State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2017

Name of Facility (as licensed) Bloomfield Health Care Center of CT, LLC		
Address (No. & Street, City, State, Zip Code) 355 Park Ave Bloomfield, CT 06002		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	913-C			07-5138

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	9134		

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

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Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Bloomfield Health Care Center of CT, LLC [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, 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) Kimberly Coleman			Printed Name (Owner) Marvin J. Ostreicher	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Bloomfield Health Care Center of CT, LLC	Period Covered:		From 10/1/2016	To 9/30/2017
Address of Facility 355 Park Ave Bloomfield, CT 06002				
Report Prepared By Blum Shapiro & Company, P.C.	Phone Number (203) 944-2100		Date 2/1/2018	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-242-8595	9/30/2017	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Bloomfield Health Care Center of CT, LLC	355 Park Ave Bloomfield, CT 06002

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	913-C			07-5138

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

○ Proprietorship ◉ LLC ○ Partnership ○ Profit Corp. ○ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
Kimberly Coleman		001856

Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
Bloomfield Health Care Center of CT, LLC	355 Park Ave Bloomfield, CT 06002	CT

Name of Partners/Members	Business Address	Title	% Owned
Marvin J. Ostreicher	355 Park Ave Bloomfield, CT 06002	President	0.5
Agnes Zitter	355 Park Ave Bloomfield, CT 06002		0.5

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ◉ No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
See attachment.		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	9134	9/30/2017	4	37

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

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #		Cost Reported	Actual Cost to the Related Party
		Yes	No	%**					
Preferred Therapy Solutions	850 Silas Deane Highway, Wethersfield, CT 06109	☑	☐	37%	PT,OT,ST Services/Consulting	13	5a,9a,10a,12	631,676	624,001
Procare LTC Pharmacy of CT	1492 Highland Ave Cheshire CT 06410	☑	☐	92%	Drugs/OTC's/Supplies/Consulting/Fees	20/13	5a2,b,j/B3,12	217,295	194,360
NOA Diagnostics	6851 Jericho Turnpike, Suite 150 Syosset, NY 11791	☑	☐	82%	Radiology	20	5f	7,392	6,826
National Health Care Associates - Aetna	850 Silas Deane Highway, Wethersfield, CT 06109	☐	☑		Health Insurance Trust***	15	1a5	591,752	591,752
National Health Care Associates	20 East Sunrise Highway, Valley Stream, NY 11581	☐	☑		Banking Transactions	16	13	12,335	12,335
Bloomfield Healthcare Realty	20 East Sunrise Highway, Valley Stream, NY 11581	☐	☑		Rent	22	9	755,000	755,000
Maple View Manor	856 Maple St, Rocky Hill, CT 06067	☐	☑		Social Services/Fiscal Operations	13/16	B6/M13	1,837	1,837
National Health Care Associates	20 East Sunrise Highway, Valley Stream, NY 11581	☐	☑		Shared Expenses	16	12	510,095	510,095
20Sunrise	20 Sunrise Highway, Valley Stream NY 11581	☐	☑		Shared Expenses	16	12	9,565	9,565
850 Silas Deane Realty	850 Silas Deane Highway, Wethersfield, Ct 06109	☐	☑		Shared Expenses	16	12	1,740	1,740
Stauderman Realty	46 Stauderman Ave, Lynbrook, NY 11563	☐	☑		Shared Expenses	16	12	238	238

* Use additional sheets if necessary.
** Provide the percentage amount of revenue received from non-related parties.
*** Consolidated for all National Healthcare CT Facilities, control and ownership pass upon transfer of funds to insurance company manager. Information required by previous state auditor.

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	9134	9/30/2017	4	37

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

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties: Yes	No	%**	Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report: Page #	Line #	Cost Reported	Actual Cost to the Related Party
National Health Care Associates - Aetna	850 Silas Deane Highway, Wethersfield, CT 06109	☐	☑		Accounts payable	33	A1	1,696,530	1,696,530
Preferred Therapy Solutions	850 Silas Deane Highway, Wethersfield, CT 06109	☑	☐	37%	Due to Related	33	A12	1,241,023	1,241,023
NOA Diagnostics	6851 Jericho Turnpike, Suite 150 Syosset, NY 11791	☑	☐	82%	Due to Related	33	A12	3,180	3,180
National Health Care Associates	20 East Sunrise Highway, Valley Stream, NY 11581	☐	☑		Due to Related	33	A12	751,837	751,837
National Health Care Associates	20 East Sunrise Highway, Valley Stream, NY 11581	☐	☑		Due to Related (Debt)	33	A12	157,399	157,399
Maple View Center for Health & Rehabilitation	856 Maple Street, Rocky Hill, CT 06067	☐	☑		Due to Related	33	A12	1,077,761	1,077,761
Procare LTC Pharmacy of CT	1492 Highland Ave Cheshire CT 06410	☑	☐	92%	Due to Related	33	A12	475,796	475,796
Cold Spring Hills Center for Nursing & Rehabilitation	378 Syosset-Woodbury Rd, Woodbury, NY 11797	☐	☑		Due to Related	33	A12	32,287	32,287
Milford Health Care Center, Inc.	195 Platt Street, Milford,CT 06460	☐	☑		Due to Related	33	A12	10,009	10,009

* Use additional sheets if necessary.
** Provide the percentage amount of revenue received from non-related parties.
*** Consolidated for all National Healthcare CT Facilities, control and ownership pass upon transfer of funds to insurance company manager. Information required by previous state auditor.

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	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.

Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.

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.

N/A

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Reliable Health Systems, Nostrand Ave, Brooklyn, NY 11230	○	⊙	Computer Equipment	10/01/08	60 / ongoing	3,708	3,708
Wescom Solutions, PO Box 674802, Detroit, MI 48267	○	⊙	Software	03/07/12	Ongoing	20,214	20,214
Leaf, P.O. Box 644006, Cincinnati, OH 45264	○	⊙	Copier	01/01/16	39 months	4,588	4,588
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ○ No **Total ***** 28,510

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
** Attach copies of newly acquired leases.
*** Amount should agree to Page 22, Line 6e.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of C	913-C	9/30/2017	7	37

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Blum Shapiro	2 Enterprise Drive, Shelton, CT 06484
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Compilation, preparation of Medicare and Medicaid cost reports, and year end tax services	$ 24,130
2		$
3		$
4		$
		Charge for Services Provided $ 24,130

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	Telephone Number
1 See attachment.	
2	
3	
4	
5	

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	See attachment.	$ 59,197
2		$
3		$
4		$
5		$
		Charge for Services Provided $ 59,197

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	9134	9/30/2017	7	37

Legal Services Information

	Name of Legal Firm or Independent Attorney	Telephone Number
1	Tomar Cooper	
2	Berchem & Moses, P.C.	(203)-783-1200
3	Treasurer State of Connecticut	
4	Amerassist	
5	Goldman Gruber & Wood	(203)-899-8900
6	Jackson Lewis PC	(631)-247-0404
7	Murtha Cullina	(860) 240-6000

	Address (*No. & Street, City, State, Zip Code*)
1	
2	75 Broad Street Milford, CT. 06460
3	Hartford, CT 06106
4	2400 Veterans Blvd Suite 300 Kenner LA 70062
5	200 Connecticut Avenue, Norwalk, CT 06854
6	58 South Service Rd Suite Melville, NY 11747
7	Dept.101011 PO Box 150435 Hartford, CT 06115-0435

	Services Provided by This Firm (*describe fully*)	
1	Labor	$ 2,500
2	Labor	$ 4,330
3	Conservator - Disallowed	$ 550
4	Collections - Disallowed	$ 44
5	Collections - Disallowed	$ 27,111
6	Labor	$ 20,580
7	Disallowed	$ 4,082
		Charge for Services Provided
		$ 59,197

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

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	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	120	120			120	120			120	120		
B. On last day of THIS report period	120	120			120	120			120	120		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	102	102			102	102			92	92		
B. As of midnight of THIS report period	97	97			92	92			97	97		
3. Total Number of Days Care Provided During Period												
A. Medicare	3,598	3,598			2,768	2,768			830	830		
B. Medicaid (Conn.)	30,046	30,046			22,346	22,346			7,700	7,700		
C. Medicaid (other states)												
D. Private Pay	682	682			666	666			16	16		
E. State SSI for RCH												
F. Other (Specify) Managed Care	120	120			108	108			12	12		
G. Total Care Days During Period (3A thru F)	34,446	34,446			25,888	25,888			8,558	8,558		
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)**	34,446	34,446			25,888	25,888			8,558	8,558		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	9	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	(Specify)	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	12	80		5				
Per Diem Rate								
a. One bed rm.	PPS	246.46		409.00				
b. Two bed rms.	PPS	246.46		380.00				
c. Three or more bed rms.	PPS							

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	4,320	4,320		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	1,678	1,678		
C. Other	9,164	9,164		
D. ***Total Physical Therapy Treatments***	15,162	15,162		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	328	328		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	155	155		
C. Other	1,089	1,089		
D. ***Total Speech Therapy Treatments***	1,572	1,572		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	3,179	3,179		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	1,321	1,321		
C. Other	10,604	10,604		
D. ***Total Occupational Therapy Treatments***	15,104	15,104		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	10	37

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	119,649	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	196,093	8,650				
5. Dietary Service						
a. Head Dietitian	30,233	864				
b. Food Service Supervisor	55,613	2,038				
c. Dietary Workers	352,627	20,843				
6. Housekeeping Service						
a. Head Housekeeper	55,724	2,080				
b. Other Housekeeping Workers	195,004	12,664				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	66,044	2,233				
b. Other Maintenance Workers	19,095	1,410				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	140,473	8,269				
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	180,031	3,357				
b. RN						
1. Direct Care	407,085	10,820				
2. Administrative**	82,804	2,015				
c. LPN						
1. Direct Care	971,301	34,417				
2. Administrative**						
d. Aides and Attendants	1,528,266	89,623				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	117,274	4,955				
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	137,528	4,256				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	4,654,844	210,574				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Therapy Consulting - Nursing	$ 11,475	Disallowed				
Therapy Consulting - Rehab Therapy and Ancillary	$ 11,528	Disallowed				
Total	$ 23,003	Disallowed	$ -	-	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	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										
Marvin J. Ostreicher, 184 Wildacre Ave, Lawrence, NY 11559				same as employees	Supervises operations, deals with DNS & financial management	55	p.16/ m13 - $20,800	See attached		
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.

MARVIN J. OSTREICHER - OWNER
TIME STUDY
YEAR END SEPTEMBER 30, 2017

Name	Beds	Total w/ Bnft
Augusta	72	53.82
Belair	102	52.61
Bethel	161	76.49
Bloomfield	120	55.03
Brattleboro	80	58.96
Brentwood	78	36.58
Brewer	111	67.73
Bristol	132	64.40
Cambridge	160	45.65
Catskill	136	51.40
Cold Spring Hills	-	-
Colony	92	44.44
Country	111	43.24
Dover	112	61.98
Eastside	69	48.07
Eliot	114	68.33
Glen Falls	120	48.68
Hudson	-	-
Huntington	320	54.42
Kennebunk	78	55.63
Hebrew Home	257	60.77
Ludlowe	144	65.00
Maple View	120	59.26
Marlborough	120	60.47
Maywood	120	47.47
Milford	120	52.00
Newton Wellseley	110	54.42
Norway	70	53.51
Poughkeepsie	200	63.19
Regency	130	48.68
Reservoir	144	53.51
Riverside	345	50.19
Ross	135	-
Rutland	125	55.93
Sachem	111	59.56
Sands Point	180	67.42
Utica	117	54.42
Village Crest	95	48.38
Water's Edge	150	57.75
Westgate	104	52.00
Winship	72	51.10
Total	5,137	2,102.50

Vacation
Sick
Personal
Holiday

Total Hours

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	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* **										
Carol Green (10/1/17-4/14/17)	71,360			same as employees	Management and Supervision of a healthcare facility	1,176	a2			
Penni Martin (4/15/17-5/11/17) - employee of management co. - no salary directly from entity				same as employees	Management and Supervision of a healthcare facility	160	a2			
Kimberly Coleman (5/12/17-9/30/17)	48,289			same as employees	Management and Supervision of a healthcare facility	744	a2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	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	8,268	Disallowed				
3. Pharmacist	10,092	Disallowed				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	280,736	4,723				
b. Other						
6. Social Worker	1,020	50				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	36,300	84				
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)						
9. Speech Therapist						
a. Resident Care	57,870	778				
b. Other						
10. Occupational Therapist						
a. Resident Care	285,644	5,567				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	64,804	667				
2. Administrative***						
b. LPN						
1. Direct Care	783	18				
2. Administrative***						
c. Aides						
d. Other	610	24				
12. Other (Specify)						
See Attached Schedule	23,003	Disallowed				
B-13 Total Fees Paid in Lieu of Salaries	769,130	11,911				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Gerident Solutions - P.O. Box 290539, Wethersfield, CT 06129	Dentist	○	⊙	
Dr Santo Buccheri - 357 Franklin Ave, Hartford, CT 06114	Medical Director	○	⊙	
Swallowing Diagnostics - PO Box 484, Avon, CT 06001	ST	○	⊙	
Procare LTC of CT - 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist / Consult nursing	⊙	○	Common Ownership
Preferred Therapy - 809 Main St., E. Hartford, CT 06108	PT, OT, ST / Consult Rehab	⊙	○	Common Ownership
Ready Nurse - 2602 Highland Blvd, N. Palm Harbor, FL 34684	C.N.A	○	⊙	
The Nurse Network - 653 Main St, Plantsville, CT 06479	RN & LPN	○	⊙	
360 Healthcare Staffing - PO Box 674009, Dallas, TX 75267-4009	RN	○	⊙	
Maxim Staffing Solutions - 12558 Collections Center Drive. Chicago, Il 60693	RN	○	⊙	
Maple View Health & Rehabilitation Center - 856 Maple Street. Rocky Hill, CT 06067	Social Worker	⊙	○	Affilidated Entity
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	295,915	295,915		
2. Disability Insurance	$				
3. Unemployment Insurance	$	69,164	69,164		
4. Social Security (F.I.C.A.)	$	356,132	356,132		
5. Health Insurance	$	593,597	593,597		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$				
(not-owners and not-operators)					
8. Uniform Allowance	$	31,468	31,468		
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	24,130	24,130		
e. Legal (*Services should be fully described on Page 7)*	$	59,197	59,197		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	17,986	17,986		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	20,821	20,821		
2. Cellular Phones	$	1,315	1,315		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$	250	250		
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	648,425	648,425		
Subtotal	$	2,118,400	2,118,400		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,118,400	2,118,400		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	821	821		
3. Gifts to Staff and Residents	$	2,830	2,830		
4. Employee Travel	$	544	544		
5. Education Expenses Related to Seminars and Conventions	$	795	795		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	10,939	10,939		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	12,163	12,163		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	2,565	2,565		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	8,849	8,849		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	375	375		
9. Subscriptions	$	121	121		
10. Contributions***	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$	502,649	502,649		
13. Other (*Specify*)	$	188,243	188,243		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,849,294	2,849,294		

* 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)
Promotional Advertising - Disallowed	$ 12,163		
Total Other Advertising	$ 12,163	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 8,539		
ACHCA	$ 310		
Total Dues	$ 8,849	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank charges - disallowed	$ 22,132		
Licenses & permits	$ 1,561		
Miscellaneous expenses - disallowed	$ 16,114		
Purchased Services - Admin Staff	$ 20,800		
Penalties- disallowed	$ 40,323		
Consulting Fees - Fiscal Operations	$ 23,095		
Background Check - Security	$ 207		
Crime Insurance - disallowed	$ 185		
Purchased Services - Fiscal Operations	$ 21,439		
Background Check - Admin	$ 4,066		
IT Services - Administration	$ 30,132		
Consulting Fees - Administration - Disallowed via management fee	$ 8,189		
Total Other Administrative and General	$ 188,243	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of CT, LL(	913-C	9/30/2017	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 #
National Healthcare Associates, Inc.	502,649	See Attached	page 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.**

National Health Care
Profit and Loss Allocated by GL Account

Start Date: 10/1/2016
End Date: 9/30/2017

		0101 Bloomfield	0102 Bristol	0103 Cambridge	0104 Ludlowe	0105 Maple View Manor	0106 Marlborough	0107 Milford	0108 New Milford	0109 Regency	0110 Riverside	0112 Water's Edge	0113 Bethel Health and Rehabilitation Center	0114 HEBREW HOME
300001-0000-00-000-0	TROY Shared Cost	(3,082.11)	(3,390.21)	(4,109.29)	(3,698.60)	(3,082.11)	(3,082.11)	(3,082.11)	(2,439.75)	(3,338.75)	(8,861.25)	(3,852.66)	(5,214.41)	(4,920.43)
391500-0000-00-000-0	Misc. Other Income-Nat. Mgmt.- - -	(230.77)	(253.85)	(307.69)	(276.93)	(230.77)	(230.77)	(230.77)	(182.66)	(249.96)	(663.47)	(288.48)	(390.42)	(494.21)
400000-0000-00-000-0	Salary-National Healthcare Management- - -	315,626.39	347,189.87	416,571.18	378,754.68	315,626.39	315,626.39	315,626.39	251,580.28	344,284.39	907,444.85	394,532.95	539,945.39	510,738.73
401000-0000-04-000-0	FICA-National Healthcare Management-Fiscal Ope- -	20,604.17	22,664.72	27,084.42	24,725.44	20,604.17	20,604.17	20,604.17	16,511.41	22,595.70	59,238.55	25,755.42	35,585.87	35,056.66
401100-0000-04-000-0	FUI-National Healthcare Management-Fiscal Oper- -	91.21	100.31	120.44	109.45	91.21	91.21	91.21	72.19	98.81	262.25	114.01	156.06	184.12
401200-0000-04-000-0	SUI-National Healthcare Management-Fiscal Oper- -	1,334.59	1,468.09	1,754.79	1,601.56	1,334.59	1,334.59	1,334.59	1,055.97	1,445.10	3,837.06	1,668.31	2,274.74	2,740.85
401201-0000-00-000-0	SUI - NY-National Healthcare Management- - -	(102.24)	(112.46)	(136.33)	(122.72)	(102.24)	(102.24)	(102.24)	(80.96)	(110.78)	(293.99)	(127.83)	(172.98)	(109.49)
401250-0000-00-000-0	NY MTA Tax-Nat. Mgmt.- - -	596.40	656.05	779.98	715.79	596.40	596.40	596.40	480.35	657.42	1,714.83	745.53	1,039.96	964.66
401300-0000-04-000-0	Health Insurance-National Healthcare-Fiscal Op- -	33,107.00	36,417.24	44,141.92	39,730.92	33,107.00	33,107.00	33,107.00	26,207.09	35,864.31	95,186.98	41,386.05	56,027.91	57,068.30
401400-0000-04-000-0	Workers Compensation-National Health-Fiscal Op- -	2,355.62	2,591.29	3,140.82	2,826.94	2,355.62	2,355.62	2,355.62	1,864.50	2,551.68	6,772.78	2,944.77	3,985.43	5,044.92
401500-0000-04-000-0	Medical Benefits-National Healthcare-Fiscal Op- -	(7.67)	(8.44)	(10.23)	(9.20)	(7.67)	(7.67)	(7.67)	(6.07)	(8.31)	(22.05)	(9.59)	(12.98)	(16.43)
401600-0000-04-000-0	Disability Expense-National Healthca-Fiscal Op- -	(91.06)	(100.12)	(121.39)	(109.29)	(91.06)	(91.06)	(91.06)	(72.05)	(98.64)	(261.82)	(113.84)	(154.04)	(133.07)
401700-0000-04-000-0	Pension-National Healthcare Manageme-Fiscal Op- -	6,418.84	7,060.44	8,558.00	7,702.73	6,418.84	6,418.84	6,418.84	5,081.06	6,953.32	18,454.51	8,023.53	10,859.59	10,007.07
401800-0000-04-000-0	Employee Benefits - Other-National H-Fiscal Op- -	708.47	779.27	944.60	850.19	708.47	708.47	708.47	560.82	767.42	2,036.84	885.57	1,198.07	1,118.67
402000-0000-04-000-0	Holiday Expense-National Healthcare -Fiscal Op- -	106.86	117.55	142.46	128.21	106.86	106.86	106.86	84.59	115.76	307.20	133.55	180.77	74.55
410000-0000-04-000-0	Supplies-National Healthcare Managem-Fiscal Op- -	2,856.68	3,142.36	3,808.96	3,428.12	2,856.68	2,856.68	2,856.68	2,261.43	3,094.65	8,213.37	3,570.94	4,791.09	5,014.89
410000-0000-08-000-0	Supplies-National Healthcare Managem-Maintenan- -	10.69	11.75	14.25	12.82	10.69	10.69	10.69	8.47	11.60	30.73	13.35	18.09	0.70
410000-0000-09-000-0	Supplies-National Healthcare Managem-Housekeep- -	22.52	24.76	30.00	27.01	22.52	22.52	22.52	17.84	24.36	64.72	28.15	40.42	42.47
411000-0000-04-000-0	Food-National Healthcare Management-Fiscal Ope- -	27.76	30.52	37.01	33.33	27.76	27.76	27.76	21.96	30.08	79.83	34.69	46.97	35.88
431000-0000-03-000-0	Consulting Fees-National Healthcare -Administr- -	18.03	19.84	24.04	21.64	18.03	18.03	18.03	14.27	19.53	51.84	22.54	30.51	38.62
431000-0000-04-000-0	Consulting Fees-National Healthcare -Fiscal Op- -	8,620.19	9,481.77	11,493.28	10,344.69	8,620.19	8,620.19	8,620.19	6,823.93	9,338.21	24,783.91	10,775.60	14,401.14	12,800.60
432000-0000-03-000-0	Accounting Fees-National Healthcare -Administr- -	541.16	595.30	721.49	649.41	541.16	541.16	541.16	428.36	586.30	1,555.96	676.47	915.53	749.23
433000-0000-03-000-0	Legal Fees-National Healthcare Manag-Administr- -	8,472.34	9,319.49	11,296.21	10,167.38	8,472.34	8,472.34	8,472.34	6,706.49	9,177.86	24,359.05	10,590.96	14,331.19	14,974.30
440000-0000-03-000-0	Purch Services-National Healthcare M-Administr- -	11,050.58	12,155.52	14,733.60	13,261.53	11,050.58	11,050.58	11,050.58	8,747.49	11,970.89	31,771.33	13,813.66	18,696.03	18,753.34
440000-0000-08-000-0	Purch Services-National Healthcare M-Maintenan- -	4,060.58	4,466.78	5,414.06	4,872.98	4,060.58	4,060.58	4,060.58	3,214.16	4,398.65	11,674.64	5,076.06	6,869.97	7,797.89
440000-0000-09-000-0	Purch Services-National Healthcare M-Housekeep- -	1,489.60	1,638.50	1,986.19	1,787.73	1,489.60	1,489.60	1,489.60	1,179.29	1,613.64	4,282.82	1,862.18	2,520.33	2,368.28
440000-0000-12-000-0	Purch Services-National Healthcare Ma-Security- -	3.49	3.83	4.65	4.18	3.49	3.49	3.49	2.76	3.78	10.03	4.36	5.90	7.47
440001-0000-08-000-0	Ground Services-Nat. Mgmt.-Maintenance- -	18.25	20.07	24.33	21.89	18.25	18.25	18.25	14.42	19.77	52.43	22.81	30.84	27.68
441000-0000-03-000-0	Computer Expense-National Healthcare-Administr- -	12,976.69	14,274.04	17,301.36	15,572.95	12,976.69	12,976.69	12,976.69	10,272.48	14,057.75	37,308.86	16,221.30	21,685.61	18,439.19
442000-0000-08-000-0	Pest Control-Nat. Mgmt.-Maintenance- -	8.17	8.98	10.89	9.80	8.17	8.17	8.17	6.47	8.85	23.49	10.21	13.82	
452000-0000-25-000-0	Equipment Rental-National Healthcare-Fiscal Op- -	2,879.22	3,166.92	3,838.70	3,455.18	2,879.22	2,879.22	2,879.22	2,279.21	3,119.01	8,277.99	3,599.21	4,871.10	4,482.71
461000-0000-03-000-0	Telephone-National Healthcare Manage-Administr- -	3,831.96	4,215.02	5,109.25	4,598.59	3,831.96	3,831.96	3,831.96	3,033.57	4,151.25	11,017.47	4,790.27	6,483.10	5,691.40
461100-0000-03-000-0	Telephone - Cell-National Healthcare-Administr- -	1,779.85	1,957.75	2,373.00	2,135.85	1,779.85	1,779.85	1,779.85	1,408.86	1,928.03	5,117.10	2,224.80	3,004.55	2,866.05
462000-0000-25-000-0	Electric-National Healthcare Manageme-Property- -	2,842.62	3,126.81	3,790.05	3,411.30	2,842.62	2,842.62	2,842.62	2,250.29	3,079.44	8,172.84	3,553.35	4,809.26	4,075.05
463000-0000-25-000-0	Gas-National Healthcare Management-Property- -	286.27	314.91	381.68	343.56	286.27	286.27	286.27	226.63	310.10	823.08	357.86	484.34	512.52
466000-0000-25-000-0	Water-National Healthcare Management-Property- -	125.39	137.94	167.19	150.50	125.39	125.39	125.39	99.25	135.83	360.51	156.75	212.16	197.85
471000-0000-25-000-0	Rent-National Healthcare Management-Property- -	11,904.14	13,093.27	15,871.29	14,285.51	11,904.14	11,904.14	11,904.14	9,424.58	12,896.53	34,225.14	14,880.11	20,139.49	12,476.79
472000-0000-25-000-0	Personal Property Taxes-National Hea-Fiscal Op- -	1,061.56	1,167.79	1,415.52	1,273.89	1,061.56	1,061.56	1,061.56	840.35	1,150.01	3,052.09	1,326.90	1,795.85	2,207.16
473000-0000-25-000-0	Real Estate Taxes-National Healthcar-Fiscal Op- -	3,443.49	3,788.25	4,591.57	4,132.72	3,443.49	3,443.49	3,443.49	2,725.32	3,729.98	9,900.97	4,305.09	5,826.20	9,261.26
484000-0000-04-000-0	Amort Exp - LHI-National Healthcare -Fiscal Op- -	2,516.86	2,768.45	3,355.70	3,020.36	2,516.86	2,516.86	2,516.86	1,992.36	2,726.52	7,236.24	3,146.16	4,258.13	3,941.29
486000-0000-04-000-0	Dep Exp - Moveable Equip-National He-Fiscal Op- -	11,227.34	12,349.82	14,969.42	13,473.47	11,227.34	11,227.34	11,227.34	8,887.35	12,162.26	32,279.85	14,034.76	18,994.98	19,585.47
491000-0000-03-000-0	Dues and Subscriptions-National Heal-Administr- -	923.05	1,015.35	1,230.71	1,107.72	923.05	923.05	923.05	730.65	999.93	2,653.89	1,153.87	1,561.71	1,636.89
500000-0000-03-000-0	Licenses and Permits-National Health-Administr- -	581.40	639.59	775.21	697.74	581.40	581.40	581.40	460.20	629.82	1,671.67	726.81	983.64	1,079.59
501000-0000-03-000-0	Advertising Employment-National Heal-Administr- -	5,904.90	6,494.59	7,872.45	7,085.66	5,904.90	5,904.90	5,904.90	4,674.72	6,396.87	16,976.31	7,380.55	9,989.70	5,795.97
501100-0000-03-000-0	Advertising Promotional-National Hea-Administr- -	6,751.42	7,426.73	9,002.04	8,102.13	6,751.42	6,751.42	6,751.42	5,344.56	7,313.87	19,411.29	8,439.87	11,380.63	10,816.81
503000-0000-03-000-0	Interest-National Healthcare Managem-Administr- -	2,273.15	2,500.56	3,030.81	2,728.05	2,273.15	2,273.15	2,273.15	1,799.44	2,462.54	6,535.70	2,841.61	3,846.98	3,787.91
503500-0000-03-000-0	Penalties-National Healthcare Manage-Administr- -													
503600-0000-03-000-0	Bank Charges-Nat. Mgmt.-Administration- -	1,390.29	1,529.34	1,853.69	1,668.44	1,390.29	1,390.29	1,390.29	1,100.51	1,506.09	3,997.26	1,737.92	2,352.16	2,304.72
504000-0000-03-000-0	Postage-National Healthcare Manageme-Administr- -	1,028.24	1,131.09	1,370.92	1,233.97	1,028.24	1,028.24	1,028.24	813.92	1,113.82	2,956.35	1,285.36	1,739.60	1,917.74
509000-0000-03-000-0	Seminars-National Healthcare Managem-Administr- -	580.46	638.51	773.95	696.66	580.46	580.46	580.46	459.55	628.81	1,668.93	725.66	981.20	904.13
510000-0000-03-000-0	Liability Insurance-National Healthc-Administr- -	2,222.62	2,444.82	2,963.43	2,667.30	2,222.62	2,222.62	2,222.62	1,759.39	2,407.73	6,390.26	2,778.40	3,760.36	3,648.18
511000-0000-03-000-0	Auto Insurance-National Healthcare M-Administr- -	1,464.24	1,610.68	1,952.30	1,757.20	1,464.24	1,464.24	1,464.24	1,159.11	1,586.22	4,209.98	1,830.43	2,477.33	2,517.47
512000-0000-03-000-0	Umbrella Insurance-National Healthca-Administr- -	1,199.48	1,319.43	1,599.27	1,439.48	1,199.48	1,199.48	1,199.48	949.48	1,299.36	3,448.64	1,499.41	2,029.36	2,047.90
513000-0000-03-000-0	Crime Insurance-National Healthcare -Administr- -	67.24	73.99	89.66	80.71	67.24	67.24	67.24	53.23	72.86	193.35	84.07	113.74	125.48
517000-0000-03-000-0	Wor`kmans Comp Insurance-National	1,245.82	1,370.25	1,660.94	1,494.91	1,245.82	1,245.82	1,245.82	986.23	1,349.58	3,581.65	1,557.19	2,107.67	1,318.23
520000-0000-03-000-0	Auto Expense-National Healthcare Man-Administr- -	1,940.32	2,134.10	2,586.87	2,328.27	1,940.32	1,940.32	1,940.32	1,536.21	2,102.07	5,578.30	2,425.16	3,282.49	1,300.95
520100-0000-03-000-0	Auto Lease Expense-National Healthca-Administr- -	3,326.39	3,658.73	4,434.78	3,991.57	3,326.39	3,326.39	3,326.39	2,633.34	3,603.08	9,563.31	4,157.82	5,641.63	4,606.91
521000-0000-00-000-0	Travel Expense-Nat. Mgmt.- - -	11.04	12.14	14.72	13.24	11.04	11.04	11.04	8.74	11.95	31.74	13.79	18.67	23.63
521000-0000-03-000-0	Travel Expense-National Healthcare M-Administr- -	7,274.81	8,002.45	9,699.71	8,730.06	7,274.81	7,274.81	7,274.81	5,758.52	7,880.71	20,915.97	9,093.90	12,267.84	12,259.94
522000-0000-03-000-0	Hotel Expense-National Healthcare Ma-Administr- -	6,265.22	6,891.68	8,353.42	7,518.61	6,265.22	6,265.22	6,265.22	4,959.41	6,786.92	18,013.18	7,831.80	10,599.82	10,784.74
541000-0000-03-000-0	Misc. Expense-Nat. Mgmt.-Administration- -	117.75	129.52	157.02	141.31	117.75	117.75	117.75	93.18	127.51	338.47	147.19	199.22	370.50
541000-0000-31-000-0	Misc. Expense-National Healthcare Ma-Misc. Exp- -	(973.14)	(1,070.55)	(1,297.65)	(1,167.88)	(973.14)	(973.14)	(973.14)	(770.27)	(1,054.09)	(2,798.09)	(1,216.71)	(1,643.72)	(2,586.93)
541001-0000-03-000-0	Political Contributions-Nat. Mgmt.-Administrat- -	12.21	13.43	16.28	14.65	12.21	12.21	12.21	9.67	13.23	35.10	15.26	20.65	13.07
542000-0000-31-000-0	Corporate Tax - State-National Healt-Misc. Exp- -	169.94	186.94	226.59	203.94	169.94	169.94	169.94	134.52	184.10	488.59	212.44	287.51	233.36
544000-0000-25-000-0	Sales Tax - Conn.-National Healthcar-Fiscal Op- -	0.00	7,216.97	8,747.91	7,873.27	0.00	0.00	0.00	5,194.14	7,108.03	18,862.83	8,201.34	11,099.29	7,905.23
	Misc. variance	(2,449.44)	(3,807.40)	(2,941.05)	(4,154.98)	(2,449.44)	(2,449.44)	(2,449.44)	(3,092.88)	(7,341.25)		(4,327.62)	(8,341.42)	2,407.09
Total														
		510,838.54	568,023.13	685,491.35	619,677.59	510,838.54	510,838.54	510,838.54	410,359.93	558,462.11	1,494,604.24	645,491.34	877,341.62	838,892.50
	Page 16 line M12	502,649.00	560,296.00	672,061.00	607,612.00	501,141.00	503,724.00	500,784.00	397,514.00	544,850.00	1,463,850.55	633,369.00	852,211.00	823,994.00
	Page 16 line M13	8,189.30	7,727.20	13,430.55	12,065.44	9,697.91	7,114.31	10,054.26	12,845.97	13,612.08	30,753.35	12,122.80	25,120.51	14,898.12

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

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	265,914	265,914		
2. Non-Food Supplies	$	25,873	25,873		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	291,787	291,787		

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

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ 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.

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

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	5,458	5,458		
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)*	$	18	18		
c. Management Services**	$				
d. Other (*Specify*) Diapers - $39,179 Supplies - $7,161	$	46,340	46,340		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	51,816	51,816		

3F.	Laundry Questionnaire			
G.	Is cost of employee laundry included in 3E?	○ Yes	⊙ No	If yes, specify cost.
H.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report?			(Page/Line Item)
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	○ Yes	⊙ No	If yes, specify cost.
K.	Did you receive revenue from these people?	○ Yes	⊙ 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	28,608	28,608		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*		$				
d. Other (*Specify*)		$	2,888	2,888		
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	31,496	31,496		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from PCA		$	169,454	169,454		
b. Medicine Cabinet Drugs		$	29,495	29,495		
c. Medical and Therapeutic Supplies		$	117,355	117,355		
d. Ambulance/Limousine***		$	5,442	5,442		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	21,944	21,944		
f. X-rays and Related Radiological Procedures***		$	8,987	8,987		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	15,550	15,550		
i. Recreation		$	32,190	32,190		
j. Other (Specify)**** See Attached Schedule		$	46,475	46,475		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	446,892	446,892		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Equipment Rental - Nursing	$ 22,567		
Equip Rental - Rehab/Therapy	$ 15,506		
Flu Vaccine	$ 3,915		
IV Thy Supplies - Rehab Therapy and Ancillary	$ 4,024		
Nursing Purchased Services	$ 463		
Total Other Resident Care	$ 46,475	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	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
ADM Environmental Group	Avenue, Brooklyn, NY 11230	○	⊙		Waster Service/ Monthly Recycling Service	25,543			22	6f
ADP	P.O. Box 842875, Boston, MA 02284	○	⊙		Payroll Processing	10,359			16	m13
M.J Daly & Sons	110 Mattatuck HTS, Waterbury CT 06705	○	⊙		HVAC	38,373			22	6A
Eagle Rivet Roof Service Corporation	15 Britton Drive Bloomfield, CT 06002	○	⊙		Roof Repair	10,087			22	6A
Xtreme Landscaping	40 Stark Drive East Granby, CT 06026	○	⊙		Landscaping/ Snow Removal	14,192			22	6F
Intergrated Health Systems	PO Box 23072 Overland Park, KS 66283	○	⊙		Computer Maintenance System	11,155			16	m13
Fire Tech	486 Derby Ave West Haven CT 06516	○	⊙		Fire Alarm Testing	11,794			22	6F
Ecolab Inc.	24673 Network Place Chicago IL 60673	○	⊙		Dietary Equipment Repair	17,135			22	6A
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* List all contracted services over $10,000. Use additional sheets if necessary.
** Refer to Page 4 for definition of related.
*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended	Page
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Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	126,754	126,754		
b. Heat	$	58,096	58,096		
c. Light & Power	$	120,422	120,422		
d. Water	$	24,860	24,860		
e. Equipment Lease (*Provide detail on page 6*)	$	28,510	28,510		
f. Other (*itemize*)	$	60,743	60,743		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	419,385	419,385		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	1,155	1,155		
d. Movable Equipment	$	49,337	49,337		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	50,492	50,492		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	71,608	71,608		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	71,608	71,608		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	755,000	755,000		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	105,508	105,508		
c. Personal property taxes	$	10,054	10,054		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	992,662	992,662		

* 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)
Pest Control	$ 3,594		
Plowing/Landscaping	$ 14,192		
Security	$ 12,718		
Carting	$ 28,605		
IT Rentals	$ 600		
Short Term Lease - Pitney Bowes Mailing Machine	$ 1,034		
Total Other Repairs and Maintenance	$ 60,743	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	5,657,365		5,657,365					
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	60,024		60,024	54,928	SL	30	1,155	
2. Disposals (attach schedule)	(23,658)			(23,658)				
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								1,155

	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					613,683		613,683	339,755	SL	Various	34,795	
b. Disposals (attach schedule)					(276,941)			(276,941)	SL	Various		
c. Acquired during this report period (attach schedule)					183,752		183,752		SL	Various	14,542	
D-3. Subtotal												49,337
E. ***Total Depreciation***												50,492

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Schedule of Land Improvements Acquired during this report period

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

***Ties to Page 23, Line A3**
****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

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

***Ties to Page 23, Line B3**
****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Non-Movable Equipment		$ -		$ -	*
Deletions:					
9/30/2017	Disposal of fully depreciated non-moveable equipment	$ (23,658)			
Total deletions for Non-Movable Equipment		$ (23,658)		$ -	**

***Ties to Page 23, Line C3**
****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/17/2016	Culinary Depot- Ice Maker Equipment	$ 2,810	10	$ 281	
12/19/2016	SWAN Assoc- 14800 BTU Chassis	$ 1,958	10	$ 163	
1/12/2017	Culinary Depot- Ice Maker	$ 5,725	10	$ 429	
3/3/2017	PC Connection_Monitor	$ 903	5	$ 105	
4/6/2017	McKesson-E Pump	$ 509	10	$ 25	
5/5/2017	PC Connection_Monitor	$ 1,095	5	$ 91	
5/16/2017	Daniels Equip CO- UniMac Dryer	$ 1,009	10	$ 42	
5/23/2017	McKesson- Medical Pump	$ 509	10	$ 21	
5/31/2017	Computer Equipment Entry	$ 157,399	5	$ 13,117	
6/30/2017	Daniels' _ UNI Dryer	$ 4,358	10	$ 145	
7/31/2017	PC Connect-Laptop	$ 224	5	$ 11	
8/31/2017	Ecolab- Steam Well Unit	$ 3,201	10	$ 53	
9/30/2017	PC Connection- 12 PCs	$ 3,034	5	$ 51	
9/30/2017	McKesson- E Pump	$ 1,018	10	$ 8	
Total additions for Movable Equipment		$ 183,752		$ 14,542	*
Deletions:					
9/30/2017	Disposal of fully depreciated moveable equipment	$ (276,941)			
Total deletions for Movable Equipment		$ (276,941)		$ -	**

***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:					
11/3/2016	Magnum-Corner Guards	$ 2,943	10	$ 270	
12/14/2016	SWAN Assoc-Heat Actuators	$ 2,573	15	$ 143	
3/13/2017	Done Right-Painting of Unit	$ 1,170	5	$ 137	
3/30/2017	Magnum Ind-Bumpers	$ 1,472	5	$ 172	
4/13/2017	Highland Orchard Construction	$ 900	20	$ 45	
5/26/2017	Hartford Sprinkler Co-Sprinkler System	$ 12,197	10	$ 508	
5/30/2017	RainTech-Wander Guard	$ 3,720	10	$ 155	
5/30/2017	RainTech-Wander Guard	$ 3,720	10	$ 155	
6/30/2017	Magnum-Corner Guards	$ 1,470	10	$ 49	
8/31/2017	Highland Orchard-Stairs	$ 1,100	10	$ 18	
9/30/2017	MJ Daly-Motor Capacitor	$ 1,200	10	$ 10	
Total additions for Leasehold Improvement		$ 32,465		$ 1,662	*
Deletions:					
9/30/2017	Disposal of fully depreciated leasehold improvements	$ (50,870)			
Total deletions for Leasehold Improvement		$ (50,870)		$ -	**

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period			Various	869,964	367,842	SL		69,946	
2. Disposals (attach schedule)			Various	(50,870)	(50,870)	SL			
3. Acquired during this report period (attach schedule)			Various	32,465		SL		1,662	
C-4. Subtotal									71,608
D. ***Total Amortization***									71,608

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, I	913-C	9/30/2017	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ○ Yes ⊙ No

If "Yes," complete Part B.
If "No," complete Part C.

*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	120
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)	Fixed			
b. Date Mortgage Obtained	07/01/02			
c. Interest Rate for the Cost Year	7.33%			
d. Term of Mortgage (number of years)	15			
e. Amount of Principal Borrowed	8,226,480			
f. Principal balance outstanding as of 9/30/17	2,858,691			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of CT,	913-C	9/30/2017	26 | 37

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

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of C	913-C	9/30/2017	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				
12. C. Movable Equipment				
1. Automotive Equipment $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*) $	7,018	7,018		
A. Item: Equipment Loan - Various / Rate: 4-5% / Amount: 7,018				
Lender: M&T Bank				
Address of Lender: PO Box 62176, Baltimore MD 21264				
B. Item / Rate / Amount				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $	7,018	7,018		
12. D. Other Interest Expense (*Specify*) $	5,248	5,248		
Admin interest				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	12,266	12,266		
14. Insurance				
a. Insurance on Property (buildings only) $	10,700	10,700		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	8,736	8,736		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $	33,426	33,426		
Liability Insurance				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	52,862	52,862		
15. ***Total All Expenditures (A-13 thru C-14)*** $	10,572,434	10,572,434		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	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.	10	12M	Salaries not related to Resident Care	$	13,724	13,724		
3.			Occupational Therapy	$				
4.			Other - See attached Schedule	$				
Page 13 - Professional Fees								
5.	13	B8c	Resident Care Physicians **	$				
6.	13	B10a	Occupational Therapy	$	285,644	285,644		
7.			Other - See attached Schedule	$	63,806	63,806		
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.			Bad Debts	$				
10.	15	1e	Accounting & Legal	$	31,787	31,787		
11.			Telephone	$				
12.	15	1h2	Cellular Telephone	$	595	595		
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 *	$	12,163	12,163		
19.	15	1j	Income Tax / Corporate Business Tax	$	250	250		
20.			Fund Raising / Contributions	$				
21.	16	m12	Unallowable Management Fees	$	270,760	270,760		
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	85,928	85,928		
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)	$	764,658	764,658		

* 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	B2	Dentist	$ 8,268		
13	B3	Pharmacist	$ 10,092		
13	B12	Therapy Consulting - Nursing	$ 11,475		
13	B12	Therapy Consulting - Rehab Therapy and Ancillary	$ 11,528		
13	B8a	Excess Disallowed of Medical Director Salary	$ 22,443		
Total Other Fees Adjustments			$ 63,806	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
15	Misc	Benefits on Salaries not Related to Resident Care	$ 3,969		
16	M13	Misc. Exp	$ 16,114		
16	M13	Bank Charge	$ 22,132		
16	M13	Crime Insurance	$ 185		
16	M8	Chamber of Commerce Dues	$ 375		
16	L3	Gifts to Staff and Residents	$ 2,830		
16	M13	Penalties	$ 40,323		
Total Other A&G Adjustments			$ 85,928	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	764,658	764,658		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $	169,454	169,454		
28.	20	5d	Ambulance/Limousine $	5,442	5,442		
29.	20	5f	X-rays, etc $	8,987	8,987		
30.	20	5h	Laboratory $	15,550	15,550		
31.	20	5c	Medical Supplies $	1,608	1,608		
32.	20	5e2	Oxygen (non emergency) $	21,944	21,944		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	62,496	62,496		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $	1,335	1,335		
36.			Depreciation on Unallowable Motor Vehicles $				
37.	22	10c	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.			Vending Machine Revenue $				
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 $	6,522	6,522		
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)*** $	1,057,996	1,057,996		

*** 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.

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Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5J	Equipment Rental - Nursing	$ 22,567		
20	5J	Equip Rental - Rehab/Therapy	$ 15,506		
20	5J	Flu Vaccine	$ 3,915		
20	5J	IV Thy Supplies - Rehab Therapy and Ancillary	$ 4,024		
20	5a2 / b	Procare Disallowance Price Markup	$ 2,349		
20	5i	Cable TV Expense - Resident Rooms	$ 13,672		
20	5J	Purchased Services - Nursing	$ 463		
Total Other Ancillary Costs			$ 62,496	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
23	2a	TV and Mattress Disallowed Depreciation Expense	$ 1,335		
Total Excess Movable Equipment Depreciation			$ 1,335	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	12D	Interest Expense	$ 5,248		
30	IV5	Interest Income	$ 117		
30	8	Misc income - other	$ 1,157		
Total Other Adjustments			$ 6,522	$ -	$ -

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LL	913-C	9/30/2017	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	10,804,309	10,804,309		
b. Medicaid Room and Board Contractual Allowance **	$	(3,847,107)	(3,847,107)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,330,718	1,330,718		
b. Medicare Room and Board Contractual Allowance **	$	500,544	500,544		
4. a. Private-Pay Residents and Other	$	953,126	953,126		
b. Private-Pay Room and Board Contractual Allowance **	$	(1,612,295)	(1,612,295)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	124,247	124,247		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(124,247)	(124,247)		
c. Prescription Drugs - Non-Medicare	$	36,850	36,850		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(34,477)	(34,477)		
2. a. Medical Supplies - Medicare	$	465	465		
b. Medical Supplies - Medicare Contractual Allowance **	$	(465)	(465)		
c. Medical Supplies - Non-Medicare	$	1,361	1,361		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(1,361)	(1,361)		
3. a. Physical Therapy - Medicare	$	443,570	443,570		
b. Physical Therapy - Medicare Contractual Allowance **	$	(329,100)	(329,100)		
c. Physical Therapy - Non-Medicare	$	76,952	76,952		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(76,293)	(76,293)		
4. a. Speech Therapy - Medicare	$	116,433	116,433		
b. Speech Therapy - Medicare Contractual Allowance **	$	(82,332)	(82,332)		
c. Speech Therapy - Non-Medicare	$	17,600	17,600		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(17,507)	(17,507)		
5. a. Occupational Therapy - Medicare	$	476,740	476,740		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(376,472)	(376,472)		
c. Occupational Therapy - Non-Medicare	$	105,899	105,899		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(69,979)	(69,979)		
6. a. Other *(Specify)* - Medicare	$	8,020	8,020		
b. Other *(Specify)* - Non-Medicare	$	944	944		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	8,426,143	8,426,143		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	117	117		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	(1,499)	(1,499)		
V. Total Other Revenue (1 thru 8)	$	(1,382)	(1,382)		
VI. Total All Revenue (III +V)	$	8,424,761	8,424,761		

* *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, line II6a	Medicare A Lab	$ 7,550		
30, line II6a	Medicare A X Ray	$ 3,898		
30, line II6a	Medicare A Contra	$ (12,906)		
30, line II6a	Medicare Pt B Prior Period	$ (3,920)		
30, line II6a	Medicare A IV Therapy	$ 210		
30, line II6a	Medicare A Speciality Beds	$ 1,249		
30, line II6a	Medicare A Oxygen	$ 1,083		
30, line II6a	Medicare A Oxygen Contra	$ (1,083)		
30, line II6a	Medicare PT A Settledment	$ 5,224		
30, line II6a	Managed Medicare Contra Other	$ (6,798)		
30, line II6a	Managed Medicare IV Therapy	$ 225		
30, line II6a	Managed Medicare Lab	$ 3,354		
30, line II6a	Managed Medicare X-Ray	$ 3,091		
30, line II6a	Managed Medicare Glucose	$ 6,715		
30, line II6a	Managed Medicare Oxygen	$ 716		
30, line II6a	Managed Medicare Oxygen Contra	$ (716)		
30, line II6a	Managed Medicare Speciality Bed	$ 128		
Total Other Resident Revenue - Medicare		$ 8,020	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30, line II6b	Commerical Insurance - LAB	$ 250		
30, line II6b	Commerical Insurance - X-RAY	$ 289		
30, line II6b	Commercial Insurance - Contra Other	$ (539)		
30, line II6b	Medicaid Lab	$ 1,062		
30, line II6b	Medicaid Contra Other	$ (3,630)		
30, line II6b	Commercial Insurance IV Therapy	$ 945		
30, line II6b	Hospice Pharmacy	$ 663		
30, line II6b	Hospice Pharmacy Contra	$ (663)		
30, line II6b	Hospice Oxygen	$ 243		
30, line II6b	Hospice Oxygen Contra	$ (243)		
30, line II6b	Medicaid Oxygen	$ 3,646		
30, line II6b	Medicaid Oxygen Contra	$ (3,646)		
30, line II6b	Medicaid Specialty Bed	$ 2,567		
30, line II6b	Commercial Insurance Oxygen	$ 60		
30, line II6b	Commerical Insurance Oxygen Contra	$ (60)		
Total Other Resident Revenue		$ 944	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30, line IV5	Interest Income (Money Market)		$ 117		
Total Interest Income			$ 117	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30, line IV8	Prior Period	$ (9,817)		
30, line IV8	Misellaneous Other Income (United Health Care $7,161; Other $1,157)	$ 8,318		
Total Other Revenue		$ (1,499)	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, L	913-C	9/30/2017	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 110,539
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,161,508
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 23,523
5. Prepaid Expenses				$ 95,565
a. Insurance		185		
b. Taxes (personal property & real estate)		39,726		
c. Management Fees		51,499		
d. Other		4,155		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 30,093
Patient Funds		30,093		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,421,228
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	873,898		$ 485,318
	Accum. Depreciation	388,580	Net	
5. Non-Movable Equipment	*Historical Cost	36,366		$ 3,941
	Accum. Depreciation	32,425	Net	
6. Movable Equipment	*Historical Cost	498,155		$ 386,004
	Accum. Depreciation	112,151	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 875,263

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, L	913-C	9/30/2017	32	37

Account				Amount
			Total Brought Forward:	$ 2,296,491
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost	5,657,365		
	Accum. Depreciation		Net	$ 5,657,365
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$ 5,657,365
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 (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 11,500
Security Deposits		11,500		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 11,500
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 7,965,356

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 2,741,083
2. Notes Payable (*itemize*)					$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$ 75,881
Name of Lender	Purpose	Amount	Date Due		
M&T Bank	Equipment	75,881	Various		
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)					$ 201,931
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 2,975,367
Accrued expenses	35,898	Accrued Accounting Fees	24,129		
Revenue assessment	162,443	Due to Third Party	51,273		
Patient personal funds	30,093				
Due to related party	2,671,531				
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 5,994,262

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	34	37

Account	Amount
Total Brought Forward:	5,994,262
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$ 140,849

Name of Lender	Purpose	Amount	Date Due
M&T Bank	Equipment	140,849	Various

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$ 1,077,761
Due to related party 1,077,761	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 1,218,610
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 7,212,872

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, I	913-C	9/30/2017	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	$ 5,657,365
3.	Reserve for depreciation value of leased personal property (*Equity)*	$
4.	Reserve for leasehold real properties on which fair rental value is based	$
5.	Reserve for funds set aside as donor restricted	$
6.	Total Reserves	$ 5,657,365
B.	**Net Worth**	
1.	Owner's Capital	$
2.	Capital Stock	$
3.	Paid-in Surplus	$
4.	Treasury Stock	$
5.	Cumulated Earnings	$ (2,757,208)
6.	Gain or Loss for Period 10/1/2016 thru 9/30/2017	$ (2,147,673)
7.	Total Net Worth	$ (4,904,881)
C.	***Total Reserves and Net Worth***	$ 752,484
D.	***Total Liabilities, Reserves, and Net Worth***	$ 7,965,356

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LI	913-C	9/30/2017	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2016			$ (2,779,019)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 8,424,761
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 10,572,434
D.	Net Income or Deficit			$ (2,147,673)
E.	Balance			$ (4,926,692)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
	Tax refund		21,811	
F-3.	Total Additions			$ 21,811
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period***	09/30/17		$ (4,904,881)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2017	37	37

Check appropriate category

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

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. 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.

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Blum Shapiro & Company, P.C.

Address	Phone Number
2 Enterprise Drive, Shelton, CT 06484	(203) 944-2100