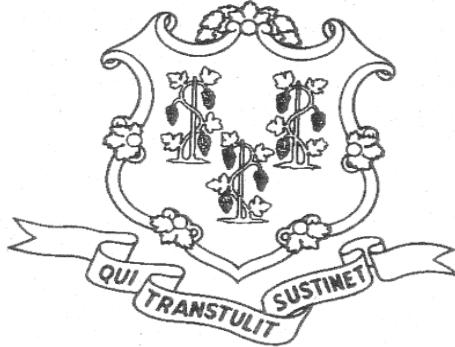


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2019

Name of Facility (as licensed) Bickford Health Care Center	
Address (No. & Street, City, State, Zip Code) 14 Main Street, Windsor Locks, CT 06096	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent <input 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 10/1/2018	Report for Year Ending 9/30/2019

License Numbers:	CCNH 2178-C	RHNS	(Specify)	Medicare Provider 07-5358
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Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) Bickford Health Care Center	License No. 2178-C	Report for Year Ended 9/30/2019	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Bickford Health Care Center [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, 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) Linda Urbanski		Printed Name (Owner)	
Subscribed and Sworn to before me:	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 Bickford Health Care Center	Period Covered:		From 10/1/2018	To 9/30/2019
Address of Facility 14 Main Street, Windsor Locks, CT 06096				
Report Prepared By Laydon and Company, LLC	Phone Number 203-799-1010	Date		
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) 623-4351	Report for Year Ended 9/30/2019	Page 2	of 37
Name of Facility (as shown on license) Bickford Health Care Center		Address (No. & Street, City, State, Zip) 14 Main Street, Windsor Locks, CT 06096	
License Numbers:	CCNH 2178-C	RHNS	(Specify)
Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)			
Type of Ownership (Check appropriate box)			
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input checked="" 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 Linda Urbanski		Nursing Home Administrator's License No.:	001171
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name		License No.:	

General Information and Questionnaire Partners/Members

General Information and Questionnaire Corporate Owners

Name of Facility Bickford Health Care Center	License No. 2178-C	Report for Year Ended 9/30/2019	Page 3A	of 37
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If this facility is owned or operated as a corporation, provide the following information:

General Information and Questionnaire
Individual Proprietorship

Name of Facility Bickford Health Care Center	License No. 2178-C	Report for Year Ended 9/30/2019	Page 3B	of 37
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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 Bickford Health Care Center		License No. 2178-C			Report for Year Ended 9/30/2019			Page 4	of 37
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?					<input checked="" type="radio"/> Yes <input type="radio"/> 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?					<input checked="" type="radio"/> Yes <input type="radio"/> 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	%**					
Somerset Health Care Management Group, LLC	PO Box 238 Granby, CT 06035	<input type="radio"/>	<input checked="" type="radio"/>		Provides Mgt Services, Administrator is rela	P 16 L m12	148,200	148,200	
Somerset Health Care Management Group, LLC	PO Box 238 Granby, CT 06035	<input checked="" type="radio"/>	<input type="radio"/>		Group Purchasing of Liab/Prof Ins	P 27 L 14a	54,414	54,414	
Somerset Health Care Management Group, LLC	PO Box 238 Granby, CT 06035	<input checked="" type="radio"/>	<input type="radio"/>		Group Purchasing of D&O Insurance	P 27 L 14c3	9,169	9,169	
		<input type="radio"/>	<input checked="" type="radio"/>						
		<input type="radio"/>	<input checked="" type="radio"/>						
		<input type="radio"/>	<input checked="" type="radio"/>						
		<input type="radio"/>	<input checked="" type="radio"/>						
		<input type="radio"/>	<input checked="" type="radio"/>						

* Use additional sheets if necessary.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Bickford Health Care Center	License No. 2178-C	Report for Year Ended 9/30/2019	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-6 Rev. 9/2002

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

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

Name of Facility Bickford Health Care Center		License No. 2178-C		Report for Year Ended 9/30/2019			Page 6 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
Is a Mileage Log Book Maintained for All Leased Vehicles ?		<input type="radio"/> Yes		<input checked="" 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 Bickford Health Care Center	License No. 2178-C	Report for Year Ended 9/30/2019	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 Laydon and Company, LLC 2 3 4	Address (No. & Street, City, State, Zip Code) PO Box 945, Orange, CT 06477
---	---

Services Provided by This Firm (*describe fully*)

1	Monthly Accounting, Cost Reports, Annual Reviewed Financial Statements and Tax return	\$ 43,494
2		\$
3		\$
4		\$
Charge for Services Provided		
		\$ 43,494

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

Yes No | Page 15 Line 1 d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Feldman, Perlstein & Greene, LLC	(203) 677-0551
2 Joseph A Vitale, Attorney at Law	(203) 439-0994
3	
4	
5	

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

1 10 Waterside Drive, Suite 303, Farmington, CT 06032
2 575 Highland Avenue, Cheshire, CT 06410
3
4
5

Services Provided by This Firm (*describe fully*)

1	#REF!	\$	#REF!
2	#REF!	\$	#REF!
3	#REF!	\$	#REF!
4		\$	
5		\$	

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

② Yes ③ No

Schedule of Resident Statistics

Name of Facility Bickford Health Care Center			License No. 2178-C			Report for Year Ended 9/30/2019				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					48	48			48	48		
A. On last day of PREVIOUS report period	48	48			48	48			48	48		
B. On last day of THIS report period	48	48			48	48			48	48		
2. Number of Residents					48	48			44	44		
A. As of midnight of PREVIOUS report period	48	48			48	48			43	43		
B. As of midnight of THIS report period	43	43			44	44			43	43		
3. Total Number of Days Care Provided During Period					1,554	1,554			423	423		
A. Medicare	1,977	1,977			6,697	6,697			2,567	2,567		
B. Medicaid (Conn.)	9,264	9,264										
C. Medicaid (other states)												
D. Private Pay	3,599	3,599			2,780	2,780			819	819		
E. State SSI for RCH												
F. Other (Specify) Managed Care	1,132	1,132			990	990			142	142		
G. Total Care Days During Period (3A thru F)	15,972	15,972			12,021	12,021			3,951	3,951		
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)	15,972	15,972			12,021	12,021			3,951	3,951		

Schedule of Resident Statistics (Cont'd)

Name of Facility Bickford Health Care Center	License No. 2178-C	Report for Year Ended 9/30/2019	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 (1)	RHNS (2)	(Specify) (3)	Lost			Gained			CCNH (1)	RHNS (2)	(Specify) (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.

1st change	Change in Resident Days			CCNH	RHNS	(Specify)
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	1	33		9				
Per Diem Rate								
a. One bed rm.				342.00				
b. Two bed rms.	524.00	193.00		326.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B	2,383	2,383	(Specify)
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	2,457	2,457	
D. Total Physical Therapy Treatments	4,840	4,840	

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	369	369	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	592	592	
D. Total Speech Therapy Treatments	961	961	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	2,519	2,519	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	2,507	2,507	
D. Total Occupational Therapy Treatments	5,026	5,026	

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2019		10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes <input type="radio"/> No			
		Total Cost and Hours			
Item	CCNH	Hours	RHNS	Hours	(Specify)
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	75,848	1,975			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	129,806	5,897			
5. Dietary Service					
a. Head Dietitian	519	19			
b. Food Service Supervisor	46,632	2,180			
c. Dietary Workers	156,292	12,316			
6. Housekeeping Service					
a. Head Housekeeper	28,276	2,219			
b. Other Housekeeping Workers	40,479	3,751			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance					
b. Other Maintenance Workers	62,628	3,470			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers	20,923	1,941			
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	123,459	3,075			
b. RN					
1. Direct Care	370,902	12,376			
2. Administrative**	81,853	2,427			
c. LPN					
1. Direct Care	186,740	7,844			
2. Administrative**					
d. Aides and Attendants	613,814	42,875			
e. Physical Therapists					
f. Speech Therapists					
g. Occupational Therapists					
h. Recreation Workers	69,715	4,500			
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	27,996	1,244			
n. Marketing					
o. Other (Specify)					
See Attached Schedule					
A-13. Total Salary Expenditures	2,035,882	108,109			

* 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)

Schedule of Other Fees (Page 13)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

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

Name of Facility Bickford Health Care Center				License No. 2178-C		Report for Year Ended 9/30/2019			Page 11	of 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.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

**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
Bickford Health Care Center				2178-C		9/30/2019			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***										
Lisa Rivard	75,848			Vacation & sick time	Responsible for daily operations (10/01/18 - 9/30/19)	1,975	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 Bickford Health Care Center	License No. 2178-C	Report for Year Ended 9/30/2019		Page 13	of 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	10,648	197			
2. Dentist					
3. Pharmacist	2,880	57			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	88,788	1,945			
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	16,800	76			
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	47,493	635			
b. Other					
10. Occupational Therapist					
a. Resident Care	95,536	1,663			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care					
2. Administrative***					
b. LPN					
1. Direct Care					
2. Administrative***					
c. Aides					
d. Other					
12. Other (Specify)					
See Attached Schedule					
B-13 Total Fees Paid in Lieu of Salaries	262,145	4,573			

* 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*

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility Bickford Health Care Center	License No. 2178-C	Report for Year Ended 9/30/2019	Page 15	of 37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 96,097	96,097		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 43,588	43,588		
4. Social Security (F.I.C.A.)	\$ 153,264	153,264		
5. Health Insurance	\$ 21,581	21,581		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$			
8. Uniform Allowance	\$			
9. Other (Specify) See Attached Schedule	\$ 268	268		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 75,896	75,896		
d. Accounting and Auditing	\$ 43,494	43,494		
e. Legal (Services should be fully described on Page 7)	\$ 5,263	5,263		
f. Insurance on Lives of Owners and Operators (Specify)*	\$			
g. Office Supplies	\$ 5,735	5,735		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 3,072	3,072		
2. Cellular Phones	\$			
i. Appraisal (Specify purpose and attach copy)*	\$			
j. Corporation Business Taxes (franchise tax)	\$			
k. Other Taxes (Not related to property - See Page 22)				
1. Income*	\$			
2. Other (Specify) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 294,112	294,112		
Subtotal	\$ 742,370	742,370		

* 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**

Attachment Page 15

Schedule of Other Employee Benefits

Schedule of Other Taxes

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

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

Name of Facility Bickford Health Care Center	License No. 2178-C	Report for Year Ended 9/30/2019		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
<i>Subtotals Brought Forward:</i>		742,370	742,370		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	4,921	4,921		
3. Gifts to Staff and Residents	\$	1,722	1,722		
4. Employee Travel	\$	1,128	1,128		
5. Education Expenses Related to Seminars and Conventions	\$	2,961	2,961		
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>)	\$	449	449		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	8,018	8,018		
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$	1,549	1,549		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$				
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>)	\$	34,185	34,185		
12. Administrative Management Services**	\$	148,200	148,200		
13. Other (<i>Specify</i>) See Attached Schedule	\$	51,085	51,085		
<i>C-14 Total Administrative & General Expenditures</i>	\$	996,588	996,588		

* 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	\$ 1,204		
Supp & Exp - Marketing	\$ 6,814		
Total Other Advertising	\$ 8,018	\$ -	\$ -

Schedule of Dues

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

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Admin. - Purchased Services	\$ 32,971		
Bank Charges	\$ 3,703		
Late Charges	\$ 6,100		
Fines & Penalties	\$ 1,658		
Lic & Dues - Pt Related	\$ 1,411		
Lic & Dues - Not Pt Related	\$ 1,025		
Rental House Expenses	\$ 4,217		
Total Other Administrative and General	\$ 51,085	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Bickford Health Care Center	License No. 2178-C	Report for Year Ended 9/30/2019	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Somerset Health Care Management Group	148,200	Manage Facility including contract negotiations, plant, financial oversight and group purchasing of insurance	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.**

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
	2178-C	9/30/2019		18 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 78,918	78,918		
2. Non-Food Supplies	\$ 7,428	7,428		
3. Other (Specify) _____	\$			
b. Purchased Services (by contract other than through Management Services) <i>(Complete Schedule C-2 att. Page 21)</i>	\$			
c. Other (Specify) _____	\$			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 86,346	86,346		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	131	131		
G. Is cost of employee meals included in 2D? <input checked="" type="radio"/> Yes <input type="radio"/> No				
H. Did you receive revenue from employees? <input checked="" type="radio"/> Yes <input type="radio"/> No			If yes, specify amt.	\$5,271
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				P 18 L2a1
Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify cost.
K. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify cost.
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility Bickford Health Care Center	License No. 2178-C	Report for Year Ended 9/30/2019		Page 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. \$	6,850	6,850	
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. \$	1,991	1,991	
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$			
c. Other (Specify)	\$			
3D. Total Laundry Expenditures (3a + b + c)	\$	8,841	8,841	
3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify cost.
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify amt.
H. Where is the revenue received reported in the Cost Report?				(Page/Line Item)
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify cost.
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify amt.
K. Where is the revenue received reported in the Cost Report?				(Page/Line Item)

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

All allocations should add to total recorded in 3D.

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

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

Name of Facility Bickford Health Care Center	License No. 2178-C	Report for Year Ended 9/30/2019		Page 20	of 37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 21,841	21,841		
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)					
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. Other (<i>Specify</i>)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	21,841	21,841		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Outside Pharmacy	\$	74,529	74,529		
b. Medicine Cabinet Drugs	\$	4,780	4,780		
c. Medical and Therapeutic Supplies	\$	87,917	87,917		
d. Ambulance/Limousine***	\$	2,480	2,480		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	12,718	12,718		
f. X-rays and Related Radiological Procedures***	\$	1,651	1,651		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$	5,472	5,472		
h. Laboratory***	\$	8,210	8,210		
i. Recreation	\$	24,479	24,479		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	373	373		
5M. Total Resident Care Expenditures (5a - 5j)	\$	222,609	222,609		

* 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

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

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

** Refer to Page 4 for definition of related.

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

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

Name of Facility Bickford Health Care Center	License No. 2178-C	Report for Year Ended 9/30/2019			Page 22 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 22,164	22,164			
b. Heat	\$ 20,743	20,743			
c. Light & Power	\$ 45,606	45,606			
d. Water	\$ 25,232	25,232			
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$				
f. Other <i>(itemize)</i>	\$ 31,251	31,251			
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 144,996	144,996			
7. Depreciation <i>(complete schedule page 23*)</i>					
a. Land Improvements	\$ 365	365			
b. Building & Building Improvements	\$ 145,200	145,200			
c. Non-Movable Equipment	\$ 6,584	6,584			
d. Movable Equipment	\$ 11,644	11,644			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 163,793	163,793			
8. Amortization <i>(Complete att. Schedule Page 24*)</i>					
a. Organization Expense	\$				
b. Mortgage Expense	\$ 8,791	8,791			
c. Leasehold Improvements	\$				
d. Other <i>(Specify)</i>	\$				
*8e. Total Amortization Costs (8a + b + c + d)	\$ 8,791	8,791			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$				
10. Property Taxes					
a. Real estate taxes paid by owner	\$ 14,994	14,994			
b. Real estate taxes paid by lessor	\$				
c. Personal property taxes	\$ 851	851			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 188,429	188,429			

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

Schedule of Other Repairs and Maintenance

Depreciation Schedule

Name of Facility Bickford Health Care Center				License No. 2178-C			Report for Year Ended 9/30/2019			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				5,469			2,917			365		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal											365	
B. Building and Building Improvements												
1. Acquired prior to this report period				3,900,487			2,808,591			144,227		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)				13,406						973		
B-4. Subtotal											145,200	
C. Non-Movable Equipment												
1. Acquired prior to this report period				76,101			44,142			6,584		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
C-4. Subtotal											6,584	
	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					530,791			497,646			11,402	
b. Disposals (attach schedule)					(2,166)			(2,166)				
c. Acquired during this report period (attach schedule)					3,131						242	
D-3. Subtotal												
E. Total Depreciation												
											11,644	
											163,793	

Schedule of Land Improvements Acquired during this report period

*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:				
1/18/2019	Metal Door & Frame Repair	\$ 3,111	15	\$ 156
3/25/2019	Roof Repair/Replacement	\$ 4,500	10	\$ 262
6/24/2019	A/C repair for Dining area & Therapy room	\$ 2,581	3	\$ 287
7/20/2019	A/C Repair (various)	\$ 3,214	3	\$ 268
Total additions for Building Improvement		\$ 13,406		\$ 973 *
Deletions:				
Total deletions for Building Improvement		\$ -		\$ - **

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

***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:				
10/25/2018	Ice Machine	\$ 1,700	10	\$ 170
7/19/2019	Fans	\$ 1,431	5	\$ 72
Total additions for Movable Equipment		\$ 3,131		\$ 242 *
Deletions:				
12/8/2003	Ice Maker	\$ (2,166)	10	\$ -
Total deletions for Movable Equipment		\$ (2,166)		\$ - **

*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:				
Total additions for Leasehold Improvements		\$ -		\$ - *
Deletions:				
Total deletions for Leasehold Improvements		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Bickford Health Care Center			License No. 2178-C		Report for Year Ended 9/30/2019			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1. Organization Expense	6	96		800,000	358,333				
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1. Refinancing (New)	6	2018		26,373	2,930			8,791	
2.									
3.									
B-4. Subtotal									8,791
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									8,791

* 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 Bickford Health Care Center	License No. 2178-C	Report for Year Ended 9/30/2019	Page 25	of 37
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11. Property Questionnaire

Part A

Is the property either owned by the Facility
or leased from a Related Party?*

Yes

No

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

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

Description	Total			
1. Date Land Purchased	6/6/1996			
2. Date Structure Completed	7/1/1997			
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure	6/1/1996			
5. Total Licensed Bed Capacity	48			
6. Square Footage	10,266			
7. Acquisition Cost				
a. Land	150,000			
b. Building	995,459			

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	5/17/2018			
c. Interest Rate for the Cost Year	6.61%			
d. Term of Mortgage (number of years)	3			
e. Amount of Principal Borrowed	2,179,191			
f. Principal balance outstanding as of 9/30/2019	2,071,556			

Complete if Mortgage was Refinanced

During Current Cost Year

g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended 9/30/2019			Page 26	of 37
Item		Total	CCNH	RHNS	(Specify)	
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage	\$	141530	141,530			
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)	\$	141,530	141,530			

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended 9/30/2019			Page 27	of 37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:			141,530	141,530		
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) Omicare \$3234; CT User Fee \$829			\$	4,063	4,063	
13. Total All Interest Expense (12B7 + 12C3 + 12D)			\$	145,593	145,593	
14. Insurance						
a. Insurance on Property (buildings only)			\$	54,414	54,414	
b. Insurance on Automobiles			\$			
c. Insurance other than Property (as specified above)			\$			
1. Umbrella (<i>Blanket Coverage</i>)			\$			
2. Fire and Extended Coverage			\$			
3. Other (Specify)			\$	9,169	9,169	
D&O \$9169						
14d. Total Insurance Expenditures (14a + b + c)			\$	63,583	63,583	
15. Total All Expenditures (A-13 thru C-14)			\$	4,176,853	4,176,853	

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of	
Item No.	Page No.	Line No.		2178-C	9/30/2019	28 37	
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.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 2,743	2,743		
			Page 13 - Professional Fees				
5.			Resident Care Physicians **	\$			
6.	13	b10a	Occupational Therapy	\$ 95,536	95,536		
7.			Other - See attached Schedule	\$			
			Pages 15 & 16 - Administrative and General				
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 75,986	75,986		
10.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	1m3	Unallowable Advertising *	\$ 8,018	8,018		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.	16	1m12	Unallowable Management Fees	\$ 96,168	96,168		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 6,100	6,100		
			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)			\$ 284,551	284,551			

* 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)
P10	A4	10% Marketing Allocation	\$ 2,743		
Total Other Salaries Adjustment			\$ 2,743	\$ -	\$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	lm13	Late Charges	\$ 6,100		
Total Other A&G Adjustments			\$ 6,100	\$ -	\$ -

Management Fees

2010	44,894	Allowable
CPI	1,0206	
2011	45,819	Allowable
	45,819	
	1,0277	
CPI	47,088	Allowable
2012	1,0097	
	47,545	Allowable
CPI	1,0133	
2013	48,177	Allowable
	48,177	
CPI	0,9933	
2014	47,854	Allowable
	47,854	
CPI	1,0146	
2015	48,553	Allowable
	48,553	
CPI	1,0223	
2016	49,636	Allowable
	49,636	
CPI	1,0223	
2017	49,636	Allowable
	49,636	
CPI	1,0228	
2018	50,767	Allowable
	50,767	
CPI	1,0249	
2019	52,032	Allowable
	52,032	

Per page 16 148,200
 Disallowable 96,168 Page 28 Line 21

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

Name of Facility Bickford Health Care Center				License No. 2178-C	Report for Year Ended 9/30/2019		Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)	
Subtotals Brought Forward				\$ 284,551	284,551			
Page 20 - Resident Care Supplies***								
27.	20	5a2	Prescription Drugs	\$ 71,200	71,200			
28.	20	5d	Ambulance/Limousine	\$ 2,480	2,480			
29.	20	5f	X-rays, etc	\$ 1,651	1,651			
30.	20	5h	Laboratory	\$ 7,982	7,982			
31.	20	5c	Medical Supplies	\$				
32.	20	5e2	Oxygen (non emergency)	\$ 9,919	9,919			
33.			Occupational Therapy	\$				
34.			Other - See Attached Schedule	\$				
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 142	142			
36.			Depreciation on Unallowable Motor Vehicles	\$				
37.			Unallowable Property and Real Estate Taxes	\$				
38.			Rental of Building Space or Rooms	\$				
39.			Other - See Attached Schedule	\$				
Page 27 - Insurance								
40.			Mortgage Insurance	\$				
41.			Property Insurance	\$				
Other - Miscellaneous								
42.			Other - Indirect	\$				
43.			Interest Income on Account Rec.	\$				
44.			Other - Miscellaneous Administrative	\$				
45.			Management Fees Direct	\$				
46.			Management Fees Indirect	\$				
47.			Other - Direct	\$				
Not For Profit Providers Only								
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$				
49.	Total Amount of Decrease (Items 1 - 48)			\$ 377,925	377,925			

*** Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Schedule of Other Ancillary Costs

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Schedule of Other - Indirect Adjustments

Total Other Adjustments		\$ -	\$ -	\$ -

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct Adjustments

Attachment Page 29

Schedule of Unallowable Building Interest

Page	Line			
29	27	Pharmacy - Private 78250-01000	71	P20 L5a2
		Pharmacy - Part A 78250-02000	39744	P20 L5a2
		Pharmacy - Managed Care 78250-08000	31385	P20 L5a2
		Pharmacy - Other 78250-100000	0	P20 L5a2
			71200	
29	30	Laboratory - Private 78300-01000	35	P20 L5h
		Laboratory - Part A 78300-02000	5013	P20 L5h
		Laboratory- Sco Part B 78300-05500	49	P20 L5h
		Laboratory - Managed Care 78300-80000	2610	P20 L5h
		Laboratory Expense (Non-Billable) 78300-99999	275	P20 L5h
			7982	
29	32	Oxygen - Private 78410-01000	8	P20 L5e2
		Oxygen - Part A 78410-02000	558	P20 L5e2
		Oxygen - Managed Care	2062	P20 L5e2
		Oxygen - Hospice 78410-09000	35	P20 L5e2
		Oxygen 78410-79000	7256	P20 L5e2
			9919	

F. Statement of Revenue

Name of Facility Bickford Health Care Center	License No. 2178-C	Report for Year Ended 9/30/2019			Page 30 37
Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 3,162,090	3,162,090			
b. Medicaid Room and Board Contractual Allowance **	\$ (1,419,137)	(1,419,137)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents(<i>all inclusive</i>)	\$ 542,806	542,806			
b. Medicare Room and Board Contractual Allowance **	\$ 237,047	237,047			
4. a. Private-Pay Residents and Other	\$ 1,837,956	1,837,956			
b. Private-Pay Room and Board Contractual Allowance **	\$ (214,451)	(214,451)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 60,654	60,654			
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$ 11,914	11,914			
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	\$ 150,713	150,713			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (24,316)	(24,316)			
c. Physical Therapy - Non-Medicare	\$ 39,246	39,246			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (960)	(960)			
4. a. Speech Therapy - Medicare	\$ 76,824	76,824			
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$ 10,166	10,166			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 176,000	176,000			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ 35,920	35,920			
c. Occupational Therapy - Non-Medicare	\$				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other (<i>Specify</i>) - Medicare	\$ (339,385)	(339,385)			
b. Other (<i>Specify</i>) - Non-Medicare	\$ (97,101)	(97,101)			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 4,245,986	4,245,986			
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$ 15,300	15,300			
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$ 141	141			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 4,816	4,816			
V. Total Other Revenue (1 thru 8)	\$ 20,257	20,257			
VI. Total All Revenue (III +V)	\$ 4,266,243	4,266,243			

* 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)
	Laboratory - Part A	\$ 4,174		
	Laboratory - Sco-Part A	\$ 1,145		
	Radiology - Part A	\$ 178		
	Resp Ther/O2 - Part A	\$ 286		
	Resp Ther/O2 - Sco -Part A	\$ 1,570		
	Contractual Adj Part A Ancil	\$ (277,738)		
	Contractual Adj Sco-Part A Ancil	\$ (69,000)		
	Total Other Resident Revenue - Medicare	\$ (339,385)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
	Laboratory -Comm Ins	\$ 889		
	Laboratory - HMO	\$ 814		
	Radiology - HMO	\$ 89		
	Resp Ther/O2 Private	\$ 137		
	Resp Ther/O2 Caid	\$ 58		
	Resp Ther/O2 -HMO	\$ 390		
	Contractual Adj Comm Ins Ancillary	\$ (52,182)		
	Contractual Adj Caid Ancill	\$ 58		
	Contractual Adj Sco Caid Ancill	\$ (112)		
	Contractual Adj HMO Ancillary	\$ (47,242)		
	Total Other Resident Revenue	\$ (97,101)	\$ -	\$ -

Interest Income**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Investment Account	27,918	\$ 65		
	Savings Account (3140)	13,509	\$ 48		
	Rehab Settlement		\$ 1		
	Various insurers posted through AR		\$ 27		
	Total Interest Income	\$ 141	\$ -	\$ -	

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Fundraising Income	\$ 2,781		
	Miscellaneous Income	\$ 35		
	Unrestricted Donations	\$ 2,000		
	Total Other Revenue	\$ 4,816	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2019	31	37
Account				Amount
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	257,558
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	699,874
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	8,462
5. Prepaid Expenses			\$	27,521
a. Prepaid Insurance	25,435			
b. Prepaid Expenses, Other	2,086			
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	1,550
Utility Deposits	1,550			
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	994,965
B. Fixed Assets				
1. Land			\$	150,000
2. Land Improvements	*Historical Cost 5,469		\$	2,187
	Accum. Depreciation 3,282	Net		
3. Buildings	*Historical Cost 3,921,865		\$	968,074
	Accum. Depreciation 2,953,791	Net		
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation	Net		
5. Non-Movable Equipment	*Historical Cost 76,101		\$	25,375
	Accum. Depreciation 50,726	Net		
6. Movable Equipment	*Historical Cost 531,756		\$	24,632
	Accum. Depreciation 507,124	Net		
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	1,170,268

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2019	32	37
Account			Amount	
			Total Brought Forward:	\$ 2,165,233
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				\$
2. Land Improvements	*Historical Cost			\$
	Accum. Depreciation	Net		
3. Buildings	*Historical Cost			\$
	Accum. Depreciation	Net		
4. Non-Movable Equipment	*Historical Cost			\$
	Accum. Depreciation	Net		
5. Movable Equipment	*Historical Cost			\$
	Accum. Depreciation	Net		
6. Motor Vehicles	*Historical Cost			\$
	Accum. Depreciation	Net		
7. Minor Equipment-Not Depreciable				\$
C-8 Total Leasehold or Like Properties (C1 thru 7)				\$
D. Investment and Other Assets				
1. Deferred Deposits				\$
2. Escrow Deposits				\$
3. Organization Expense	*Historical Cost	800,000		
	Accum. Depreciation	358,333	Net	\$ 441,667
4. Goodwill (Purchased Only)				\$ 14,652
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)				\$
See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)				\$ 456,319
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)				\$ 2,621,552

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

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref Line Ref Description

Total Prepaid Expenses		\$ -

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

Page Ref Line Ref Description

Total Other Current Assets (Itemize)		\$ -

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

Page Ref Line Ref Description

Total Other Other Fixed Assets (Itemize)		\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref Line Ref Description

Total Other Assets		\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref Line Ref Description

Total Notes Payable		\$ -

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

Page Ref Line Ref Description

	Other Liabilities	\$ 303
Total Other Current Liabilities (Itemize)		\$ 303

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

Page Ref Line Ref Description

Total Other Current Liabilities (Itemize)		\$ -

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Bickford Health Care Center	2178-C	9/30/2019	33 37
Account			Amount
Liabilities			
A. Current Liabilities			
1. Trade Accounts Payable			\$ 762,414
2. Notes Payable (<i>itemize</i>)			\$
See Schedule			
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)			\$
Name of Lender	Purpose	Amount	Date Due
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)			\$ 190,190
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$
6. Accrued Payroll Taxes Payable			\$
7. Medicare Final Settlement Payable			\$
8. Medicare Current Financing Payable			\$
9. Mortgage Payable (<i>Current Portion</i>)			\$ 95,526
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)			\$ 11,030
11. Accrued Income Taxes*			\$
12. Other Current Liabilities (<i>itemize</i>)			\$ 164,544
Accrued Expenses 21,276 Security Deposits 2,625			
Medicaid User Fee Payable 74,137 Notes Payable-Omnicare 30,768			
Credit Balance Liabilities 17,805 Accrued Real Estate Tax 617			
Residents Deposits 17,013 See Schedule 303			
A-13. Total Current Liabilities (Lines A1 thru 12)			\$ 1,223,704

* 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 Bickford Health Care Center	License No. 2178-C	Report for Year Ended 9/30/2019	Page 34	of 37
Account			Amount	
Total Brought Forward:			1,223,704	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)			\$	
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable			\$	1,976,030
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>)			\$	
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$	1,976,030
C. Total All Liabilities (Lines A-13 + B-5)			\$	3,199,734

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

Name of Facility Bickford Health Care Center	License No. 2178-C	Report for Year Ended 9/30/2019	Page 35	of 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			\$	(667,572)
6. Gain or Loss for Period	10/1/2018	thru	9/30/2019	\$ 89,390
7. Total Net Worth			\$	(578,182)
C. Total Reserves and Net Worth				\$ (578,182)
D. Total Liabilities, Reserves, and Net Worth				\$ 2,621,552

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of			
Bickford Health Care Center	2178-C	9/30/2019	36	37			
Account				Amount			
A. Balance at End of Prior Period as shown on Report of 09/30/2018				\$ (667,572)			
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 4,266,243			
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 4,176,853			
D. Net Income or Deficit				\$ 89,390			
E. Balance				\$ (578,182)			
F. Additions							
1. Additional Capital Contributed (<i>itemize</i>)							
2. Other (<i>itemize</i>)							
F-3. Total Additions				\$			
G. Deductions							
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)				\$			
Name and Address (No., City, State, Zip)	Title	Amount					
2. Other Withdrawings (<i>Specify</i>)				\$			
Purpose	Amount						
3. Total Deductions				\$			
H. Balance at End of Period				\$ (578,182)			

I. Preparer's/Reviewer's Certification

Name of Facility Bickford Health Care Center	License No. 2178-C	Report for Year Ended 9/30/2019	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

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		
Laydon and Company, LLC		
Address	Phone Number	
PO Box 945, Orange, CT 06477	203-799-1040	
Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number	
Elmer A. Laydon, CPA	203-799-1040	
Contact Email Address		
elaydon@laydoncpa.com		