ -	
RENT OTHER	\$ -				\$ -	
Total Other Repairs and Maintenance	\$ 393,786	\$ -	\$ -	\$ -	\$ -	\$ -

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
SecureCare Options, LLC			2389	9/30/2023			22b	37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease		Amount Claimed
	Yes	No						
ADP, Inc., One ADP Drive MS-100, Augusta, GA 30909	<input type="radio"/>	<input checked="" type="radio"/>	Time Clocks and Payroll Punch Equip	06/01/10	automatic renewals	7,165		7,165
GE Capital C/O Wells Fargo, P.O.Box 41564, Philadelphai, PA 19101	<input type="radio"/>	<input checked="" type="radio"/>	Copier	03/05/14	automatic renewals	4,360		4,360
Mail Financ Dept 3682, PO Box 123682, Dallas, TX 75312-3682	<input type="radio"/>	<input checked="" type="radio"/>	Postage Rental	03/23/18	Month to month	875		875
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
							Total ***	12,400

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.

Depreciation Schedule

Name of Facility SecureCare Options, LLC			License No. 2389		Report for Year Ended 9/30/2023			Page 23	of 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													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal													
C. Non-Movable Equipment													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal													
			Is a mileage logbook maintained?	Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
			Yes	No	Month	Year							
D. Movable Equipment													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a.													
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period							1,766,991	1,766,991	1,555,945			49,223	
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
c. Administrative							15,317					922	
d. Standard Resident							18,362					1,074	
e. Specialized Resident													
Total Acquired during this report period							33,679					1,996	
D-3. Subtotal													51,219
E. Total Depreciation													51,219

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

Amortization Schedule*

Name of Facility SecureCare Options, LLC			License No. 2389		Report for Year Ended 9/30/2023			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1. Start Up Costs - Employee Labor				260,781	260,781				
2. Start Up Costs - Other				603,959	603,959				
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				1,007,923	604,117			70,498	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				63,209				2,911	
C-4. Subtotal									73,408
D. Total Amortization									73,408

* Straight-line method must be used.

** Specify which of the following bases were used:

- A. Minimum of 5 years or 60 months.
- B. Life of mortgage; OR
- C. Remaining Life of Lease; OR
- D. Actual Life if owned by Related Party.

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

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2023	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*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				
2. Date Structure Completed		11/13/12		
3. If NOT Original Owner, Date of Purchase		11/13/12		
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity		95		
6. Square Footage		43,827		
7. Acquisition Cost				
a. Land				
b. Building				
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)		Comm Real Estate		
b. Date Mortgage Obtained		11/01/22		
c. Interest Rate for the Cost Year		597.00%		
d. Term of Mortgage (number of years)		2 years 11 months		
e. Amount of Principal Borrowed		2,299,484		
f. Principal balance outstanding as of 9/30/2023		2,299,484		
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

Note: Be sure required copies of leases are attached to Page 25 and real estate taxes paid by lessor are included on Page 22, Item 10b.

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

Name of Facility		License No.	Report for Year Ended				Page	of
SecureCare Options, LLC		2389	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)

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

Name of Facility		License No.		Report for Year Ended				Page	of	
SecureCare Options, LLC		2389		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										
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$						
14. Insurance										
a. Insurance on Property (buildings only)				\$ 9,468	9,468					
b. Insurance on Automobiles				\$						
c. Insurance other than Property (as specified above)										
1. Umbrella (Blanket Coverage)				\$ 103,523	103,523					
2. Fire and Extended Coverage				\$						
3. Other (Specify)				\$ 9,878	9,878					
Other insurance, crime										
14d. Total Insurance Expenditures (14a + b + c)				\$ 122,869	122,869					
15. Total All Expenditures (A-13 thru C-14)				\$ 14,505,263	14,505,263					

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
SecureCare Options, LLC	2389	9/30/2023		30	37
Item	Total	CCNH / RHNS	(Specify)	Other	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 14,549,052	14,549,052			
b. Medicaid Room and Board Contractual Allowance **	\$				
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 326,504	326,504			
b. Medicare Room and Board Contractual Allowance **	\$				
4. a. Private-Pay Residents and Other	\$ 397,449	397,449			
b. Private-Pay Room and Board Contractual Allowance **	\$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 4,590	4,590			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (4,540)	(4,540)			
c. Prescription Drugs - Non-Medicare	\$ 26,468	26,468			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (26,468)	(26,468)			
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	\$ 26,016	26,016			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (3,619)	(3,619)			
c. Physical Therapy - Non-Medicare	\$ 82,602	82,602			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (82,602)	(82,602)			
4. a. Speech Therapy - Medicare	\$ 6,936	6,936			
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$ 21,811	21,811			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (21,811)	(21,811)			
5. a. Occupational Therapy - Medicare	\$ 23,647	23,647			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (4,246)	(4,246)			
c. Occupational Therapy - Non-Medicare	\$ 76,229	76,229			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (8,210)	(8,210)			
6. a. Other (<i>Specify</i>) - Medicare	\$ (99,840)	(99,840)			
b. Other (<i>Specify</i>) - Non-Medicare	\$ 134,446	134,446			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 15,424,413	15,424,413			
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$ 136,124	136,124			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ (262,282)	(262,282)			
V. Total Other Revenue (1 thru 8)	\$ (126,157)	(126,157)			
VI. Total All Revenue (III +V)	\$ 15,298,256	15,298,256			

* 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 / RHINS	(Specify)	Other
	Lab Medicare	\$ 329		
	Lab Medicare CA	\$ (329)		
	Oxygen Medicare	\$ 170		
	Oxygen Medicare CA	\$ (170)		
	Equipment rental	\$ -		
	Equipment rental CA	\$ -		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds Medicare	\$ -		
	Therapy Beds Medicare CA	\$ -		
	Radiology Medicare	\$ 656		
	Radiology Medicare CA	\$ (656)		
	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	\$ (99,840)		
Total Other Resident Revenue - Medicare		\$ (99,840)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHINS	(Specify)	Other
	Lab	871		
	Lab CA	(871)		
	Oxygen	\$ 3,851		\$ -
	Oxygen CA	\$ (3,851)		\$ -
	Equipment rental	\$ -		
	Equipment rental CA	\$ -		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds	\$ -		
	Therapy Beds CA	\$ -		
	Radiology	\$ 221		
	Radiology CA	\$ (221)		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose Testing	\$ -		
	Glucose Testing CA	\$ -		
	IV therapy	\$ 1,118		\$ -
	IV therapy CA	\$ (1,118)		\$ -
	Flu shot revenue	\$ 1,928		
	Outpatient therapy	\$ -		
	prior period revenue	\$ (4,057)		
	Optum B	\$ 278,009		
	Optum B CA	\$ (141,434)		
	C/A VBP	\$ -		
	rounding	\$ -		
Total Other Resident Revenue		\$ 134,446	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHINS	(Specify)	Other
	INTEREST INCOME		\$ 136,124		
Total Interest Income			\$ 136,124	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHINS	(Specify)	Other
	MEALS	\$ -		
	TELEVISION INCOME	\$ -		
	OTHER INCOME: DMHAS OPERATING REVENUE	\$ -		
	OTHER INCOME: DMHAS ORGANIZATIONAL REV	\$ 71,231		
	OTHER INCOME: DEFERRED REVENUE	\$ -		
	MEDICARE COVID STIMULUS REVENUE	\$ -		
	CONCESSIONS / VENDING INCOME	\$ -		
	RESIDENT LATE FEE REVENUE	\$ -		
	RESIDENT ATTORNEY FEE REVENUE	\$ -		
	TELEPHONE INCOME	\$ -		
	OTHER INCOME	\$ 500		
	OPTUM DIVIDENDS REVENUE	\$ 32,120		
	OPTUM OUTLIERS	\$ -		
	HHS GENERAL FUND REVENUE	\$ -		
	HHS INFECTION CONTROL REVENUE	\$ -		
	CARES ACT REVENUE	\$ -		
	EMPLOYEE TESTING REVENUE	\$ -		
	COVID ECHO TRAINING REVENUE	\$ -		
	DMHAS	\$ (231,552)		
	VARIANCE	\$ (134,581)		
Total Other Revenue		\$ (262,282)	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
SecureCare Options, LLC	2389	9/30/2023	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	4,161,570
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	692,821
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	8,896
5. Prepaid Expenses			\$	121,307
a. Prepaid Insurance	88,716			
b. Prepaid Property Taxes	28,180			
c. Prepaid Expenses Other	4,412			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	(4,208,916)
Due From (to) Related Parties	(72,980)			
Other Owners reserves	(4,135,936)			
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	775,678
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
4. Leasehold Improvements	*Historical Cost <u>1,071,133</u>		\$	393,607
	Accum. Depreciation <u>677,526</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>1,800,669</u>		\$	193,505
	Accum. Depreciation <u>1,607,164</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
Construction in Progress				
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	587,112

* 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)			\$ -

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
SecureCare Options, LLC	2389	9/30/2023	32	37
Account			Amount	
Total Brought Forward:			\$	1,362,791
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			\$	
3. Organization Expense				
	*Historical Cost	864,740		
	Accum. Depreciation	864,740	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	79,462
	Patient Trust Funds	71,762		
	Long Term Deposit - primecare	7,700		
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	
	RIGHT TO USE ASSET			
	ACCUM RIGHT TO USE ASSET			
See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	79,462
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	1,442,252

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

G. Balance Sheet (cont'd)

Name of Facility SecureCare Options, LLC		License No. 2389	Report for Year Ended 9/30/2023	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	205,592
2. Notes Payable (<i>itemize</i>)				\$	

See Schedule					
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	210,225
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	640,354
Related Party Payables					
Accrued Expenses		640,354			
Accrued Resident User Fees					
Accrued Workers Comp Expense		See Schedule			
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	1,056,171

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2023	Page 34	of 37
Account				Amount
Total Brought Forward:				1,056,171
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				
				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$
Patient Trust Funds		71,762		
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 71,762
C. Total All Liabilities (Lines A-13 + B-5)				\$ 1,127,933

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

Name of Facility	License No.	Report for Year Ended	Page	of
SecureCare Options, LLC	2389	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 (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	5,000
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(483,674)
6. Gain or Loss for Period			\$	792,993
	10/1/2022	thru	9/30/2023	
7. Total Net Worth			\$	314,319
C. Total Reserves and Net Worth			\$	314,319
D. Total Liabilities, Reserves, and Net Worth			\$	1,442,252

H. Changes in Total Net Worth

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2023	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2022			\$	
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$ 15,298,256	
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$ 14,505,263	
D. Net Income or Deficit			\$ 792,993	
E. Balance			\$ 792,993	
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions				
G. Deductions			\$	
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	
Name and Address (<i>No., City, State, Zip</i>)	Title	Amount		
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose	Amount			
3. Total Deductions			\$	
H. Balance at End of Period			\$ 792,993	
09/30/23				

I. Preparer's/Reviewer's Certification

Name of Facility SecureCare Options, LLC	License No. 2389	Report for Year Ended 9/30/2023	Page 37	of 37
<i>Check appropriate category</i>				
<input type="checkbox"/> Chronic and Convalescent Nursing <input type="checkbox"/> Home (CCNH) & RHNS <input type="checkbox"/> Combined	<input checked="" type="checkbox"/> (Specify)	<input checked="" type="checkbox"/> Other		
Preparer/Reviewer Certification				
<p>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.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Jon Lanczak				
Address Address			Phone Number	
3000 Town Center Suite 400, Southfield, MI 48034			248-223-3569	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Kartik Patel			860-570-2140	
Contact Email Address				
kpatel@icarehn.com				