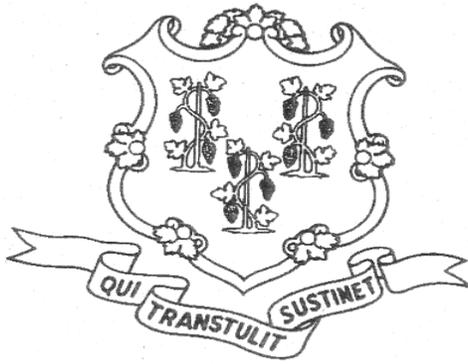


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2015

Name of Facility (as licensed) Paradigm Healthcare Center of South Windsor, LLC	
Address (No. & Street, City, State, Zip Code) 1060 Main Street, South Windsor, CT 06074	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH 2349	RHNS	(Specify)	Medicare Provider 07-5422
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Medicaid Provider Numbers:	CCNH 20470	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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Paradigm Healthcare Center of South Windsor, LLC	2349	9/30/2015	1	37

Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR 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 Paradigm Healthcare Center of South Windsor, LLC [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, 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. **{a}**

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.

{a} SUBJECT TO DESK AUDIT REVIEW

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) Tracy Newport			Printed Name (Owner) See Page 3		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires	
/ /					
Address of Notary Public					

(Notary Seal)

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 Paradigm Healthcare Center of South Windsor, LLC	Period Covered:	From 10/1/2014	To 9/30/2015	
Address of Facility 1060 Main Street, South Windsor, CT 06074				
Report Prepared By Marcum LLP	Phone Number 203-781-9600	Date 2/9/2016		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire

Type of Facility - Organization Structure

	Phone No. of Facility 860-289-7771	Report for Year Ended 9/30/2015	Page 2	of 37
Name of Facility (as shown on license) Paradigm Healthcare Center of South Windsor, LLC		Address (No. & Street, City, State, Zip) 1060 Main Street, South Windsor, CT 06074		
License Numbers:	CCNH 2349	RHNS	(Specify)	Medicare Provider No. 07-5422
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 type="checkbox"/> (Specify)				
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 Tracy Newport		Nursing Home Administrator's License No.:	1214	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name N/A		License No.:		

General Information and Questionnaire Corporate Owners

Name of Facility Paradigm Healthcare Center of South Winds	License No. 2349	Report for Year Ended 9/30/2015	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address		State(s) in Which Incorporated	
N/A				
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
N/A				
Names of Stockholders Owning at Least 10% of Shares				
N/A				

General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Paradigm Healthcare Center of South Windsor, LL	2349	9/30/2015	3B	37

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

Owner(s) of Facility

N/A

**General Information and Questionnaire
Related Parties***

Name of Facility Paradigm Healthcare Center of South Windsor, LLC	License No. 2349	Report for Year Ended 9/30/2015	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Paradigm Management, LLC	177 Whitewood Road, Waterbury, CT 06708	<input type="radio"/>	<input checked="" type="radio"/>		Management of HR, Finance, Clinical, Ops	Pg. 16 / Line m12	290,318	236,226
Paradigm Management, LLC	177 Whitewood Road, Waterbury, CT 06708	<input type="radio"/>	<input checked="" type="radio"/>		Copr Policy Worker Comp - allocated to each	Pg. 15 / Line 1a1	322,669	322,669
Paradigm Management, LLC	177 Whitewood Road, Waterbury, CT 06708	<input type="radio"/>	<input checked="" type="radio"/>		Corp Policy Disability Insurance - billed sep	Pg. 15 / Line 1a2	9,111	9,111
Paradigm Management, LLC	177 Whitewood Road, Waterbury, CT 06708	<input type="radio"/>	<input checked="" type="radio"/>		Corp Policy Life Insurance - billed separately	Pg. 15 / Line 1a6	3,330	3,330
Paradigm Management, LLC	177 Whitewood Road, Waterbury, CT 06708	<input type="radio"/>	<input checked="" type="radio"/>		Corporate Health/Dental Policy-ea entity bill	Pg. 15 / Line 1a5	726,133	726,133
Paradigm Healthcare Development, LLC	177 Whitewood Road, Waterbury, CT 06708	<input type="radio"/>	<input checked="" type="radio"/>		401k Plan - No employer contribution	N/A		3,530
Paradigm Healthcare Development, LLC	177 Whitewood Road, Waterbury, CT 06708	<input type="radio"/>	<input checked="" type="radio"/>		Corp Work Capital Interest - allocation basis	Pg. 27 / Line 12D	116,426	116,426
Paradigm Healthcare Development, LLC	177 Whitewood Road, Waterbury, CT 06708	<input type="radio"/>	<input checked="" type="radio"/>		Liability Insurance (PL/GL)	Pg. 27 / Line 14c3	60,504	60,504
Paradigm Healthcare Development, LLC	177 Whitewood Road, Waterbury, CT 06708	<input type="radio"/>	<input checked="" type="radio"/>		Property Insurance - allocated to each entity	Pg. 27 / Line 14a	8,585	8,585

* 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	License No.	Report for Year Ended	Page	of
Paradigm Healthcare Center of South Windsor,	2349	9/30/2015	5	37

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

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

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

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

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

Workers comp corp policy allocated, corporate health and dental is billed separately to each facility, interest on line of credit based on A/R balance. Advertising/promotional and general legal shared equally.

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 Paradigm Healthcare Center of South Windsor, LLC			License No. 2349	Report for Year Ended 9/30/2015			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						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input type="radio"/> No Total ***	

* 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 Paradigm Healthcare Center of Sou	License No. 2349	Report for Year Ended 9/30/2015	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:
 Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm 1 Marcum LLP 2 3 4	Address (No. & Street, City, State, Zip Code) 555 Long Wharf Drive, New Haven, CT 06511
--	--

Services Provided by This Firm (*describe fully*)

1 Audit, tax preparation, cost report and reimbursement advisory services	\$ 20,100
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 20,100

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No Page 15, Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney 1 MidCap Financial 2 Robinson & Cole, LLP 3 Murtha Cullina, LLP 4 Reid & Reige 5 Various	Telephone Number 301-841-3736 860-275-8200 860-240-6000 860-278-1150 Various
--	---

Address (<i>No. & Street, City, State, Zip Code</i>) 1 7255 Woodmont Ave., Ste200, Bethesda, MD 20814 2 280 Trumbull Street, Hartford, CT 06103 3 185 Asylum St., Hartford, CT 4 One Financial Plaza, Hartford, CT 06103 5 Various

Services Provided by This Firm (*describe fully*)

1 Due dilligence and line of credit legal fees (Disallowed Pg. 28)	\$ 8,153
2 General representation	\$ 5,642
3 General representation	\$ 7,560
4 Settlements (Disallowed Pg. 28 - \$312)	\$ 625
5 COP/COE Application (Disallowed on Pg. 28)	\$ 200
	Charge for Services Provided
	\$ 22,180

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No Page 15, Line 1e

Schedule of Resident Statistics

Name of Facility Paradigm Healthcare Center of South Windsor, LLC			License No. 2349			Report for Year Ended 9/30/2015				Page 8		of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	100	100			100	100			100	100			
B. On last day of THIS report period	100	100			100	100			100	100			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	81	81			81	81			74	74			
B. As of midnight of THIS report period	70	70			74	74			70	70			
3. Total Number of Days Care Provided During Period													
A. Medicare	3,257	3,257			2,811	2,811			446	446			
B. Medicaid (Conn.)	24,076	24,076			18,032	18,032			6,044	6,044			
C. Medicaid (other states)													
D. Private Pay	1,153	1,153			924	924			229	229			
E. State SSI for RCH													
F. Other (Specify) Managed Care	239	239			145	145			94	94			
G. Total Care Days During Period (3A thru F)	28,725	28,725			21,912	21,912			6,813	6,813			
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)	28,725	28,725			21,912	21,912			6,813	6,813			

Schedule of Resident Statistics (Cont'd)

Name of Facility Paradigm Healthcare Center of South Windsor	License No. 2349	Report for Year Ended 9/30/2015	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? Yes No
 If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	2	64		4				
Per Diem Rate								
a. One bed rm.	Various	224.59		430.50				
b. Two bed rms.	Various	224.59		388.50				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	6,698	6,698		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,326	1,326		
2. Restorative Treatments				
C. Other	7,119	7,119		
D. Total Physical Therapy Treatments	15,143	15,143		

8. Total Number of Speech Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	412	412		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	22	22		
2. Restorative Treatments				
C. Other	287	287		
D. Total Speech Therapy Treatments	721	721		

9. Total Number of Occupational Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	4,244	4,244		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	859	859		
2. Restorative Treatments				
C. Other	6,647	6,647		
D. Total Occupational Therapy Treatments	11,750	11,750		

Report of Expenditures - Salaries & Wages

Name of Facility Paradigm Healthcare Center of South Windsor, LLC	License No. 2349	Report for Year Ended 9/30/2015	Page 10	of 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	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	124,905	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	112,101	5,599				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	366,482	21,581				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	141,469	9,868				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	77,625	3,765				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	97,817	6,841				
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	122,965	2,424				
b. RN						
1. Direct Care	380,314	11,541				
2. Administrative**	225,365	6,564				
c. LPN						
1. Direct Care	849,046	28,937				
2. Administrative**						
d. Aides and Attendants	1,108,743	63,297				
e. Physical Therapists	274,560	7,374				
f. Speech Therapists	3,157	63				
g. Occupational Therapists	159,940	4,684				
h. Recreation Workers	71,206	3,272				
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	83,035	1,993				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	30,635	1,877				
<i>A-13. Total Salary Expenditures</i>	4,229,365	181,760				

* 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		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Medical Records	\$ 30,635	1,877				
Total	\$ 30,635	1,877	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Audiology	\$ 1,675	45				
Medical Records	\$ 971	40				
Total	\$ 2,646	85	\$ -	-	\$ -	-

**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	
Paradigm Healthcare Center of South Windsor, LLC				2349	9/30/2015			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
Paradigm Healthcare Center of South Windsor, LLC				2349	9/30/2015			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Tracy Newport	124,905			Non-discrim	Administrator	2,080	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		
Paradigm Healthcare Center of South Windsor, LLC	2349	9/30/2015	13	37		
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	5,025	134				
3. Pharmacist	10,304	228				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	62,022	1,169				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	50,123	240				
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) Physicians Resident Care	4,800	40				
9. Speech Therapist						
a. Resident Care	2,507	32				
b. Other						
10. Occupational Therapist						
a. Resident Care	8,513	170				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	6,370	192				
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	2,646	85				
B-13 Total Fees Paid in Lieu of Salaries	152,310	2,290				

* 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 Paradigm Healthcare Center of South Windsor, LLC		License No. 2349	Report for Year Ended 9/30/2015	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
United Dental Resources, LLC; 411 Highland Ave., Ste 1-N; Waterbury CT 06708 203-527-	Dentist / Audiology	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
LTC Dental LLP 174 Scott Road, Prospect, CT 06712	Dentist / Audiology	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
LifeMed Pharmacy LLC.; 447 Doughty Blvd; Inwood NY 11096	Pharmacist / Medical Records	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Accuscript Consulting Servies LLC; 276 CEDARBRIDGE AVE.;LAKEWOOD NJ 08701	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Omnicare of CT, PO Box 715268, Columbus, OH 43271-5268	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Synergy Therapy Solutions 44 Bluff Point Road South Glastonbury CT 06073	PT, OT and ST Resident Care	<input checked="" type="radio"/>	<input type="radio"/>	Wife of Scott Ziskin	
Stern Therapy Consultants LLC; 50 Lyncrest Drive; Monsey, NY 10952	PT Resident Care	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
CAROLINE LaPLANTE; 2618 CANYON RIDGE DRIVE; BROAD BROOK CT 06016	PT Resident Care	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
NATIONAL STAFFING SOLUTIONS, INC; P.O. BOX 9310; WINTERHAVEN FL 33883	PT Resident Care	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
SDX Swallowing Diagnostics, LLC; 21 Waterville Rd.; Avon, CT 06001	ST Resident Care	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Mohammed Memon M D; 415 Silar Deane Hwy, Ste 210; Weathersfield, CT 06109	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Connecticut Multispecialty Group, P.C., PO Box 587, Rocky Hill, CT 06067-0587	Physicians Resident Care	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Lisa M. Meadows	MDS Consultant	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input 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
Paradigm Healthcare Center of South Windsor, L	2349	9/30/2015		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 322,669	322,669			
2. Disability Insurance	\$ 9,111	9,111			
3. Unemployment Insurance	\$ 136,058	136,058			
4. Social Security (F.I.C.A.)	\$ 318,712	318,712			
5. Health Insurance	\$ 726,133	726,133			
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 3,330	3,330			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 665	665			
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$ 144	144			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 59,541	59,541			
d. Accounting and Auditing	\$ 20,100	20,100			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 22,180	22,180			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 4,637	4,637			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 37,661	37,661			
2. Cellular Phones	\$				
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	\$ 535,338	535,338			
Subtotal	\$ 2,196,279	2,196,279			

* 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**

Paradigm Healthcare Center of South Windsor, LLC
9/30/2015

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
	-		
Employee Physicals/Pre Employment	\$ 144		
Total	\$ 144	\$ -	\$ -

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Paradigm Healthcare Center of South Windsor, LLC	2349	9/30/2015	16	37
Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	2,196,279	2,196,279		
1. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$			
3. Gifts to Staff and Residents	\$ 3,478	3,478		
4. Employee Travel	\$ 1,685	1,685		
5. Education Expenses Related to Seminars and Conventions	\$ 267	267		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$			
7. Other (<i>Specify</i>) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 834	834		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$			
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 1,589	1,589		
4. Fund-Raising***	\$			
5. Medical Records	\$ 69	69		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$			
7. Postage	\$ 1,513	1,513		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 6,824	6,824		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$			
10. Contributions*** See Attached Schedule	\$			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 62,608	62,608		
12. Administrative Management Services**	\$ 290,318	290,318		
13. Other (<i>Specify</i>) See Attached Schedule	\$ 23,424	23,424		
C-14 Total Administrative & General Expenditures	\$ 2,588,888	2,588,888		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
	-		
Advertising - Promotional	\$ 1,589		
Total Other Advertising	\$ 1,589	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
	-		
CAHCF	\$ 6,824		
Total Dues	\$ 6,824	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
	-		
Bank Charges	\$ 19,599		
Printing	\$ 419		
Business License Fees	\$ 1,441		
License & Permits - CLIA Laboratory Program	\$ 150		
License & Permits - Tracy Newport - MA License Renewal	\$ 315		
License & Permits - Treasurer, State of CT	\$ 940		
Fines & Penalties	\$ 560		
Total Other Administrative and General	\$ 23,424	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Paradigm Healthcare Center of South Wir	2349	9/30/2015	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 #
Paradigm Management, LLC	290,318	Management of HR, Finance, Clinical, Operations	Pg. 16 / Line m12

*** 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 Paradigm Healthcare Center of South Windsor, LLC	License No. 2349	Report for Year Ended 9/30/2015	Page 18	of 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 169,733	169,733		
2. Non-Food Supplies	\$ 8,922	8,922		
3. Other (Specify) _____	\$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 20,638	20,638		
c. Management Services**	\$			
d. Other (Specify) _____	\$			
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 199,293	199,293		
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*				
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.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Name of Facility Paradigm Healthcare Center of South Windsor, LLC		License No. 2349	Report for Year Ended 9/30/2015	Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*		Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$	10,867	10,867	
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)		\$			
c. Management Services**		\$			
d. Other (Specify)		\$			
3E. Total Laundry Expenditures (3a + b + c + d)		\$	10,867	10,867	
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.

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

*** 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
Paradigm Healthcare Center of South Windsor		2349	9/30/2015		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	25,123	25,123		
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. \$				
c.	Management Services*		\$			
d.	Other (<i>Specify</i>)		\$			
4E.	Total Housekeeping Expenditures (4a + b + c + d)		\$ 25,123	25,123		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy		\$			
	2. Purchased from Pharmacy		\$ 121,188	121,188		
b.	Medicine Cabinet Drugs		\$ 13,542	13,542		
c.	Medical and Therapeutic Supplies		\$			
d.	Ambulance/Limousine***		\$ 3,912	3,912		
e.	Oxygen					
	1. For Emergency Use		\$			
	2. Other***		\$ 12,767	12,767		
f.	X-rays and Related Radiological Procedures***		\$ 1,438	1,438		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)		\$			
h.	Laboratory***		\$ 9,714	9,714		
i.	Recreation		\$ 30,350	30,350		
j.	Other (Specify)**** See Attached Schedule		\$ 140,762	140,762		
5K.	Total Resident Care Expenditures (5a - 5j)		\$ 333,673	333,673		

* 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.

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

Name of Facility Paradigm Healthcare Center of South Windsor, LLC			License No. 2349	Report for Year Ended 9/30/2015	Page of 21 37					
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
MDI Achieve, Inc.	Minneapolis, MN	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Software support	11,614			16	m11
Unicorn	25 B Hanover Road, Florham Park, NJ 07932	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Payroll Processing	20,626			16	m11
Joslin Concrete and Snow Plowing, LLC	Bridgeport, CT	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Snow Removal	10,116			22	6f
Caretech Supplies, LLC	1123 McDonald Ave, Brooklyn, NY 11230	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Dietary Purchased Service	18,000			18	2b
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

* 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
Paradigm Healthcare Center of South Windsor	2349	9/30/2015			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 24,950	24,950				
b. Heat	\$ 65,735	65,735				
c. Light & Power	\$ 73,980	73,980				
d. Water	\$ 17,419	17,419				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$					
f. Other (<i>itemize</i>)	\$ 45,324	45,324				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 227,408	227,408				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 9,302	9,302				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 9,302	9,302				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 43,288	43,288				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 43,288	43,288				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 355,556	355,556				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 94,426	94,426				
c. Personal property taxes	\$ 163	163				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 502,735	502,735				

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
	-		
Contract Svcs Maintenance	\$ 16,008		
Pest Control	\$ 1,556		
Groundskeeing/Snow Removal	\$ 11,632		
Trash Removal	\$ 16,128		
Total Other Repairs and Maintenance	\$ 45,324	\$ -	\$ -

Depreciation Schedule

Name of Facility Paradigm Healthcare Center of South Windsor, LLC				License No. 2349			Report for Year Ended 9/30/2015			Page 23	of 37	
Property Item				Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals	
A. Land Improvements												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal												
B. Building and Building Improvements												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
B-4. Subtotal												
C. Non-Movable Equipment												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
C-4. Subtotal												
	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. Movable Equipment												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period												
			Var	Var	37,476		37,476	10,647	S/L	Var	7,716	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)												
			Var	Var	15,857		15,857		S/L	5 Yrs	1,586	
D-3. Subtotal												9,302
E. Total Depreciation												9,302

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
7/31/2015	WFM-HP-4000 Biometric Time Collection Device	\$ 2,857	5	\$ 286
9/30/2015	WIFI APS and Set Up	\$ 13,000	5	\$ 1,300
Total additions for Movable Equipment		\$ 15,857		\$ 1,586 *
Deletions:				
Total deletions for Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/17/2014	Kitchen Floor	\$ 7,975	10	\$ 399
Total additions for Leasehold Improvement		\$ 7,975		\$ 399 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility			License No.		Report for Year Ended			Page	of
Paradigm Healthcare Center of South Windsor, LLC			2349		9/30/2015			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							
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	Var	Var	Various	530,477	71,848	S/L	Var	42,889	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	Var	Var	10 Yrs	7,975		S/L	10 Yrs	399	
C-4. Subtotal									43,288
D. Total Amortization									43,288

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility Paradigm Healthcare Center of South	License No. 2349	Report for Year Ended 9/30/2015	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description	Total				
1. Date Land Purchased					
2. Date Structure Completed					
3. If NOT Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	100				
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	
Independence Senior Holdings LLC, 13 Freedom Drive, Lakewood, NJ 08707	Building and all Assets	12/30/11	15 Years	355,556	

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
Paradigm Healthcare Center of South	2349	9/30/2015	26	37
Item	Total	CCNH	RHNS	(Specify)
12. Interest				
A. Building, Land Improvement & Non-Movable Equipment				
1. First Mortgage	\$			
Name of Lender	Rate			
Address of Lender				
2. Second Mortgage	\$			
Name of Lender	Rate			
Address of Lender				
3. Third Mortgage	\$			
Name of Lender	Rate			
Address of Lender				
4. Fourth Mortgage	\$			
Name of Lender	Rate			
Address of Lender				
B. CHEFA Loan Information				
1. Original Loan Amount	\$			
2. Loan Origination Date				
3. Interest Rate %				
4. Term				
5. CHEFA Interest Expense				
12 B7. Total Building Interest Expense (A1 - A4 + B5)	\$			

(Carry Subtotals forward to next page)

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

Name of Facility Paradigm Healthcare Center of So		License No. 2349		Report for Year Ended 9/30/2015		Page 27		of 37	
Item				Total	CCNH	RHNS	(Specify)		
Subtotals Brought Forward:									
12. C. Movable Equipment									
1. Automotive Equipment				\$					
A. Item		Rate	Amount						
Lender									
Address of Lender									
2. Other (Specify)				\$					
A. Item		Rate	Amount						
Lender									
Address of Lender									
B. Item		Rate	Amount						
Lender									
Address of Lender									
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$					
12. D. Other Interest Expense (Specify) Working Capital = \$116,426 / Other = \$17,500				\$	133,926	133,926			
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	133,926	133,926			
14. Insurance									
a. Insurance on Property (buildings only)				\$	8,585	8,585			
b. Insurance on Automobiles				\$					
c. Insurance other than Property (as specified above)									
1. Umbrella (Blanket Coverage)				\$					
2. Fire and Extended Coverage				\$					
3. Other (Specify) Insurance - Non Property				\$	60,504	60,504			
14d. Total Insurance Expenditures (14a + b + c)				\$	69,089	69,089			
15. Total All Expenditures (A-13 thru C-14)				\$	8,472,677	8,472,677			

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Paradigm Healthcare Center of South Windsor, LLC				2349	9/30/2015	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	A12g	Occupational Therapy	\$ 159,940	159,940		
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$ 8,513	8,513		
7.			Other - See attached Schedule	\$ 4,800	4,800		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 59,541	59,541		
10.	15	1e	Accounting & Legal	\$ 8,665	8,665		
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	L3	Gifts, flowers and coffee shops	\$ 687	687		
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 *	\$ 1,589	1,589		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.	16	m12	Unallowable Management Fees	\$ 72,153	72,153		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 7,528	7,528		
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)				\$ 323,416	323,416		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B8e	Physicians Resident Care	\$ 4,800		
Total Other Fees Adjustments			\$ 4,800	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Non-Allowable Banke Charges	\$ 5,563		
16	m13	License & Permits - CLIA Laboratory Program	\$ 150		
16	m13	License & Permits - Tracy Newport - MA License Renewal	\$ 315		
16	m13	License & Permits - Treasurer, State of CT	\$ 940		
16	m13	Fines & Penalties	\$ 560		
Total Other A&G Adjustments			\$ 7,528	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Paradigm Healthcare Center of South Windsor, LLC			2349	9/30/2015	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 323,416	323,416		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 121,188	121,188		
28.	20	5d	Ambulance/Limousine	\$ 3,912	3,912		
29.	20	5f	X-rays, etc	\$ 1,438	1,438		
30.	20	5h	Laboratory	\$ 9,714	9,714		
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 12,767	12,767		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 59,126	59,126		
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.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.	30	IV 8	Vending Machine Revenue	\$ 562	562		
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$ 18,379	18,379		
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51.	Total Amount of Decrease (Items 1 - 50)			\$ 550,502	550,502		

*** 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.

Paradigm Healthcare Center of South Windsor, LLC
9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5i	Cable TV Disallowance	\$ 15,646		
20	5j	I.V. Therapy/RT Exp	\$ 14,098		
20	5j	Med Equip Rental - Oxygen Rental	\$ 18,046		
20	5j	Patient Expenses	\$ 1,318		
20	5j	Patient Consolidated Billing	\$ 10,018		
Total Other Ancillary Costs			\$ 59,126	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	12d	Interest - Other	\$ 17,500		
30	IV 8	Acceleratd Care Plus Account Closing	\$ 875		
30	IV 8	Miscellaneous Income	\$ 4		
Total Other Adjustments			\$ 18,379	\$ -	\$ -

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility		License No.		Report for Year Ended		Page	of
Paradigm Healthcare Center of South Wit		2349		9/30/2015		30	37
Item				Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue							
1.	a.	Medicaid Residents (<i>CT only</i>)	\$	9,376,889	9,376,889		
	b.	Medicaid Room and Board Contractual Allowance **	\$	(3,992,103)	(3,992,103)		
2.	a.	Medicaid (<i>All other states</i>)	\$				
	b.	Other States Room and Board Contractual Allowance **	\$				
3.	a.	Medicare Residents (<i>all inclusive</i>)	\$	1,243,908	1,243,908		
	b.	Medicare Room and Board Contractual Allowance **	\$	431,423	431,423		
4.	a.	Private-Pay Residents and Other	\$	531,458	531,458		
	b.	Private-Pay Room and Board Contractual Allowance **	\$	3,628	3,628		
II. Other Resident Revenue							
1.	a.	Prescription Drugs - Medicare	\$	108,379	108,379		
	b.	Prescription Drugs - Medicare Contractual Allowance **	\$				
	c.	Prescription Drugs - Non-Medicare	\$	28,049	28,049		
	d.	Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
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	\$	458,309	458,309		
	b.	Physical Therapy - Medicare Contractual Allowance **	\$				
	c.	Physical Therapy - Non-Medicare	\$	60,435	60,435		
	d.	Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4.	a.	Speech Therapy - Medicare	\$	51,942	51,942		
	b.	Speech Therapy - Medicare Contractual Allowance **	\$				
	c.	Speech Therapy - Non-Medicare	\$	3,061	3,061		
	d.	Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5.	a.	Occupational Therapy - Medicare	\$	394,401	394,401		
	b.	Occupational Therapy - Medicare Contractual Allowance **	\$				
	c.	Occupational Therapy - Non-Medicare	\$	46,400	46,400		
	d.	Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6.	a.	Other (<i>Specify</i>) - Medicare	\$	(674,463)	(674,463)		
	b.	Other (<i>Specify</i>) - Non-Medicare	\$	(133,854)	(133,854)		
III. Total Resident Revenue (Section I. thru Section II.)				\$	7,937,862	7,937,862	
IV. Other Revenue*							
1.	Meals sold to guests, employees & others			\$			
2.	Rental of rooms to non-residents			\$			
3.	Telephone			\$			
4.	Rental of Television and Cable Services			\$			
5.	Interest Income (<i>Specify</i>)			\$	19	19	
6.	Private Duty Nurses' Fees			\$			
7.	Barber, Coffee, Beauty and Gift shops			\$			
8.	Other (<i>Specify</i>)			\$	1,441	1,441	
V. Total Other Revenue (1 thru 8)				\$	1,460	1,460	
VI. Total All Revenue (III +V)				\$	7,939,322	7,939,322	

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
		-		
30 II 6a	Lab - MA	\$ 8,968		
30 II 6a	Oxygen - MA	\$ 3,434		
30 II 6a	X-Ray - MA	\$ 205		
30 II 6a	Contractual Allowance (Ancillaries) - MA	\$ (623,429)		
30 II 6a	IV Therapy - M MA	\$ 9		
30 II 6a	Contractual Allowance (Ancillaries) - M MA	\$ (9)		
30 II 6a	Contractual Allowance (Ancillaries) - Medicare B	\$ (58,536)		
30 II 6a	Sequester Med B	\$ (5,105)		
Total Other Resident Revenue - Medicare		\$ (674,463)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
		-		
30 II 6b	IV Therapy - MD	\$ 232		
30 II 6b	Oxygen - MD	\$ 11,365		
30 II 6b	Contractual Allowance (Ancillaries) - MD	\$ (101,053)		
30 II 6b	Contractual Allowance (BC/BS Disc) - MA	\$ (5,164)		
30 II 6b	Contractual Allowance (Ancillaries) - Hospice	\$ (83)		
30 II 6b	Lab - Managed Care	\$ 690		
30 II 6b	Oxygen - Managed Care	\$ 282		
30 II 6b	Contractual Allowance (Anc.) - Managed Care	\$ (40,123)		
Total Other Resident Revenue		\$ (133,854)	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
			-		
30 IV 5	Interest Income	N/A	\$ 19		
Total Interest Income			\$ 19	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
		-		
30 IV 8	Vending Income	\$ 562		
30 IV 8	Acceleratd Care Plus Account Closing	\$ 875		
30 IV 8	Miscellaneous Income	\$ 4		
Total Other Revenue		\$ 1,441	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Paradigm Healthcare Center of South W	2349	9/30/2015	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	5,478
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	891,745
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	12,778
5. Prepaid Expenses			\$	88,741
a. Prepaid Expenses	88,741			
b. _____				
c. _____				
d. _____				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	237,211
Due To/From Seller/Receiver	13,310			
Due To/From Paradigm HC Development/Mgmt	150,618			
Due To/From NH, Pros, Torr, Wtby, WH	(6,532)			
Deposits/Donations	79,815			
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,235,953
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
4. Leasehold Improvements	*Historical Cost <u>538,452</u>		\$	423,316
	Accum. Depreciation <u>115,136</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	110,388
Construction in Progress	581			
F/S vs C/R NBV	109,807			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	533,704

* 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 Paradigm Healthcare Center of South W	License No. 2349	Report for Year Ended 9/30/2015	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$ 1,769,657	
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	
		53,333		
		19,949		33,384
6. Motor Vehicles			\$	
	*Historical Cost _____	Accum. Depreciation _____	Net	
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$ 33,384	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense			\$	
	*Historical Cost _____	Accum. Depreciation _____	Net	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	
	Webster Advances	(465,723)	(465,723)	

D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ (465,723)	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 1,337,318	

* 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 Paradigm Healthcare Center of South Windsor		License No. 2349	Report for Year Ended 9/30/2015	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	1,281,553
2. Notes Payable (<i>itemize</i>)				\$	177,389
Note Payable HCSG					176,607
Note Pay - Medline					782
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>)				\$	187,482
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	9,835
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>)				\$	563,787
Accrued Provider Tax Payable		133,834	Patient Funds Liability	4,142	
Union Dues Withholding		(420)	Medicaid Medicare Rese:	61,000	
Rent Accrual		399,785			
Patient Refund		(34,554)			
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	2,220,046

* 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 Paradigm Healthcare Center of South Wind		License No. 2349	Report for Year Ended 9/30/2015	Page 34	of 37
Account				Amount	
Total Brought Forward:				2,220,046	
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>)					
Line of Credit		477,125			
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$	477,125
C. Total All Liabilities (Lines A-13 + B-5)				\$	2,697,171

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

Name of Facility	License No.	Report for Year Ended	Page	of
Paradigm Healthcare Center of South	2349	9/30/2015	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			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(867,353)
6. Gain or Loss for Period			\$	(492,500)
	10/1/2014	thru	9/30/2015	
7. Total Net Worth			\$	(1,359,853)
C. Total Reserves and Net Worth			\$	(1,359,853)
D. Total Liabilities, Reserves, and Net Worth			\$	1,337,318

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Paradigm Healthcare Center of South W	2349	9/30/2015	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2014			\$	(865,946)
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	7,939,322
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	8,431,822
D. Net Income or Deficit			\$	(492,500)
E. Balance			\$	(1,358,446)
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
Total Expenses Per Pg. 27 \$8,472,677				
F/S vs C/R Depreciation (40,855)				
Total F/S Expenses \$8,431,822				
2. Other (<i>itemize</i>)				
Prior Period Adjustment				(1,407)
F-3. Total Additions			\$	(1,407)
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			\$	(1,359,853)
09/30/15				

I. Preparer's/Reviewer's Certification

Name of Facility Paradigm Healthcare Center of South	License No. 2349	Report for Year Ended 9/30/2015	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 type="checkbox"/> (Specify)		
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				
Matthew S. Bovolack				
Address Address			Phone Number	
555 Long Wharf Drive, New Haven, CT 06511			203-781-9600	