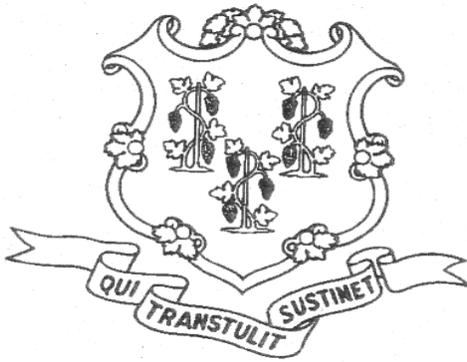


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2022

Name of Facility (as licensed) Meriden Care Center, LLC	
Address (No. & Street, City, State, Zip Code) 33 Roy St. Meriden, CT 06450	
Type of Facility <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 10/1/2021	Report for Year Ending 9/30/2022

License Numbers:	CCNH 2448	RHNS	Other	Medicare Provider 07-5337
------------------	--------------	------	-------	------------------------------

Medicaid Provider Numbers:	CCNH 10660	RHNS	ICF-IID
----------------------------	---------------	------	---------

**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) Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2022	Page 1	of 37
------------------------------------------------------------	---------------------	------------------------------------	-----------	----------

#### 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 Meriden Care Center, LLC [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

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

(Notary Seal)

# 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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Meriden Care Center, LLC		Period Covered:	From 10/1/2021	To 9/30/2022
Address of Facility 33 Roy St. Meriden, CT 06450				
Report Prepared By iCare Management, LLC		Phone Number 860-570-2140	Date 2/15/2023	
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. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (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 203-237-8457	Report for Year Ended 9/30/2022	Page 2	of 37
Name of Facility (as shown on license) Meriden Care Center, LLC		Address (No. & Street, City, State, Zip) 33 Roy St. Meriden, CT 06450		
License Numbers:	CCNH 2448	RHNS	Other	Medicare Provider No. 07-5337
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.				
<b>Administrator</b>				
Name of Administrator Raymond Hackling		Nursing Home Administrator's License No.:	000853	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		







**General Information and Questionnaire  
 Related Parties\***

Name of Facility Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2022	Page 4	of 37
----------------------------------------------	---------------------	------------------------------------	-----------	----------

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?     Yes     No    If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
See Attached.		<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.  
 \*\* Provide the percentage amount of revenue received from non-related parties.

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2022	Page 5	of 37
----------------------------------------------	---------------------	------------------------------------	-----------	----------

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

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist ( <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 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 Meriden Care Center, LLC			License No. 2448	Report for Year Ended 9/30/2022	Page 6	of 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	60 months & automatic	8,633	8,633	
Quadient Leasing USA Inc PO Box 123682, Dept 3682, Dallas, TX 75312-3682	<input type="radio"/>	<input checked="" type="radio"/>	Postage Meter Rental		Monthly	727	727	
CIT Finance LLC	<input type="radio"/>	<input checked="" type="radio"/>	Copier	11/06/14		-9,182	-9,182	
Xerox Financial Services LLC, PO Box 202882, Dallas, TX 75320-2882	<input type="radio"/>	<input checked="" type="radio"/>	Copier			23,603	23,603	
	<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"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<b>Total ***</b>	23,781

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 Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2022	Page 7	of 37
----------------------------------------------	---------------------	------------------------------------	-----------	----------

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

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

**Independent Accounting Firm**

Name of Accounting Firm 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 (*describe fully*)

1 Taxes, financial statements, accounting support	\$ 10,170
2	\$
3	\$
4	\$
<b>Charge for Services Provided</b>	
	\$ 10,170

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 iCare Health Management LLC	Telephone Number 860-570-2140 860-275-8200  860-678-7775 & 860-570-2140
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------

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

1 341 Bidwell Street, Manchester CT
2 280 Trumbull St, Hartford, CT
3
4
5 341 Bidwell Street, Manchester CT

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	\$ 3,768
3 Employment Arbitrations, healthcare law & Conservatorships	\$ 1,940
4	\$
5 Collections	\$ 0
<b>Charge for Services Provided</b>	
	\$ 5,707

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

**Schedule of Resident Statistics**

Name of Facility Meriden Care Center, LLC			License No. 2448		Report for Year Ended 9/30/2022				Page 8	of 37			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total Other	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	Other	Total	CCNH	RHNS	Other	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	159	159			159	159							
B. On last day of THIS report period	159	159							159	159			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	131	131			131	131							
B. As of midnight of THIS report period	149	149							149	149			
3. Total Number of Days Care Provided During Period													
A. Medicare	1,343	1,343			999	999			344	344			
B. Medicaid (Conn.)	46,328	46,328			34,027	34,027			12,301	12,301			
C. Medicaid (other states)													
D. Private Pay	270	270			201	201			69	69			
E. State SSI for RCH													
F. Other (Specify) Insurance	4,973	4,973			3,861	3,861			1,112	1,112			
G. Total Care Days During Period (3A thru F)	52,914	52,914			39,088	39,088			13,826	13,826			
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. <b>Total Resident Days (3G + 4A + 4B)</b>	52,914	52,914			39,088	39,088			13,826	13,826			

### Schedule of Resident Statistics (Cont'd)

Name of Facility Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2022	Page 9	of 37
----------------------------------------------	---------------------	------------------------------------	-----------	----------

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

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	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	3		135		11				
Per Diem Rate									
a. One bed rm.	610.00		298.00		348.00				
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	1,025	1,025		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	540	540		
2. Restorative Treatments	2,675	2,675		
C. Other	2,998	2,998		
D. <b>Total Physical Therapy Treatments</b>	7,238	7,238		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	129	129		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	91	91		
2. Restorative Treatments	171	171		
C. Other	405	405		
D. <b>Total Speech Therapy Treatments</b>	796	796		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	3,068	3,068		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,452	1,452		
2. Restorative Treatments	3,781	3,781		
C. Other	5,182	5,182		
D. <b>Total Occupational Therapy Treatments</b>	13,483	13,483		

**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		
Meriden Care Center, LLC	2448	9/30/2022	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)	198,622	2,086				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	227,036	9,964				
5. Dietary Service						
a. Head Dietitian	19,749	437				
b. Food Service Supervisor	63,347	1,991				
c. Dietary Workers	592,830	28,739				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	62,711	2,022				
b. Other Maintenance Workers	51,939	2,254				
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	258,096	4,239				
b. RN						
1. Direct Care	509,455	7,837				
2. Administrative**	238,774	5,780				
c. LPN						
1. Direct Care	1,716,395	47,783				
2. Administrative**	24,958	623				
d. Aides and Attendants	1,992,621	88,708				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	155,936	7,731				
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	164,560	4,159				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	60,499	3,086				
<i>A-13. Total Salary Expenditures</i>	6,337,525	217,439				

\* 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	\$ 42,554	2,151			\$ -	-
MEDICAL RECORDS SALARIES	\$ -	-			\$ -	-
CENTRAL SUPPLY SALARIES	\$ 17,945	935			\$ -	-
RESPIRATORY THERAPY SALARIES	\$ -	-			\$ -	-
PLANT SECURITY SALARIES	\$ -	-			\$ -	-
MEDICAL RECORDS SALARIES SPCL	\$ -	-			\$ -	-
<b>Total</b>	\$ 60,499	3,086	\$ -	-	\$ -	-

## Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		Other	
	\$	Hours	\$	Hours	\$	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$ 19,990	Storage			\$ -	-
ADMISSIONS C/S LABOR	\$ 56,428	1,024			\$ -	-
CENTRAL SUPPLY CONTRACT SERVICE	\$ 7,514	204			\$ -	-
ADMINISTRATIVE CONTRACT SERVICE LABOR	\$ 169,253	4,512			\$ -	-
RESPIRATORY THERAPY CONTRACT SERVICES	\$ 2,100	8			\$ -	-
PHYSICAL THERAPY C/S MEDICIAD	\$ -	-			\$ -	-
SPEECH THERAPY C/S Medicaid	\$ -	-			\$ -	-
OCCUPATIONAL THERAPY C/S MEDICIAD	\$ -	-			\$ -	-
<b>Total</b>	\$ 255,284	5,749	\$ -	-	\$ -	-

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

Name of Facility				License No.	Report for Year Ended			Page	of	
Meriden Care Center, LLC				2448	9/30/2022			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	Other							
<b>Section I - Operators/Owners</b>										
<b>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).</b>										

\* 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	
Meriden Care Center, LLC				2448	9/30/2022			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	Other							
<b>Section III - Administrators***</b>										
Raymond Hackling	198,622			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			
<b>Section IV - Assistant Administrators</b>										

\*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		
Meriden Care Center, LLC	2448	9/30/2022	13	37		
<b>Total Cost and Hours</b>						
Item	CCNH	Hours	RHNS	Hours	Other	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary</b> (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist	32,152	253				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	127,248	2,438				
b. Other						
6. Social Worker	11,581	144				
7. Recreation Worker	12,787	3 Hours +Ca				3 Hours +Ca
8. Physicians						
a. Medical Director (entire facility)	36,000	148				
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	3,091	37				
9. Speech Therapist						
a. Resident Care	28,154	539				
b. Other						
10. Occupational Therapist						
a. Resident Care	235,148	4,505				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	392,453	2,894				
2. Administrative***	37,811	736				
b. LPN						
1. Direct Care	163,558	1,755				
2. Administrative***						
c. Aides	700,218	16,409				
d. Other						
12. Other (Specify) See Attached Schedule	255,284	5,749				
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>2,035,486</b>	<b>35,607</b>				

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

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

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

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

Name of Facility Meriden Care Center, LLC		License No. 2448	Report for Year Ended 9/30/2022	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"/>		
IPC Hospitalists	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"/>		

\* 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
Meriden Care Center, LLC	2448	9/30/2022		15	37
Item	Total	CCNH	RHNS	Other	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 192,231	192,231			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$				
4. Social Security (F.I.C.A.)	\$ 528,345	528,345			
5. Health Insurance	\$ 1,126,407	1,126,407			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 370,843	370,843			
8. Uniform Allowance	\$				
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 43,505	43,505			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 182,088	182,088			
d. Accounting and Auditing	\$ 10,170	10,170			
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 5,707	5,707			
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$				
g. Office Supplies	\$ 14,914	14,914			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 42,546	42,546			
2. Cellular Phones	\$ 1,523	1,523			
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	\$ 1,083,834	1,083,834			
<b>Subtotal</b>	\$ 3,602,113	3,602,113			

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

(Carry Subtotals forward to next page)

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

**Schedule of Other Employee Benefits**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>Other</b>
UNION TRAINING	\$ 43,505		\$ -
<b>Total</b>	\$ 43,505	\$ -	\$ -

-----  
**Schedule of Other Taxes**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>Other</b>
<b>Total</b>	\$ -	\$ -	\$ -

-----

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

Name of Facility	License No.	Report for Year Ended		Page	of
Meriden Care Center, LLC	2448	9/30/2022		16	37
Item	Total	CCNH	RHNS	Other	
<b>Subtotals Brought Forward:</b>	3,602,113	3,602,113			
<b>l. Travel and Entertainment</b>					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 2,650	2,650			
5. Education Expenses Related to Seminars and Conventions	\$ 3,032	3,032			
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$				
7. Other ( <i>Specify</i> ) See Attached Schedule	\$ 908	908			
<b>m. Other Administrative and General Expenses</b>					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$ 25,429	25,429			
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 20,801	20,801			
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 1,617	1,617			
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 10,769	10,769			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 1,026	1,026			
10. Contributions*** See Attached Schedule	\$ 250	250			
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$ 123,364	123,364			
12. Administrative Management Services**	\$ 477,456	477,456			
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 24,298	24,298			
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 4,293,713	4,293,713			

\* 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	\$ 908		\$ -
<b>Total Other Travel and Entertainment</b>	<b>\$ 908</b>	<b>\$ -</b>	<b>\$ -</b>

## Schedule of Other Advertising

Description	CCNH	RHNS	Other
COMMUNICATIONS SPECIAL EVENTS	\$ 20,801		\$ -
<b>Total Other Advertising</b>	<b>\$ 20,801</b>	<b>\$ -</b>	<b>\$ -</b>

## Schedule of Dues

Description	CCNH	RHNS	Other
ALTCFM			
CAHCF Dues	\$ 10,769		\$ -
OTHER DUES			
<b>Total Dues</b>	<b>\$ 10,769</b>	<b>\$ -</b>	<b>\$ -</b>

## Schedule of Contributions

Description	CCNH	RHNS	Other
CONTRIBUTIONS	\$ 250		\$ -
<b>Total Contributions</b>	<b>\$ 250</b>	<b>\$ -</b>	<b>\$ -</b>

## Schedule of Other Administrative and General

Description	CCNH	RHNS	Other
SOCIAL SERVICE SUPPLIES	\$ -		\$ -
SOC SVC MINOR EQUIPMENT	\$ -		\$ -
ADMINISTRATIVE MINOR EQUIPMENT	\$ 6,755		\$ -
EMPLOYEE RELATIONS	\$ 1,338		\$ -
EMPLOYEE RELATIONS-OTHER	\$ -		\$ -
PERMITS & LICENSES	\$ 2,016		\$ -
VOLUNTEER EXPENSE	\$ -		\$ -
BANK FEES	\$ 5,456		\$ -
CMS REVISIT USER FEES	\$ -		\$ -
PENALTIES	\$ -		\$ -
LATE FEES	\$ 1,828		\$ -
INTERNET EXPENSES	\$ 6,905		\$ -
Rounding	\$ -		
<b>Total Other Administrative and General</b>	<b>\$ 24,298</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule C-1 - Management Services\***

Name of Facility	License No.	Report for Year Ended	Page of
Meriden Care Center, LLC	2448	9/30/2022	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	477,456	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	187,498	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	45,071	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 Meriden Care Center, LLC		License No. 2448	Report for Year Ended 9/30/2022	Page 18	of 37
Item		Total	CCNH	RHNS	Other
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 442,479	442,479		
2.	Non-Food Supplies	\$ 53,467	53,467		
3.	Other ( <i>Specify</i> ) _____ DIETARY SUPPLEMENTS	\$ 15,970	15,970		
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)		\$ 23,507	23,507		
c. Other ( <i>Specify</i> ) _____ DIETARY MINOR EQUIPMENT		\$ 6,069	6,069		
<b>2D. Total Dietary Expenditures</b> (2a + b + c + d)		\$ 541,492	541,492		
2E. Dietary Questionnaire		Total	CCNH	RHNS	Other
F.	Resident Meals: Total no. of meals served per day:*	435	435		
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
Meriden Care Center, LLC		2448	9/30/2022	19	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. \$	1,116	1,116		
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)	\$	446,055	446,055		
c. Other (Specify) LAUNDRY MINOR EQUIPMENT	\$	482	482		
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	\$	447,653	447,653		
<b>3E. Laundry Questionnaire</b>					
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
Meriden Care Center, LLC		2448	9/30/2022		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. \$	39,238	39,238		
	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. \$	491,275	491,275		
	C. Other ( <i>Specify</i> )		\$			
	HOUSEKEEPING MINOR EQUIPMENT					
4D.	<b>Total Housekeeping Expenditures</b> (4a + b + c)		\$ 530,513	530,513		
5.	Resident Care (Supplies)**					
	a. Prescription Drugs***					
	1. Own Pharmacy		\$			
	2. Purchased from PHARMACY		\$ 245,311	245,311		
	b. Medicine Cabinet Drugs		\$ 7,424	7,424		
	c. Medical and Therapeutic Supplies		\$ 176,968	176,968		
	d. Ambulance/Limousine***		\$ 4,512	4,512		
	e. Oxygen					
	1. For Emergency Use		\$ 3,646	3,646		
	2. Other***		\$			
	f. X-rays and Related Radiological Procedures***		\$ 1,708	1,708		
	g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )		\$			
	h. Laboratory***		\$ 44,953	44,953		
	i. Recreation		\$			
	j. Direct Management Services*		\$ 187,498	187,498		
	k. Indirect Management Services*		\$ 45,071	45,071		
	l. Other (Specify)**** See Attached Schedule		\$ 138,952	138,952		
5M.	<b>Total Resident Care Expenditures</b> (5a - 5j)		\$ 856,043	856,043		

\* 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	\$ 1,021		\$ -
NURSING MINOR EQUIP	\$ 4,645		\$ -
MEDICAL RECORDS SUPPLIES	\$ 149		\$ -
MEDICAL RECORDS MINOR EQUIPMENT	\$ -		\$ -
NON-COVERED PPS DR. VISITS	\$ 26,625		\$ -
RESIDENT CARE SUPPLIES	\$ 178		\$ -
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 16,956		\$ -
PERSONAL CARE SUPPLIES	\$ 1,699		\$ -
INCONTINENCY SUPPLIES	\$ 2,043		\$ -
VACCINE RESIDENTS	\$ 5,669		\$ -
PATIENT SPECIAL NEEDS	\$ -		\$ -
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	\$ 43,404		\$ -
EQUIPMENT RENTAL: AIDS UNIT	\$ -		\$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ 3,959		\$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ 1,839		\$ -
HI LOW BED RENTAL & MATTRESSES	\$ -		\$ -
IV THERAPY SUPPLIES	\$ 15,302		\$ -
IV THERAPY CONTRACT SERVICE	\$ -		\$ -
MEDICAL WASTE CONTRACT SERVICE	\$ 1,760		\$ -
ACTIVITIES SUPPLIES	\$ 12,982		\$ -
ACTIVITIES MINOR EQUIPMENT	\$ 721		\$ -
ADMISSIONS SUPPLIES	\$ -		\$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS			
STRIKE COSTS NON REIMBURSABLE	\$ -		\$ -
COVID NON REIMBURSABLE	\$ -		\$ -
<b>Total Other Resident Care</b>	<b>\$ 138,952</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility Meriden Care Center, LLC			License No. 2448	Report for Year Ended 9/30/2022	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	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Housekeeping Services	491,275			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	446,055			19	3b
Eagle Elevator		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Elevator Contract	9,613			22	6F
Brightview Landscapes LLC		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Landscaping	8,608			22	6F
Amaya Landscaping LLC		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Snow Removal	22,014			22	6F
CWPM LLC		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Trash removal	51,034			22	6F
Facility Complainece		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Plant Contract Services				22	6F
American HealthTech	P.O. Box 9001006, Louisville, KY 40290	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Software Maintenance Contract	18,248			16	M11
Automatic Data Processing		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Payroll Services	40,638			16	M11
National Datacare Corp		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Resident Trust Software	5,355			16	M11
Prime Care Technology services		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Computer Consulting Services	37,560			16	M11
Priotiry Express		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Courier Services	3,292			16	M11
Point Right Inc		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Nursing Software	5,011			16	M11
		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR						

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

\*\* Refer to Page 4 for definition of related.

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

**Annual Report of Long-Term Care Facility**

CSP-22 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended			Page	of
Meriden Care Center, LLC	2448	9/30/2022			22	37
Item	Total	CCNH	RHNS	Other		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 35,717	35,717				
b. Heat	\$ 30,770	30,770				
c. Light & Power	\$ 115,841	115,841				
d. Water	\$ 92,122	92,122				
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 23,781	23,781				
f. Other ( <i>itemize</i> )	\$ 125,071	125,071				
See Attached Schedule						
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$ 423,301	423,301				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$					
b. Building & Building Improvements	\$ 22,984	22,984				
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 70,830	70,830				
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$ 93,813	93,813				
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 57,252	57,252				
d. Other ( <i>Specify</i> )	\$					
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$ 57,252	57,252				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 608,203	608,203				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 143,592	143,592				
c. Personal property taxes	\$ 14,437	14,437				
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$ 917,297	917,297				

\* 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	\$ 11,678		\$ -
PLANT CONTRACT SERVICE LABOR	\$ 558		\$ -
ELEVATOR CONTRACT SERVICE	\$ 9,613		\$ -
FIRE/SPRINKLER CONTRACT SERVICE	\$ 5,178		\$ -
LANDSCAPING CONTRACT SERVICE	\$ 8,608		\$ -
SNOW REMOVAL CONTRACT SERVICE	\$ 22,014		\$ -
TRASH REMOVAL CONTRACT SERVICE	\$ 51,034		\$ -
PLANT (POOL) CONTRACT SERVICES OTHER	\$ -		\$ -
SECURITY CONTRACT SERVICE	\$ -		\$ -
PLANT CONTRACT SERVICE OTHER	\$ 3,199		\$ -
PLANT MINOR EQUIPMENT	\$ 11,639		\$ -
RENT AUTO	\$ -		\$ -
RENT EQUIPMENT	\$ 1,550		\$ -
RENT OTHER	\$ -		\$ -
<b>Total Other Repairs and Maintenance</b>	<b>\$ 125,071</b>	<b>\$ -</b>	<b>\$ -</b>

### Depreciation Schedule

Name of Facility Meriden Care Center, LLC			License No. 2448			Report for Year Ended 9/30/2022			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			
<b>A. Land Improvements</b>													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal													
<b>B. Building and Building Improvements</b>													
1. Acquired prior to this report period			416,163		416,163	147,016			22,984				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal										22,984			
<b>C. Non-Movable Equipment</b>													
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								
<b>D. Movable Equipment</b>													
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													
						1,020,468		1,020,468	822,895			67,739	
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
						5,568						928	
						50,213						2,162	
						55,781						3,090	
D-3. Subtotal													
												69,901	
<b>E. Total Depreciation</b>													
												92,885	

## Schedule of Land Improvements Acquired during this report period

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

\*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
<b>Additions:</b>				
<b>Total additions for Building Improvements</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
<b>Total additions for Non-Movable Equipment</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ - **

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2



**Annual Report of Long-Term Care Facility**

CSP-24 Rev. 10/2006

**Amortization Schedule\***

Name of Facility			License No.		Report for Year Ended			Page	of
Meriden Care Center, LLC			2448		9/30/2022			24	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							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period				874,548	522,417			41,279	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				265,758				15,973	
C-4. Subtotal									57,252
<b>D. Total Amortization</b>									57,252

\* 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) - Interest**

Name of Facility		License No.	Report for Year Ended		Page	of
Meriden Care Center, LLC		2448	9/30/2022		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. <b>Total Building Interest Expense</b> (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
Meriden Care Center, LLC		2448		9/30/2022			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 ( <i>Specify</i> )				\$				
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 ( <i>Specify</i> )				\$	45	45		
INTEREST								
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>				\$	45	45		
14. Insurance								
a. Insurance on Property (buildings only)				\$	11,641	11,641		
b. Insurance on Automobiles				\$				
c. Insurance other than Property (as specified above)								
1. Umbrella ( <i>Blanket Coverage</i> )				\$	105,733	105,733		
2. Fire and Extended Coverage				\$				
3. Other ( <i>Specify</i> )				\$	17,030	17,030		
Other insurance, crime								
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$	134,403	134,403		
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$	16,517,472	16,517,472		

### D. Adjustments to Statement of Expenditures

Name of Facility Meriden Care Center, LLC				License No. 2448	Report for Year Ended 9/30/2022	Page 28	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	C	Bad Debts	\$ 182,088	182,088		
10.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m3	Unallowable Advertising *	\$ 20,801	20,801		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 1,828	1,828		
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
<b>Subtotal (Items 1 - 26)</b>				\$ 204,716	204,716		

\* 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
<b>Total Other Salaries Adjustment</b>			\$ -	\$ -	\$ -

## Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
<b>Total Other Fees Adjustments</b>			\$ -	\$ -	\$ -

## Schedule of Other A&amp;G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
16a		PENALTIES	\$ -		\$ -
16a		LATE FEES	\$ 1,828		\$ -
16a		PRIOR PERIOD EXPENSES			
		rounding			
<b>Total Other A&amp;G Adjustments</b>			\$ 1,828	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC				2448	9/30/2022	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
Subtotals Brought Forward				\$ 204,716	204,716		
<b>Page 20 - Resident Care Supplies***</b>							
27.			Prescription Drugs	\$			
28.	20	5d	Ambulance/Limousine	\$ 4,512	4,512		
29.	20	5f	X-rays, etc	\$ 1,708	1,708		
30.	20	5h	Laboratory	\$ 44,953	44,953		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 26,625	26,625		
<b>Page 22 - Maintenance and Property</b>							
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	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 282,515	282,515		

\*\*\* 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.

## Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Other
20	5J	Non Covered PPS Visits	26,625.00		-
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	-		
13	B9A	ST- Resident Care (for outpatient therapy - see schedule)	-		
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)	-		
<b>Total Other Ancillary Costs</b>			\$ 26,625	\$ -	\$ -

## Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Other
<b>Total Excess Movable Equipment Depreciation</b>			\$ -	\$ -	\$ -

## Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
<b>Total Other Property Adjustments</b>			\$ -	\$ -	\$ -

Schedule of Other - Indirect Adjustments

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

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

Schedule of Other - Direct Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Other
<b>Total Unallowable Building Interest</b>			\$ -	\$ -	\$ -

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended			Page	of
Meriden Care Center, LLC	2448	9/30/2022			30	37
Item	Total	CCNH	RHNS	Other		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 13,607,978	13,607,978				
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> )	\$ 984,753	984,753				
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$ 1,975,280	1,975,280				
b. Private-Pay Room and Board Contractual Allowance **	\$					
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 83,352	83,352				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (83,202)	(83,202)				
c. Prescription Drugs - Non-Medicare	\$ 398,863	398,863				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (398,863)	(398,863)				
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	\$ 65,279	65,279				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (52,243)	(52,243)				
c. Physical Therapy - Non-Medicare	\$ 167,465	167,465				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (167,465)	(167,465)				
4. a. Speech Therapy - Medicare	\$ 6,329	6,329				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (4,827)	(4,827)				
c. Speech Therapy - Non-Medicare	\$ 49,234	49,234				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (49,234)	(49,234)				
5. a. Occupational Therapy - Medicare	\$ 101,834	101,834				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (74,998)	(74,998)				
c. Occupational Therapy - Non-Medicare	\$ 293,875	293,875				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (82,978)	(82,978)				
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 31,898	31,898				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 198,810	198,810				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 17,051,140	17,051,140				
<b>IV. Other Revenue*</b>						
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> )	\$ 19,479	19,479				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$ 110,800	110,800				
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 130,279	130,279				
<b>VI. Total All Revenue</b> (III +V)	\$ 17,181,419	17,181,419				

\* 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	\$ 5,674		
	Lab Medicare CA	\$ (5,674)		
	Oxygen Medicare	\$ -		
	Oxygen Medicare CA	\$ -		
	Equipment rental	\$ 1,610		
	Equipment rental CA	\$ (1,610)		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds Medicare	\$ -		
	Therapy Beds Medicare CA	\$ -		
	Radiology Medicare	\$ 63		
	Radiology Medicare CA	\$ (63)		
	IV Therapy	\$ -		
	IV Therapy CA	\$ -		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose testing	\$ -		
	Glucose testing CA	\$ -		
	Outpatient therapy Medicare	\$ -		
	MEDICAID COVID REVENUE	\$ -		
	CRF MEDICAID REVENUE	\$ 98,238		
	MEDICAID WAGE & ENHANCEMENT RESERVE	\$ (66,340)		
	<b>Total Other Resident Revenue - Medicare</b>	<b>\$ 31,898</b>	<b>\$ -</b>	<b>\$ -</b>

## Schedule of Other Non-Medicare Resident Revenue

## Related Exp

Page Ref	Description	CCNH	RHNS	Other
	Lab	14,484		
	Lab CA	(14,484)		
	Oxygen	\$ -		\$ -
	Oxygen CA	\$ -		\$ -
	Equipment rental	\$ 17,544		
	Equipment rental CA	\$ (17,544)		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds	\$ -		
	Therapy Beds CA	\$ -		
	Radiology	\$ 1,645		
	Radiology CA	\$ (1,645)		
	Medical Transportation	\$ 6,648		
	Medical Transportation CA	\$ (6,648)		
	Glucose Testing	\$ -		
	Glucose Testing CA	\$ -		
	IV therapy	\$ -		\$ -
	IV therapy CA	\$ -		\$ -
	Flu shot revenue	\$ 2,805		
	Outpatient therapy	\$ -		
	prior period revenue	\$ 42,555		
	Optum B	\$ 285,529		
	Optum B CA	\$ (132,079)		
	C/A VBP	\$ -		
	rounding	\$ (0)		
	<b>Total Other Resident Revenue</b>	<b>\$ 198,810</b>	<b>\$ -</b>	<b>\$ -</b>

## Interest Income

## Account

Page Ref	Account	Balance	CCNH	RHNS	Other
	INTEREST INCOME		\$ 19,479		
	<b>Total Interest Income</b>		<b>\$ 19,479</b>	<b>\$ -</b>	<b>\$ -</b>

## Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Other
	MEALS	\$ -		
	TELEVISION INCOME	\$ -		
	OTHER INCOME: DMHAS OPERATING REVENUE	\$ -		
	OTHER INCOME: DMHAS ORGANIZATIONAL REV	\$ -		
	OTHER INCOME: DEFERRED REVENUE	\$ 17,500		
	MEDICARE COVID STIMULUS REVENUE	\$ -		
	CONCESSIONS / VENDING INCOME	\$ -		
	RESIDENT LATE FEE REVENUE	\$ -		
	RESIDENT ATTORNEY FEE REVENUE	\$ -		
	TELEPHONE INCOME	\$ -		
	OTHER INCOME	\$ -		
	OPTUM DIVIDENDS REVENUE	\$ 31,385		
	OPTUM OUTLIERS	\$ -		
	HHS GENERAL FUND REVENUE	\$ -		
	HHS INFECTION CONTROL REVENUE	\$ 61,915		
	CARES ACT REVENUE	\$ -		
	EMPLOYEE TESTING REVENUE	\$ -		
	COVID ECHO TRAINING REVENUE	\$ -		
	<b>Total Other Revenue</b>	<b>\$ 110,800</b>	<b>\$ -</b>	<b>\$ -</b>

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2022	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	1,064,534
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	4,410,289
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	158,495
a. Prepaid Insurance	126,775			
b. Prepaid Property Taxes	28,391			
c. Prepaid Expenses Other	3,329			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	(1,059,334)
Due From (to) Related Parties	(158,716)			
Other Owners reserves	(900,618)			
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	4,573,984
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost 416,163		\$	246,164
	Accum. Depreciation 169,999	Net		
4. Leasehold Improvements	*Historical Cost 1,140,306		\$	560,637
	Accum. Depreciation 579,669	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost 1,076,249		\$	182,524
	Accum. Depreciation 893,725	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>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	989,324

\* 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	
<b>Total Prepaid Expenses</b>			\$ -

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

Page Ref	Line Ref	Description	
<b>Total Other Current Assets (Itemize)</b>			\$ -

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

Page Ref	Line Ref	Description	
<b>Total Other Other Fixed Assets (Itemize)</b>			\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
<b>Total Other Assets</b>			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
<b>Total Notes Payable</b>			\$ -

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

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			\$ -

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

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			\$ -

### G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2022	32	37
<b>Account</b>			<b>Amount</b>	
Total Brought Forward:			\$	5,563,309
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			\$	
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	597,106
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	115,073
	Patient Trust Funds	103,218		
	Long Term Deposit - primecare	11,855		
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	
Name and Address	Amount	Loan Date		
7. Other Assets ( <i>itemize</i> )			\$	
_____				
See Schedule				
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$	712,178
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$	6,275,487

\* 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 Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2022	Page 34	of 37
Account			Amount	
Total Brought Forward:			2,828,378	
<b>Liabilities (cont'd)</b>				
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		103,218	103,218	
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 103,218
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 2,931,596

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

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2022	35	37
Account			Amount	
<b>A. Reserves</b>				
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>B. Net Worth</b>				
1. Owner's Capital			\$	25,000
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	2,654,944
6. Gain or Loss for Period			\$	663,947
	10/1/2021	thru 9/30/2022		
7. Total Net Worth			\$	3,343,891
<b>C. Total Reserves and Net Worth</b>			\$	3,343,891
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	6,275,487

### H. Changes in Total Net Worth

Name of Facility Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2022	Page 36	of 37	
Account			Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2021			\$		
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$ 17,181,419		
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$ 16,517,472		
D. Net Income or Deficit			\$ 663,947		
E. Balance			\$ 663,947		
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 Withdrawals ( <i>Specify</i> )			\$		
Purpose		Amount			
3. Total Deductions			\$		
H. <b>Balance at End of Period</b>		09/30/22	\$ 663,947		

### I. Preparer's/Reviewer's Certification

Name of Facility Meriden Care Center, LLC	License No. 2448	Report for Year Ended 9/30/2022	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		
<b>Preparer/Reviewer Certification</b>				
<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	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Kartik Patel			860-570-2140	
Contact Email Address				
kpatel@icarehn.com				