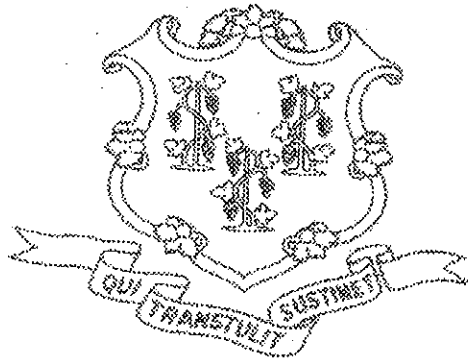


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2018

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	
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)
<input checked="" type="checkbox"/> Other	
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018

License Numbers:	CCNH 2149-C	RHNS	Other	Medicare Provider 07-5251
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Medicaid Provider Numbers:	CCNH 10447	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) Farmington Care Center, LLC	License No. 2149-C	Report for Year Ended 9/30/2018	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 Farmington Care Center, LLC [facility name], for the cost report period beginning October 1, 2017 and ending September 30, 2018, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) John Zazzaro			Printed Name (Owner) Chris Wright		2/13/19
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)		Comm. Expires
Branda Walsh	CT	2/13/19	Branda Walsh		BRENDA WALSH Notary Public - Connecticut My Commission Expires February 29, 2020
Address of Notary Public 341 Bidwell St., Manchester, CT 06040					

(Notary Seal)

General Information

Name of Facility (as licensed) Farmington Care Center, LLC	License No. 2149-C	Report for Year Ended 9/30/2018	Page 1	of 37
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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) <i>John Zazzaro</i>	Date 2-11-19	Signed (Owner)	Date
---	-----------------	----------------	------

Printed Name (Administrator) John Zazzaro	Printed Name (Owner) Chris Wright
--	--------------------------------------

SANDRA M. HOLLIS
NOTARY PUBLIC
 MY COMMISSION EXPIRES APR. 30, 2019

Subscribed and Sworn to before me:	State of CT	Date 02-11-19	Signed (Notary Public) <i>Sandra M. Hollis</i>
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Address of Notary Public
 341 BOWELL STREET MANCHESTER, CT 06040

(Notary Seal)

Table of Contents

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

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Farmington Care Center, LLC	Period Covered:	From 10/1/2017	To 9/30/2018	
Address of Facility 20 Scott Swamp Road, Farmington, CT 06032				
Report Prepared By iCare Management, LLC	Phone Number 860-570-2140	Date 2/15/2019		
Item	Total	CCNH	RHNS	Other
1. Dietary wages paid \$				
2. Laundry wages paid \$				
3. Housekeeping wages paid \$				
4. Nursing wages paid \$				
5. All other wages paid \$				
6. Total Wages Paid \$				
7. Total salaries paid \$				
8. Total Wages and Salaries Paid (As per page 10 of Report) \$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-677-7707		Report for Year Ended 9/30/2018	Page 2	of 37
Name of Facility (as shown on license) Farmington Care Center, LLC		Address (No. & Street, City, State, Zip) 20 Scott Swamp Road, Farmington, CT 06032		
License Numbers:	CCNH 2149-C	RHNS	Other	Medicare Provider No. 07-5251
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <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 John Zazzaro		Nursing Home Administrator's License No.:	001734	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

Related Parties*

Name of Facility Farmington Care Center, LLC	Business Address	License No. 2149-C		Report for Year Ended 9/3/2018		Indicate Where Costs are Included in Annual Report Page # / Line #	Description of Goods/Services Provided	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**					
Bidwell Care Center, LLC	333 Bidwell St. Manchester, CT 06040					-	Shared Employees	(281)	281
Cheslea Place Care Center, LLC	25 Lorraine St. Hartford, CT 06105					-	Shared Employees	(287)	287
Chestnut Point Care Center, LLC	171 Main St. East Windsor, CT 06088					19	Laundry Services		-
Chestnut Point Care Center, LLC	171 Main St. East Windsor, CT 06088					-	Shared Employees	3,448	(3,448)
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032					16	Bank Fees		-
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032					-	Shared Employees		-
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088					19	Laundry Services		-
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088					-	Shared Employees	16,419	(16,419)
Meriden Care Center, LLC (Silver Springs)	33 Roy St. Meriden, CT 06450					-	Shared Employees	1,703	(1,703)
Trinity Hill Care Center, LLC	151 Hillside Ave. Hartford, CT 06106					-	Shared Employees	14,093	(14,093)
Westside Care Center, LLC	349 Bidwell St. Manchester, CT 06040					-	Shared Employees	(284)	284
Wintonbury Care Center, LLC	140 Park Ave. Bloomfield, CT 06002					-	Shared Employees	24,180	(24,180)
Secure Care Center LLC	60 West Street, Rocky Hill, CT 06067					-	Shared Employees	36,775	(36,775)
Touchpoints at Homecare LLC	1838 Silas Deane Hwy, Rocky Hill, CT 06067					-	Shared Employees		-
Touchpoints therapy	171 Main St. East Windsor, CT 06088					13	OT/PT/ST	796,372	(796,372)
Bidwell Realty, LLC	341 Bidwell St. Manchester, CT 06040					22,22,27	Building Lease & Rent		-
iCare Management, LLC	341 Bidwell St. Manchester, CT 06040					16, 15	Postage & Legal	13,441	(13,441)
iCare Health Management, LLC	341 Bidwell St. Manchester, CT 06040					-	Shared EEs not part of mgmt agmt Management Services, Direct	170,477	(170,477)
						20	Management Services, Indirect	105,323	(105,323)
						20	Management Services, Administrative	14,438	(14,438)
						16	Management Services, Administrative	331,358	(331,358)
						-			-
						-			-
						-			-
						-			-
						-			-
						-			-
All 9 Care Centers, mgmt co, really cos							Share Common 401k, Pension and Insurance plans, courier, legal and various other services		

* 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 Farmington Care Center, LLC	License No. 2149-C	Report for Year Ended 9/30/2018	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.

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

**General Information and Questionnaire
 Leases (Excluding Real Property)**

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

Name of Facility		License No.	Report for Year Ended		Page	of	
Farmington Care Center, LLC		2149-C	9/30/2018		6	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					
Accelerated Care Plus Corp. 4850 Joule Street, Suite A-1 Reno, ADP, Inc., One ADP Drive MS-100, Augusta, GA 30909	<input type="radio"/>	<input checked="" type="radio"/>	Omnistim Electrotherapy and Omnisound Therapeutic Ultrasound Equipment	05/18/10	1 yr with automatic	22,726	22,726
Canon Financial Services, 14904 Collection Center Drive, Chicago, IL 60693	<input type="radio"/>	<input checked="" type="radio"/>	Time Clocks and Payroll Punch Equip Copier	06/01/10	60 months & automatic	8,817	8,817
GE Capital C/O Ricoh USA, P.O.Box 41564, Philadelphia, PA 19101	<input type="radio"/>	<input checked="" type="radio"/>	Copier	03/02/12	60 Months	2,955	2,955
Mail Finance/Neopost New England, 25881 Newtrwork Place, Chicago, IL 60673	<input type="radio"/>	<input checked="" type="radio"/>	Postage Meter Rental	03/04/14	48 Months	3,707	3,707
	<input type="radio"/>	<input checked="" type="radio"/>			Monthly	1,374	1,374
	<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 ***	39,580

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.

General Information and Questionnaire
Accounting Basis

Name of Facility Farmington Care Center, LLC	License No. 2149-C	Report for Year Ended 9/30/2018	Page 7	of 37
The records of this facility for the period covered by this report were maintained on the following basis: <input checked="" type="radio"/> Accrual <input type="radio"/> Cash <input type="radio"/> Modified Cash				
Is the accounting basis for this period the same as for the previous period? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain.				
Independent Accounting Firm				
Name of Accounting Firm 1 O'Connor, Davies LLP 2 3 4		Address (No. & Street, City, State, Zip Code) 100 Great Meadow Road, Ste 401, Wethersfield, CT 06109		
Services Provided by This Firm (<i>describe fully</i>)				
1	Taxes, financial statements, accounting support	\$	9,749	
2		\$		
3		\$		
4		\$		
			Charge for Services Provided	
			\$	9,749
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. <input checked="" type="radio"/> Yes <input type="radio"/> No 15D				
Legal Services Information				
Name of Legal Firm or Independent Attorney 1 iCare Health Management, LLC 2 Starble and Harris 3 Durant Nichols / Robinson & Cole, LLP 4 Various others (American Arbitration , Various Arbitration, Murtha Cullina, Jackson Lewis)) 5 Starble and Harris, iCare Health Management LLC			Telephone Number 860-570-2140 860-678-7775 860-275-8200 860-678-7775 & 860-570-2140	
Address (<i>No. & Street, City, State, Zip Code</i>) 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 (<i>describe fully</i>)				
1	Lease and contract issues, general legal advice, Labor Law	\$	10,292	
2	Lease and contract issues, general legal advice, union funds advice	\$	188	
3	Employment law, arbitrations, contract negotiations	\$	65	
4	Employment Arbitrations, healthcare law	\$	2,915	
5	Conservatorships & Collections	\$	2,465	
			Charge for Services Provided	
			\$	15,926
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. <input checked="" type="radio"/> Yes <input type="radio"/> No 15E				

Schedule of Resident Statistics

Name of Facility Farmington Care Center, LLC	License No. 2149-C	Report for Year Ended 9/30/2018						Page 8	of 37
		Period 10/1 Thru 6/30		Period 7/1 Thru 9/30		Total	Other		
		Total CCNH Level	Total RHNS Level	Total CCNH	Total RHNS				
1. Certified Bed Capacity									
A. On last day of PREVIOUS report period	150	150			150	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	94	94			94	90			
B. As of midnight of THIS report period	90	90			90	90			
3. Total Number of Days Care Provided During Period									
A. Medicare	4,717	4,717			3,517	3,517			
B. Medicaid (Conn.)	26,166	26,166			19,737	19,737			
C. Medicaid (other states)									
D. Private Pay	1,697	1,697			1,225	1,225			
E. State SSI for RCH									
F. Other (Specify) Insurance	559	559			343	343			
G. Total Care Days During Period (3A thru F)	33,139	33,139			24,822	24,822			
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)	33,139	33,139			24,822	24,822			
					8,317	8,317			

Schedule of Resident Statistics (Cont'd)

Name of Facility Farmington Care Center, LLC			License No. 2149-C			Report for Year Ended 9/30/2018			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	Other	Lost			Gained			CCNH	RHNS	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	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	CCNH	RHNS	Other	R.C.H.	ICF-MR				
No. of Residents	12		70		8								
Per Diem Rate													
a. One bed rm.	525.00		237.00		451.00								
b. Two bed rms.													
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	Other		
A. Medicare - Part B								8,103	8,103				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								405	405				
2. Restorative Treatments								1,346	1,346				
C. Other								12,657	12,657				
D. Total Physical Therapy Treatments								22,511	22,511				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								122	122				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								22	22				
2. Restorative Treatments								49	49				
C. Other								589	589				
D. Total Speech Therapy Treatments								782	782				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								3,714	3,714				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								398	398				
2. Restorative Treatments								820	820				
C. Other								11,868	11,868				
D. Total Occupational Therapy Treatments								16,800	16,800				

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Farmington Care Center, LLC	2149-C	9/30/2018	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Other	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)	135,745	2,086				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	144,381	6,888				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	53,123	2,086				
c. Dietary Workers	337,844	18,456				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	33,333	1,825				
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	194,756	4,356				
b. RN						
1. Direct Care	440,515	10,561				
2. Administrative**	132,279	3,348				
c. LPN						
1. Direct Care	988,806	33,251				
2. Administrative**						
d. Aides and Attendants	1,234,749	70,203				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	128,625	6,691				
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	59,006	2,730				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	42,518	2,242				
A-13. Total Salary Expenditures	3,925,680	164,723				

* 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)

Position	CCNH		RHNS		Other	
	\$	Hours	\$	Hours	\$	Hours
UNIT SECRETARIES SALARIES	\$ 18,150	1,050			\$ -	-
MEDICAL RECORDS SALARIES	\$ 24,368	1,192			\$ -	-
CENTRAL SUPPLY SALARIES	\$ -	-			\$ -	-
RESPIRATORY THERAPY SALARIES	\$ -	-			\$ -	-
Total	\$ 42,518	2,242	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		Other	
	\$	Hours	\$	Hours	\$	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$ 6,687	-			\$ -	-
ADMISSIONS C/S LABOR	\$ 33,414	733			\$ -	-
CENTRAL SUPPLY CONTRACT SERVICE	\$ 6,655	487			\$ -	-
ADMINISTRATIVE CONTRACT SERVICE LABOR	\$ 160,651	4,082			\$ -	-
RESPIRATORY THERAPY CONTRACT SERVICES	\$ 4,284	27			\$ -	-
PHYSICAL THERAPY C/S MEDICIAD	\$ 34,409	452			\$ -	-
SPEECH THERAPY C/S Medicaid	\$ 3,000	34			\$ -	-
OCCUPATIONAL THERAPY C/S MEDICIAD	\$ 26,383	315			\$ -	-
Total	\$ 275,484	6,130	\$ -	-	\$ -	-

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

Name of Facility		License No.		Report for Year Ended		Page	of		
Farmington Care Center, LLC		2149-C		9/30/2018		11	37		
Name	Salary Paid			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	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) Farmington Care Center, LLC	License No. 2149-C	Report for Year Ended 9/30/2018			Line Where Claimed on Page 10	Name and Address of All Other Employment**	Page	of	
		Total Hours Worked	Full Description of Services Rendered	Fringe Benefits and/or Other Payments (describe fully)					Total Hours Worked
Name	CCNH	RHNS	Other	Salary Paid				Total Hours Worked	Compensation Received
Section III - Administrators***									
John Zazzaro	135,745			same as employees less union funds	Administrator	2,086	A2		
				same as employees less union funds	Administrator		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.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Farmington Care Center, LLC	2149-C	9/30/2018	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	Other	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	28,822	638				
2. Dentist						
3. Pharmacist	16,360	491				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	399,478	5,243				
b. Other						
6. Social Worker	17,846	344				
7. Recreation Worker	18,237	35+Cable				35+Cable
8. Physicians						
a. Medical Director (entire facility)	36,000	277				
b. Utilization Review (Title 18 and 19 only) monthly meeting		5				
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	19,643	119				
9. Speech Therapist						
a. Resident Care	28,342	367				
b. Other						
10. Occupational Therapist						
a. Resident Care	305,105	4,004				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	99,485	1,381				
2. Administrative***	55,501	1,172				
b. LPN						
1. Direct Care	10,963	261				
2. Administrative***						
c. Aides	9,649	524				
d. Other						
12. Other (Specify) See Attached Schedule	275,484	6,130				
B-13 Total Fees Paid in Lieu of Salaries	1,320,915	20,956				

* 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 management. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

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

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

Name of Facility Farmington Care Center, LLC		License No. 2149-C		Report for Year Ended 9/30/2018	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Omnicare/ Pharm Scripts	Pharmacy Consulting	<input checked="" type="radio"/>	<input type="radio"/>			
Touhpoints Therapy	Therapy	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver Springs, Westside Care Centers, iCare Health and iCare Management, SecureCare Options, Home Care	Shared Employees	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Healthdrive Physician Services	Audiology, Dental and Podiatry	<input type="radio"/>	<input checked="" type="radio"/>			
Ready Nurse, Nurse Network	Nursing pool (RN, LPN, CNA)	<input type="radio"/>	<input checked="" type="radio"/>			
Dr Bodanski	Medical Director	<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"/>			
		<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
Farmington Care Center, LLC	2149-C	9/30/2018		15	37
Item	Total	CCNH	RHNS	Other	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 148,183	148,183			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$				
4. Social Security (F.I.C.A.)	\$ 345,438	345,438			
5. Health Insurance	\$ 699,656	699,656			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 229,631	229,631			
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$ 28,856	28,856			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 149,176	149,176			
d. Accounting and Auditing	\$ 9,749	9,749			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 15,926	15,926			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 19,069	19,069			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 25,696	25,696			
2. Cellular Phones	\$ 653	653			
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	\$ 696,582	696,582			
Subtotal	\$ 2,368,614	2,368,614			

* 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**

Farmington Care Center, LLC
9/30/2018

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Other
UNION TRAINING	\$ 28,856		\$ -
Total	\$ 28,856	\$ -	\$ -

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
Farmington Care Center, LLC	2149-C	9/30/2018		16	37
Item	Total	CCNH	RHNS	Other	
Subtotals Brought Forward:		2,368,614	2,368,614		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 1,068	1,068			
3. Gifts to Staff and Residents	\$ 339	339			
4. Employee Travel	\$ 489	489			
5. Education Expenses Related to Seminars and Conventions	\$ 2,553	2,553			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$ 486	486			
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 3,955	3,955			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 15,874	15,874			
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	\$ 4,078	4,078			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 7,165	7,165			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$ 1,674	1,674			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 141,695	141,695			
12. Administrative Management Services**	\$ 331,358	331,358			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 21,022	21,022			
C-14 Total Administrative & General Expenditures	\$ 2,900,370	2,900,370			

* 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	Other
MEALS	\$ 486		\$ -
Total Other Travel and Entertainment	\$ 486	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	Other
COMMUNICATIONS-SPECIAL EVENTS	\$ 15,874		\$ -
Total Other Advertising	\$ 15,874	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	Other
ALTCFM			
CAHCF Dues	\$ 7,005		\$ -
OTHER DUES	\$ 160		\$ -
Total Dues	\$ 7,165	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	Other
CONTRIBUTIONS	\$ 1,674		\$ -
Total Contributions	\$ 1,674	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	Other
SOCIAL SERVICE SUPPLIES	\$ -		\$ -
SOC-SVC MINOR EQUIPMENT	\$ -		\$ -
ADMINISTRATIVE MINOR EQUIPMENT	\$ 1,774		\$ -
EMPLOYEE RELATIONS	\$ 3,912		\$ -
EMPLOYEE RELATIONS-OTHER	\$ 125		\$ -
PERMITS & LICENSES	\$ 980		\$ -
VOLUNTEER EXPENSE	\$ -		\$ -
BANK FEES	\$ 11,547		\$ -
CMS REVISIT USER FEES	\$ -		\$ -
PENALTIES	\$ -		\$ -
LATE FEES	\$ (422)		\$ -
INTERNET EXPENSES	\$ 3,107		\$ -
Rounding			\$ -
Total Other Administrative and General	\$ 21,022	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Farmington Care Center, LLC	2149-C	9/30/2018	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	331,358	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	105,323	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	14,438	MANAGEMENT FEES- INDIRECT CARE	Pg 20 j

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

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

Name of Facility Farmington Care Center, LLC		License No. 2149-C	Report for Year Ended 9/30/2018	Page 18	of 37
Item	Total	CCNH	RHNS	Other	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$ 193,730	193,730			
2. Non-Food Supplies	\$ 13,748	13,748			
3. Other (Specify) _____ DIETARY SUPPLEMENTS	\$ 13,892	13,892			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 906	906			
c. Other (Specify) _____ DIETARY MINOR EQUIPMENT	\$ 2,266	2,266			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 224,543	224,543			
2F. Dietary Questionnaire					
G. Resident Meals: Total no. of meals served per day:*	272	272			
H. Is cost of employee meals included in 2E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No			
I. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
L. Is any revenue collected from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
O. Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
P. 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 Farmington Care Center, LLC		License No. 2149-C	Report for Year Ended 9/30/2018	Page 19	of 37
Item		Total	CCNH	RHNS	Other
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)	\$	257,653	257,653		
c. Other (Specify) LAUNDRY MINOR EQUIPMENT	\$				
3D. Total Laundry Expenditures (3a + b + c)	\$	257,653	257,653		
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
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 laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K. Did you receive revenue 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)				

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

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Farmington Care Center, LLC		2149-C	9/30/2018		20	37
Item			Total	CCNH	RHNS	Other
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt.	\$ 18,201	18,201		
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.	\$ 246,206	246,206		
C. Other (<i>Specify</i>)			\$ 68	68		
HOUSEKEEPING MINOR EQUIPMENT						
4D.	Total Housekeeping Expenditures (4a + b + c)		\$ 264,475	264,475		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy		\$			
	2. Purchased from OMNICARE PHARMACY		\$ 229,364	229,364		
b.	Medicine Cabinet Drugs		\$ 4,978	4,978		
c.	Medical and Therapeutic Supplies		\$ 68,080	68,080		
d.	Ambulance/Limousine***		\$			
e.	Oxygen					
	1. For Emergency Use		\$ 4,640	4,640		
	2. Other***		\$			
f.	X-rays and Related Radiological Procedures***		\$ 10,170	10,170		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)		\$			
h.	Laboratory***		\$ 24,470	24,470		
i.	Recreation		\$			
j.	Direct Management Services*		\$			
k.	Indirect Management Services*		\$			
l.	Other (<i>Specify</i>)**** See Attached Schedule		\$ 255,610	255,610		
5M.	Total Resident Care Expenditures (5a - 5j)		\$ 597,312	597,312		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	Other
NURSING ADMIN SUPPLIES	\$ 444		\$ -
NURSING MINOR EQUIP	\$ 7,403		\$ -
MEDICAL RECORDS SUPPLIES	\$ 310		\$ -
MEDICAL RECORDS MINOR EQUIPMENT	\$ -		\$ -
MANAGEMENT ALLOCATIONS - DIRECT	\$ 105,323		\$ -
NON-COVERED PPS DR. VISITS	\$ 1,712		\$ -
RESIDENT CARE SUPPLIES	\$ 206		\$ -
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 8,127		\$ -
PERSONAL CARE SUPPLIES	\$ 1,616		\$ -
INCONTINENCY SUPPLIES	\$ 10,754		\$ -
VACCINE RESIDENTS	\$ 12,541		\$ -
PATIENT SPECIAL NEEDS	\$ 1,092		\$ -
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	\$ 35,454		\$ -
EQUIPMENT RENTAL: AIDS UNIT	\$ -		\$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ 2,155		\$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ -		\$ -
HI LOW BED RENTAL & MATTRESSES	\$ -		\$ -
IV THERAPY SUPPLIES	\$ 24,805		\$ -
IV THERAPY CONTRACT SERVICE	\$ -		\$ -
MEDICAL WASTE CONTRACT SERVICE	\$ 1,448		\$ -
ACTIVITIES SUPPLIES	\$ 1,820		\$ -
ACTIVITIES MINOR EQUIPMENT	\$ -		\$ -
MANAGEMENT ALLOCATION - INDIRECT	\$ 14,438		\$ -
ADMISSIONS SUPPLIES	\$ -		\$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$ 25,961		\$ -
STRIKE COSTS NON REIMBURSABLE	\$ -		\$ -
Total Other Resident Care	\$ 255,610	\$ -	\$ -

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

Name of Facility Farmington Care Center, LLC		License No. 2149-C		Report for Year Ended 9/30/2018		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	Other	Pg	Line	
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	O	O	VENDOR	Housekeeping Services	246,206				20	4b
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	O	O	VENDOR	Laundry Services	257,653				19	3b
Eagle Elevator		O	O	VENDOR	Elevator Contract	4,703				22	6F
Bioserve, Inc.		O	O	VENDOR	Medical Waste Snow	1,448				22	6F
Brightview Landscaping/Twin Landscaping		O	O	VENDOR	Removal/Landscaping	25,107				22	6F
CWPM		O	O	VENDOR	Trash removal	30,351				22	6F
American HealthTech		O	O	VENDOR	Software Maintenance Contract	18,443				16	M11
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	O	O	VENDOR	Payroll Services	35,733				16	M11
National Datacare Corp		O	O	VENDOR	Resident Trust Software Computer Consulting Services	2,396				16	M11
Prime Care Technology services		O	O	VENDOR		35,229				16	M11
Priority Express		O	O	VENDOR	Courier Services	2,541				16	M11
Point Right Inc		O	O	VENDOR	Nursing Software Security Contract Services	4,680				16	M11
Aron Security Inc		O	O	VENDOR						22	6F

* 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
Farmington Care Center, LLC	2149-C	9/30/2018			22	37
Item	Total	CCNH	RHNS	Other		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 44,353	44,353				
b. Heat	\$ 25,221	25,221				
c. Light & Power	\$ 63,651	63,651				
d. Water	\$ 30,408	30,408				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 39,580	39,580				
f. Other (<i>itemize</i>)	\$ 97,976	97,976				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 301,189	301,189				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$ 232	232				
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 59,093	59,093				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 59,325	59,325				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 85,330	85,330				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 85,330	85,330				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 246,552	246,552				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 62,891	62,891				
c. Personal property taxes	\$ 6,332	6,332				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 460,429	460,429				

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	Other
PLANT SUPPLIES	\$ 12,703		\$ -
PLANT CONTRACT SERVICE LABOR	\$ -		\$ -
ELEVATOR CONTRACT SERVICE	\$ 4,703		\$ -
FIRE/SPRINKLER CONTRACT SERVICE	\$ 3,098		\$ -
LANDSCAPING CONTRACT SERVICE	\$ 8,663		\$ -
SNOW REMOVAL CONTRACT SERVICE	\$ 16,444		\$ -
TRASH REMOVAL CONTRACT SERVICE	\$ 30,351		\$ -
HVAC CONTRACT SERVICE	\$ -		\$ -
SECURITY CONTRACT SERVICE	\$ -		\$ -
PLANT CONTRACT SERVICE OTHER	\$ 11,053		\$ -
PLANT MINOR EQUIPMENT	\$ 9,461		\$ -
RENT AUTO	\$ -		\$ -
RENT EQUIPMENT	\$ 1,500		\$ -
RENT OTHER	\$ -		\$ -
Total Other Repairs and Maintenance	\$ 97,976	\$ -	\$ -

Depreciation Schedule

Name of Facility Farmington Care Center, LLC		License No. 2149-C		Report for Year Ended 9/30/2018				Page 23	of 37			
Property Item	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
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	193			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												
D. Movable Equipment												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. Van Repair, Hillside Automotive Ceix												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period				1,009,441		1,009,441	838,330			56,560		
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)										2,533		
D-3. Subtotal				25,649							59,093	
E. Total Depreciation											59,325	

Farmington Care Center, LLC
9/30/2018

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 Farmington Care Center, LLC	License No. 2149-C		Report for Year Ended 9/30/2018			Page 24	of 37
	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
	Month	Year					
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				1,388,547	896,808		85,330
2. Disposals (attach schedule)							
3. Acquired during this report period (attach schedule)							
C-4. Subtotal							
D. Total Amortization							85,330
							85,330

* 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.

Annual Report of Long-Term Care Facility

CSP-25 Rev. 9/2002

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

Name of Facility Farmington Care Center, LLC	License No. 2149-C	Report for Year Ended 9/30/2018	Page 25	of 37
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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					
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 2 year extension	297,000

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
Farmington Care Center, LLC		2149-C	9/30/2018		26	37
Item			Total	CCNH	RHNS	Other
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		
Farmington Care Center, LLC	2149-C	9/30/2018	27	37		
Item			Total	CCNH	RHNS	Other
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						
			15,490	15,490		
13. Total All Interest Expense (12B7 + 12C3 + 12D)						
\$						
			15,490	15,490		
14. Insurance						
a. Insurance on Property (buildings only)						
\$						
			6,787	6,787		
b. Insurance on Automobiles						
\$						
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)						
\$						
			36,819	36,819		
2. Fire and Extended Coverage						
\$						
3. Other (Specify)						
Other insurance, crime						
			4,161	4,161		
14d. Total Insurance Expenditures (14a + b + c)						
\$						
			47,767	47,767		
15. Total All Expenditures (A-13 thru C-14)						
\$						
			10,315,823	10,315,823		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Farmington Care Center, LLC			2149-C	9/30/2018	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
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.			Bad Debts	\$ 149,176	149,176		
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.			Unallowable Advertising *	\$ 15,874	15,874		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 105,186	105,186		
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)				\$ 270,236	270,236		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Other Fees Adjustments			\$ -	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
16a		PENALTIES	\$ -		\$ -
16a		LATE FEES	\$ (422)		\$ -
16a		PRIOR PERIOD EXPENSES			
		rounding	\$ -		
		Provider User Fee for Medicare days	\$ 105,608		\$ -
Total Other A&G Adjustments			\$ 105,186	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Farmington Care Center, LLC			2149-C	9/30/2018	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
Subtotals Brought Forward				\$ 270,236	270,236		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$			
28.			Ambulance/Limousine	\$			
29.			X-rays, etc	\$ 10,170	10,170		
30.			Laboratory	\$ 24,470	24,470		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 2,878	2,878		
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	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$ 5	5		
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)				\$ 307,759	307,759		

*** 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.

Farmington Care Center, LLC
9/30/2018

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Other
20	5J		1,712.03		-
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	389		
13	B9A	ST- Resident Care (for outpatient therapy - see schedule)	389		
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)	389		
Total Other Ancillary Costs			\$ 2,878	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Excess Movable Equipment Depreciation			\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Other Property Adjustments			\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	Other
20	4A1	Houskeeping Supplies (for Outpatient Therapy - see schedule)	\$ 0		
20	4B	Housekeeping purchased services (for Outpatient Therapy see schedule)	\$ 3		
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)	\$ 1		
22	6A	Repair&Maint (for outpatient therapy see schedule)	\$ 0		
Total Other Adjustments			\$ 5	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Unallowable Building Interest			\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Farmington Care Center, LLC	2149-C	9/30/2018			30	37
Item	Total	CCNH	RHNS	Other		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (CT only)	\$ 6,231,766	6,231,766				
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)	\$ 2,326,809	2,326,809				
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$ 878,366	878,366				
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 189,376	189,376				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (189,376)	(189,376)				
c. Prescription Drugs - Non-Medicare	\$ 36,063	36,063				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (36,063)	(36,063)				
2. a. Medical Supplies - Medicare	\$ 2,413	2,413				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (2,413)	(2,413)				
c. Medical Supplies - Non-Medicare	\$ 1,908	1,908				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (1,908)	(1,908)				
3. a. Physical Therapy - Medicare	\$ 611,304	611,304				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (423,719)	(423,719)				
c. Physical Therapy - Non-Medicare	\$ 109,262	109,262				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (109,262)	(109,262)				
4. a. Speech Therapy - Medicare	\$ 59,322	59,322				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (47,922)	(47,922)				
c. Speech Therapy - Non-Medicare	\$ 8,790	8,790				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (8,790)	(8,790)				
5. a. Occupational Therapy - Medicare	\$ 513,792	513,792				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (411,973)	(411,973)				
c. Occupational Therapy - Non-Medicare	\$ 90,201	90,201				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (68,584)	(68,584)				
6. a. Other (Specify) - Medicare	\$ 32,398	32,398				
b. Other (Specify) - Non-Medicare	\$ 79,368	79,368				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 9,871,128	9,871,128				
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)	\$ 40	40				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (Specify)	\$ 19,504	19,504				
V. Total Other Revenue (1 thru 8)	\$ 19,544	19,544				
VI. Total All Revenue (III + V)	\$ 9,890,672	9,890,672				

* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.
 ** Facility should report all contractual allowances and/or payer discounts.

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	Other
	Lab Medicare	\$ 30,434		
	Lab Medicare CA	\$ (30,434)		
	Oxygen Medicare	\$ 238		
	Oxygen Medicare CA	\$ (238)		
	Equipment rental	\$ 9,523		
	Equipment rental CA	\$ (9,523)		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds Medicare	\$ -		
	Therapy Beds Medicare CA	\$ -		
	Radiology Medicare	\$ 9,352		
	Radiology Medicare CA	\$ (9,352)		
	IV Therapy	\$ 31,943		
	IV Therapy CA	\$ (31,943)		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose testing	\$ -		
	Glucose testing CA	\$ -		
	Outpatient therapy Medicare	\$ 32,298		
	Total Other Resident Revenue - Medicare	\$ 32,798	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Other
	Lab	3,121.79		
	Lab CA	(3,121.79)		
	Oxygen	\$ 238		\$ -
	Oxygen CA	\$ (338)		\$ -
	Equipment rental	\$ 7,450		
	Equipment rental CA	\$ (7,450)		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds	\$ -		
	Therapy Beds CA	\$ -		
	Radiology	\$ 819		
	Radiology CA	\$ (819)		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose Testing	\$ -		
	Glucose Testing CA	\$ -		
	IV therapy	\$ 8,760		\$ -
	IV therapy CA	\$ (8,760)		\$ -
	Flu shot revenue	\$ 120		
	Outpatient therapy	\$ (9,195)		
	prior period revenue	\$ 76,192		
	Opioid B	\$ 23,719		
	Opioid B CA	\$ (11,669)		
	rounding	\$ 0		
	Total Other Resident Revenue	\$ 79,368	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	Other
	INTEREST INCOME		\$ 40		
	Total Interest Income		\$ 40	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Other
	MEALS	\$ -		
	TELEVISION INCOME	\$ 289		
	CONCESSIONS / VENDING INCOME	\$ -		
	RESIDENT LATE FEE REVENUE	\$ -		
	RESIDENT ATTORNEY FEE REVENUE	\$ -		
	TELEPHONE INCOME	\$ -		
	OTHER INCOME	\$ -		
	OPTUM DIVIDENDS REVENUE	\$ 15,234		
	Total Other Revenue	\$ 15,504	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2018	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	(201,538)
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,080,557
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	739,578
a. Prepaid Insurance	706,064			
b. Prepaid Property Taxes	27,216			
c. Prepaid Expenses Other	6,298			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	(1,057,016)
Due From (to) Related Parties	(108,448)			
Other Owners reserves	(948,568)			
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,561,581
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost		\$	
	Accum. Depreciation	Net		
3. Buildings	*Historical Cost	1,161	\$	735
	Accum. Depreciation	426 Net		
4. Leasehold Improvements	*Historical Cost	1,388,547	\$	406,408
	Accum. Depreciation	982,139 Net		
5. Non-Movable Equipment	*Historical Cost		\$	
	Accum. Depreciation	Net		
6. Movable Equipment	*Historical Cost	1,035,090	\$	137,667
	Accum. Depreciation	897,423 Net		
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	2,207
Construction in Progress	2,207			
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	547,017

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2018	32	37
Account			Amount	
Total Brought Forward:			\$	2,108,598
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			\$	174,340
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	30,062
	Patient Trust Funds	27,507		
	Long Term Deposit - primicare	2,555		
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	
See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	204,403
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	2,313,001

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of	
Farmington Care Center, LLC	2149-C	9/30/2018	33	37	
Account			Amount		
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable			\$	358,511	
2. Notes Payable (<i>itemize</i>)			\$	230,674	
Working Capital Line of Credit				230,674	
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>)			\$	258,626	
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>)			\$	2,260,280	
Related Party Payables		1,538,077			
Accrued Expenses		(10,668)			
Accrued Resident User Fees		144,151			
Accrued Workers Comp Expense		588,720	See Schedule		
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	3,108,092	

* 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 Farmington Care Center, LLC	License No. 2149-C	Report for Year Ended 9/30/2018	Page 34	of 37
Account				Amount
Total Brought Forward:				3,108,092
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>)				\$ 27,507
Patient Trust Funds		27,507		
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 27,507
C. Total All Liabilities (Lines A-13 + B-5)				\$ 3,135,599

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC	2149-C	9/30/2018	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			\$	25,000
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(422,446)
6. Gain or Loss for Period			\$	(425,151)
	10/1/2017	thru 9/30/2018		
7. Total Net Worth			\$	(822,598)
C. Total Reserves and Net Worth			\$	(822,598)
D. Total Liabilities, Reserves, and Net Worth			\$	2,313,001

H. Changes in Total Net Worth

Name of Facility		License No.	Report for Year Ended	Page	of
Farmington Care Center, LLC		2149-C	9/30/2018	36	37
Account				Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2017				\$	
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 9,890,672	
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 10,315,823	
D. Net Income or Deficit				\$ (425,151)	
E. Balance				\$ (425,151)	
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				\$ (425,151)	
			09/30/18		

I. Preparer's/Reviewer's Certification

Name of Facility Farmington Care Center, LLC	License No. 2149-C	Report for Year Ended 9/30/2018	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<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				
iCare Management, LLC				
Address Address			Phone Number	
341 Bidwell Street, Manchester, CT 06040			860-570-2140	
Annual Report Contact			Phone Number	
Annual Report Contact Email Address				