State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2016

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	Report for Year Ending	
10/1/2015	9/30/2016	

913-C 07-5138

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	9134		

For Department Use Only

Sequence Number	Signed and	Date	Sequence Number	Signed and Notarized	Date Received
Assigned	Notarized	Received	Assigned	8	

Table of Contents

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

Name of Facility (as licensed)		Io Domor	t for Voor Ended – I	Page o
Bloomfield Health Care Center of CT, L	License N LC 913-C	9/30/2		Page of 1 3
MISREPRESENTATION OF COST REPORT MAY BE PU FEDERAL LAW.	R FALSIFICATION OF			
I HEREBY CERTIFY that I h Cost Report and supporting so name], for the cost report peri the best of my knowledge and and records of the provider(s)	chedules prepared for B od beginning October 1 I belief, it is a true, corre	oomfield Health Care Ce , 2015 and ending Septem ect, and complete statement	nter of CT, LLC [fac ber 30, 2016, and th	cility at to
I hereby certify that I have direct Schedule of Resident Statistics, Balance Sheet of this Facility in year ended as specified above.	Statements of Reported E	xpenditures, Statements of	Revenues and the relat	ted
I have read this Report and he my knowledge under the pena presented in this Report as a k	alty of perjury. I also ce		n-salary expenses d/or other State assis	sted
residents were incurred to pro recorded have been retained a request.	vide resident care in thi		-	
residents were incurred to pro recorded have been retained a request.	vide resident care in thi		-	upon
residents were incurred to pro recorded have been retained a request.	vide resident care in thi s required by Connectic	ut law and will be made a	wailable to auditors u	upon
residents were incurred to pro- recorded have been retained a request. Signed (Administrator) Printed Name (Administrator)	vide resident care in thi s required by Connectic	ut law and will be made a	Dat	upon
residents were incurred to pro- recorded have been retained a request. Signed (Administrator) Printed Name (Administrator) Carol Green	vide resident care in thi s required by Connectic	ut law and will be made a Signed (Owner) Printed Name (Owner)	Dat	upon

General Information

(Notary Seal)

State of Connecticut Department of Social Services

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	stm	ent		Page	of	
				1Å	37	
Name of Facility		Period Cov	ered:	From	То	
Bloomfield Health Care Center of CT, LLC				10/1/2015	9/30/2016	
Address of Facility						
355 Park Ave Bloomfield,CT 06002				-		
Report Prepared By		Phone Nun	nber	Date		
Blum Shapiro & Company, P.C.		(203) 944-2	2100	2/7/2017		
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

	Pho	ne No. of Fac	ility	Report for Yea	r Ended	Page	of
	860-	242-8595		9/30/2016		2	37
Name of Facility (as shown on license)		Address (No). & S	Street, City, Stat	te, Zip)		
Bloomfield Health Care Center of CT, LLC		355 Park Av	e Bl	oomfield,CT 06	002		
CCNH		RHNS		(Specify)			Provider No
License Numbers: 913-C						07-5138	
Type of Facility (Check appropriate box(es))							
Chronic and Convalescent Nursing Home only (CCNH)		Home with lervision only			(Specify))	
Type of Ownership (Check appropriate box)							
O Proprietorship O LLC O Partnership	0	Profit Corp.	0	Non-Profit Corp	р. О	Government	O Trust
If this facility opened or closed during report year provi	de:		Date	Opened	Date Clo	osed	
Has there been any change in ownership							
or operation during this report year?	0	Yes	\odot	No	lf "Yes,"	explain full	y.
Administrator							
Name of Administrator				Nursing Ho	me		
Carol Green				Administrate	or's	001973	
				License N	o.:		
Other Operators/Owners who are assistant administrator	rs (full	or part time)	of th	•			
Name				License N	0.:		

General Information and Questionnaire Partners/Members

Name of Facility		License No.	Report for `	Page	of		
Bloomfield Health Care Cente	er of CT, LLC	913-C	9/30/2016		3	37	
Legal Name of Par		Business				nd/or Town(s) in n Registered	
Bloomfield Health Care Cente	r of CT, LLC	355 Park Ave 2 06002	Bloomfield,C	TCT			
Name of Partners/Members	Business	Address		Title			
Marvin J. Ostreicher	355 Park Ave Bloom	President		0.	5		
Agnes Zitter	355 Park Ave Bloom	nfield, CT 06002			0.	5	

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	9/30/2016		3A 37
If this facility is owned or operated as a corpo	ration, provide the	following information	on:	
Legal Name of Corporation		s Address		ch Incorporated
				•
Name of Directors, Officers	Busines	s Address	Title	No. Shares
Name of Directors, officers	Dusines		The	Held by Each
Names of Stockholders Owning at Least 10%				
of Shares				

State of Connecticut Annual Report of Long-Term Care Facility CSP-3B Rev. 10/2005

General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2016	3B 37
If this facility is owned or operated as an individu			tion:
Ov	wner(s) of Facility		

General Information and Questionnaire Related Parties*

Name of Facility		License	e No.		Report for Year Ended		Page	of
Bloomfield Health Care G	Center of CT, LLC		913-C		9/30/2016		4	37
-	ving compensation from the fa	•		•		If "Yes," provide th		
marriage, ability to control	ol, ownership, family or busin	ess asso	ciation?	0	Yes O No	complete the inform	nation on Pa	ge 11 of the report.
•	mpanies which provide goods							
	operty or the loaning of funds							
	sociation, common ownership				⊙ Yes O No			
association to any of the	owners, operators, or officials	of this f	facility?			If "Yes," provide th	ne following	information:
		Als	so Provi	ides		Indicate Where		
			ls/Servi			Costs are Included		
Name of Related	Business		Related		Description of Goods/Services	in Annual Report	Cost	Actual Cost to the
Individual or Company	Address	Yes	No	%**	Provided	Page # / Line #	Reported	Related Party
See attachment.		0	0					
		0	0					
		0	0					
		0	0					
		0	0					
		0	0					
		0	0					
		0	0					
		0	0					

* Use additional sheets if necessary.

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

Annual Report of Long-Term Care Facility CSP-4 Rev. 10/2005

General Information and Questionnaire Related Parties*

Name of Facility Bloomfield Health Care		License 9134	No.		Report for Year Ended 9/30/2016			Page 4	of 37
		,			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
Are any individuals rece	eiving compensation from the fa	cility re	lated the	rough		If "Yes," p	rovide the Name/	Address and	1
marriage, ability to cont	rol, ownership, family or busine	ss assoc	ciation?		Tes V No	complete the	he information or	n Page 11 of	the report.
Are any individuals or c	companies which provide goods	or servi	ces,						
including the rental of p	roperty or the loaning of funds to	o this fa	acility.						
<u> </u>	ssociation, common ownership,			iness					
	owners, operators, or officials of				🗹 Yes 🗖 No	If "Yes," pr	ovide the following	g information	:
								-	
		Al	so Prov	ides					
		Goo	ds/Servi	ces to		Indicate V	Where Costs are		Actual Cost to the
Name of Related	Business	Non-l	Related	Parties	Description of Goods/Services	Included i	n Annual Report	Cost	Related
Individual or Company	Address	Yes	No	%**	Provided	Page # / Line #		Reported	Party
	850 Silas Deane Highway,								
Preferred Therapy Solutions Procare LTC Pharmacy of	Wethersfield, CT 06109 1492 Highland Ave Cheshire CT	\checkmark		32%	PT,OT,ST Services/Consulting	13	5a,9a,10a,12	634,406	610,006
CT	06410	~		91%	Drugs/OTC's/Supplies/Consulting/Fees	20/13	5a2,b,j/B3,12	324.822	295,293
01	6851 Jericho Turnpike, Suite 150			2170	brugs of e subupplies consutting rees	20/15	542,0,725,12	521,022	275,275
NOA Diagnostics	Syosset, NY 11791	\checkmark		80%	Radiology	20	5f	10,466	9,429
National Health Care	850 Silas Deane Highway,		~						
Associates - Aetna	Wethersfield, CT 06109 85 Stage Harbor Rd, Marlborough,		<u> </u>		Health Insurance Trust***	15 / 30	1a5 / IV8	547,449	547,449
Marlborough Health Care	Ct 06447		\checkmark		Bank Charges	16	13	587	587
National Health Care	20 East Sunrise Highway, Valley				Durk Charges	10	15	507	507
Associates	Stream, NY 11581		\checkmark		Banking Transactions	16	13	11,989	11,989
Bloomfield Healthcare	20 East Sunrise Highway, Valley								
Realty	Stream, NY 11581		~		Rent	22	9	630,000	630,000
Milford Health Care	195 Platt St Milford CT 06460		\checkmark		Social Services/Maintenance Services	22/13	6f/6	21,951	21,951
National Health Care	20 East Sunrise Highway, Valley								
Associates	Stream, NY 11581		\checkmark		Shared Expenses	16	12	473,359	473,359
20Sunrise	20 Sunrise Highway, Valley Stream NY 11581		\checkmark		Shared Expenses	16	12	11,474	11,474
205411150	850 Silas Deane Highway,					10	12	11,174	11,474
850 Silas Deane Realty	Wethersfield, Ct 06109		\checkmark		Shared Expenses	16	12	1,641	1,641
	1 Columbia Circle, STE 105 Albany								
Columbia Circle Assoc. LLC	C NY 12203		\checkmark		Shared Expenses	16	12	85	85

 * 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 previou state auditor.

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		9/30/2016	5	37		
If the facility is licensed as CDH and/or RCH or	provides A	DS or TBI	services with special Medicaid	rates, cost	S		
must be allocated to CCNH and RHNS as follow	vs:						
Item			Method of Allocation				
Dietary		Number of	meals served to residents				
Laundry		Number of	pounds processed				
Housekeeping		Number of	square feet serviced				
		Number of	hours of routine care provided	by EACH			
Nursing		employee o	classification, i.e., Director (or	Charge Nu	rse),		
		Registered Nurses, Licensed Practical Nurses, Aides and					
		Attendants					
Direct Resident Care Consultants		Number of	hours of resident care provided	l by EACH	ł		
		^	(See listing page 13)				
Maintenance and operation of plant		Square feet					
Property costs (depreciation)		Square feet					
Employee health and welfare		Gross salar					
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 follo	owing questi	ons applical					
1. In the preparation of this Report, were all	• Yes	O No	If "No," explain fully why suc	h allocatio	n was not		
costs allocated as required?	0 103	0 110	made.				
2. Evaluin the allocation of related company and		ttaah aanu	formation and the data				
2. Explain the allocation of related company ex							
Shared expenses, allocated by bed size or geogra		y. see page	17 attachment.				
3. Did the Facility appropriately allocate and se (e.g., Assisted Living, Home Health, Outpati				ie cost cen	iters?		
	• Yes	O No	If "No," explain fully why suc made.	h allocatio	n was not		
N/A							

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

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility			License No.	Report for Y	Year Ended		Page	of
Bloomfield Health Care Center of CT, LLC			913-C	9/30/2016			6	37
		ed * to						
		ners,				A 1		
	-	ators, icers		Date of	Term of	Annual Amount	Amo	unt
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	of Lease	Clair	
Reliable Health Systems, Nostrand Ave, Brooklyn, NY 11230	0	0	Computer Equipment	10/01/08	60 months / ongoing	21,066	21,066	lieu
Wescom Solutions, PO Box 674802, Detroit, MI 48267	0	۲	Software	03/07/12	Ongoing	18,432	4,384	
Wells Fargo Financial Leasing, PO Box 6434, Carol Stream, IL 60197-6434	0	۲	Copier	10/01/12	36 months	5,170	1,491	
Leaf, P.O. Box 644006, Cincinnati, OH 45264	0	۲	Copier	01/01/16	39 months	4,588	3,441	
Honda Financial Services P.O. Box 165378, Irving, TX 75016	0	۲	Auto Lease	01/25/13	36 months	4,065	2,033	
	0	۲						
	0	۲						
	0	0						
	0	0						
	0	0						
Is a Mileage Log Book Maintained for All L	eased V	ehicles	? O Yes		No	Total ***	32,415	

* 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.





The Office Works, Inc. 45 Corporate Avenue Plainville, CT 06062

1-800-634-481	0 1-860-793-9994			
BILL TO:			SHIP TO:	
Bloomfield Health 355 Park Avenue Bloomfield, CT_0	,		Same	
ITEM	DESCRIPTION	QTY	UNIT PRICE	EXTENDED PRICE
e-Studio 757 MJ1027	75 ppm Toshiba multifunctional copier Cosole finisher with mult-position stapling	1		
e-Studio 357 MR3028	35 ppm multifunction copier Automatic document handler	1		39- month lease @ \$359.53 per month
MJ1032n KD 1026	Inner finisher Large Capacity paper feed pedestal	1		
		-	L SALE PRICE	Lease
			S TAX	N/C N/A

Notes / Provisions:

- Delivery, installation and training included. The Office Works will remove and return the "off lease" copiers to the leasing company.

- The Office Works will issue a check in the amount of \$400.00 to cover the final payment of the current copier lease.

CUSTOMER: Bloomfield Health Care

Authorized Signature	\geq
Print Name Michael Bokow	
Title Materials Ment.	
Date 12 2015	
Phone	

THE OFFICE WORKS, INC.

DATE: December 4, 2015

Accepted By_____

Print Name_____

Title_____

Sales Associate_____

DLFAF

LEASE AGREEMENT

1720A Crete Street, Moberly, MO 65270 Phone: 800-662-3759, Fax: 800-426-2626

LESSEE LEGALN Bloomfield He		Tax ID#:		Telephone No: 8602428595			
Billing Address: 355 Park Avenue, Bloomfield, CT 06002			Equipment Location (if other than Billing Address): 355 Park Avenue, Bloomfield, CT 06002				
EQUIPMENT D	ESCRIPTION: (indicate quantity, new or u	used and include make, model, so	erial # and all attachment	s – see below	and/or attache	d Schedule A)	
Unit Quantity	Description of Equipm	Make and Typ	c	Model	Number	Serial Number	
	* PLEASE REFER TO	SCHEDULE A					
BASE TERM IN MONTHS	TOTAL NUMBER OF LEASE PAYMENTS	END OF I X Fair market value, plus t	LEASE PURCHASE OF	PTION		(a) Advance Pay	/ment: \$0.00
32	39 @ \$359.53 (plus taxes)	10% of Equipment cost, \$1.00, plus taxes					pasit: \$0,00
		(FMV unless another option is selected. You may not exercise a purchase option (c) Document					ion Fee: \$95.00
		if you are in default. If you exercise a purchase option we will convey all of our right, title and interest in such Equipment to you on an AS-IS WHERE IS without Total due a + b + c =: \$95.0 warranty.)					+ c=: \$95.00
**If more than one lease naument is required as an A drance Payment, the balance will be applied to lease navments in inverse order starting with the last lease navment							

Your obligation to pay all amounts and perform all other obligations is non-cancellable, absolute, unconditional and not subject to abatement, set-off or defense.

TERMS AND CONDITIONS

In this agreement ("Lease"), "we," "our," and "us" refers to LEAF Capital Funding, LLC as Lessor and "you" and "you" and "you" refer to the Lessee. You agree to lease the Equipment upon the following terms and conditions:

1. LEASE PAYMENTS AND TERM: The Lease is enforceable on you upon your execution. The term of the Lease shall commence on the date the Equipment is delivered to you ("Lease Commencement Date"). The first Lease Payment shall be due on the date we specify in the month following the Lease Commencement Date as set forth in our invoice, and the remaining Lease Payments will be due on the same day of each subsequent month (each, a "Payment Date") until paid in full. The Base Term shall commence on the date one month prior to the first Payment Date. We may charge you a portion of one Lease Payment for the period from the Lease Commencement Date until the first day of the Base Term ("Interim Rent"). The Interim Rent shall be due as invoiced. We may adjust the Lease Payments up to 15% if the actual costs are different than the estimate used to calculate the Lease Payments.

2. DELIVERY, ACCEPTANCE, USE AND REPAIR: You are responsible for Equipment delivery and installation. Unless you notify us otherwise in writing within 10 days of delivery, you unconditionally accept the Equipment. You authorize us to fill in the Lease Commencement Date, serial numbers and other information. You will not move the Equipment from the above location without our written consent and are responsible for maintaining the Equipment in good repair. We are not responsible for Equipment or vendor

3. INDEMNIFICATION: You agree to indemnify, defend and hold us harmless from and against any losses, damages, penalties, claims and suits, including attorneys' fees and expenses related to the ordering, manufacture, installation, ownership, condition, use, lease, possession, delivery or return of Equipment 4. LEASE EXPIRATION, RENEWAL: Unless you notify us at least 90 days prior to the

expiration of the Lease of your election to return or purchase the Equipment, this Lease will renew on a month-to-month basis at the same monthly Lease Payment until you either exercise the purchase option or provide us with at least 90 days notice and return the Equipment. If you return the Equipment, (i) it must be to the location we designate and you are responsible for all return costs and we may charge a Restocking Fee equal to one Lease Payment, and (ii) you must securely remove all data from any and all disk drives or magnetic media prior to returning the Equipment (and you are solely responsible for selecting an appropriate removal standard that meets your business needs and complies with applicable laws). You will pay us for any loss in value resulting from failure to maintain the Equipment in accordance with this Lease or for damages incurred in shipping and handling. If you exercise a purchase option we will convey all of our interest in such Equipment to you on an AS-IS WHERE IS basis without representation or warranty.

5. LATE FEES AND CHARGES: If any amount is not paid within five (5) days of when due, you agree to pay us a late charge equal to the lesser of 10% of the amount past due or the maximum legal amount. Amounts which are not paid within 30 days of when due shall accrue interest at 1.5% per month (or if less, the maximum legal rate) until paid. You agree to pay \$25 for each pay by phone and \$35 for each returned payment.

5.25 for each pay optione and 555 for each returned payment.
6. NO WARRANTY: We do not manufacture the Equipment and you have selected the Equipment and the supplier. WE MAKE NO EXPRESS OR IMPLIED WARRANTIES, INCLUDING THOSE OF MERCHANTABILITY OR FITNESS FOR A PURPOSE AND ARE NOT RESPONSIBLE FOR CONSEQUENTIAL OR INCIDENTAL. DAMAGES.

7. INSURANCE, RISK OF LOSS: You bear all risk of loss or damage to the Equipment from its order until it is returned in the required condition or purchased by you ("Risk Period"). During the Risk Period you will maintain property and liability insurance on the Equipment acceptable to us, naming us loss payee and additional insured. If you do not

may be more than the cost to obtain your own insurance and on which we may make a profit. 8. OWNERSHIP AND TAXES: We own the Equipment (excluding licensed software). If you are deemed to own it, you grant us a security interest in the Equipment. You authorize us

for the UCC financing statements to confirm our interest. You will pay, when due, all taxes, fines and penalties relating to the purchase, use, leasing and/or ownership of the Equipment. For administrative purposes, unless we otherwise direct in writing, you will list Lessee as the owner of the Equipment for property tax purposes and file and pay when due any property taxes relating to the Equipment directly to the taxing authority and provide us with evidence of compliance. If we pay any taxes, fees or penalties on your behalf, you will pay us the amount we paid plus an administrative fee. You agree to pay us the documentation fee specified above or if not so specified, the greater of either \$125 or 0.5% of the Equipment cost. If we require an Equipment site inspection, or you request administrative services, you agree to reimburse our costs.

9. DEFAULT: If you or any guarantor do not pay us any amount within ten (10) days of its due date, or breach any terms of this Lease, any guaranty or any license relating to the Equipment, you will be in default. If you default, we may require you to do any combination of the following: (a) immediately pay all amounts then due, plus the present value of the remaining Lease Payments, Interim Rent and residual value of the Equipment, as determined by us, discounted at an annual rate of 3%; (b) return all of the Equipment; (c) allow us to repossess the Equipment, or (d) use any and all remedies available to us under applicable law. If you default, you agree to pay the cost of repossession and our attorney's fees and costs. In addition to all other charges and as reimbursement for expenses incurred and not as a penalty, we may require you to reimburse us for the phone calls, letters, and any additional expense incurred in the collection or servicing of this Lease for you. If we take possession of the Equipment, we may sell or otherwise dispose of it with or without notice, at a public or private sale, and apply the net proceeds (after we have deducted all costs related to the sale or disposition of the Equipment) to the amounts that you owe us. You agree that if notice of sale is required by law, 10 days' notice shall constitute reasonable notice. You remain responsible for any amounts that are due after we have applied such net proceeds. We may apply any security deposits to your obligations and if you do not default, the balance will be refunded without interest.

10. ASSIGNMENT: You have no right to sell or assign the Equipment or Lease. We may sell or assign our rights in the Lease and/or Equipment and the new owner will have all our

set of assist our lights in the subject to any claim or defense you have against us. 11. ARTICLE 2A: You agree this Lease is a "finance lease" as defined in Article 2A of the Uniform Commercial Code. You waive all rights and remedies conferred upon a lessee by Article 2A (508-522) of the UCC. You have received a copy of the Supply Contract or been informed of the identity of the Supplier and you may have rights under the Supply Contract and may contact the Supplier for a description of those rights.

12. CREDIT INFORMATION: You authorize us or any of our affiliates to obtain credit

bureau reports, and make other credit inquiries that we deem necessary. 13. CHOICE OF LAW: THIS LEASE WILL BE GOVERNED BY PENNSYLVANIA LAW. YOU CONSENT TO JURISDICTION IN THE STATE OR FEDERAL COURTS IN PENNSYLVANIA AND WAIVE ANY RIGHT TO A TRIAL BY JURY.

14. MISCELLANEOUS: This Lease is the parties' entire agreement and can be amended only in writing signed by both parties. A fax of the Lease with fax signatures may be treated as an original and will be admissible as evidence. You will use the Equipment only for business purposes and not for personal, family or household use.

ACCEPTED BY LESSEE: Bloomfield Health Care	Print Name: MICI.	AEZ BOKO~	Title:
X Lessee Authorized Signature	E-Mail Address:		Date:
PERSONAL GUARANTY: Undersigned guarantees t guaranty of payment and not of collection, and that w suretyship defenses and notification if the Lessee is in a fees) we incur in enforcing our rights against undersign us and our affiliates to obtain credit bureau reports and expressly waive any right to a trial by jury.	te can proceed directly against undersigned without fi default and consents to any extensions or modification ed or Lessee. If more than one person signs this guaran	rst proceeding against Lessee or t s granted to Lessee. Undersigned w ty, each agrees that his/her liability	he Equipment Undersigned also waives al vill pay us all expenses (including attorneys is joint and several, Undersigned authorize
SIGNED X	Print Name;	E-Mail Addi	2225
Accepted by: LEAF Capital Funding, LLC By:	Title:	Date:	

LEASE01 8-20-2012 App=336952



SCHEDULE A TO LEASE AGREEMENT (EQUIPMENT DESCRIPTION)

Lease Application No.: 336952

QNT	Equipment Description	New/Used	Make	Modei	Serial Number
Loca	tion: 355 Park Avenue, Bloomfield, CT 06002				
1	Toshiba E-STUDIO 757	New		E-STUDIO 757	
1	Toshiba E-STUDIO 357	New		E-STUDIO 357	

-

LESSEE: Bloomfield Health Care
A
BY:
PRINT NAME Charl Solo-
TITLE: Materials Ment.
DATE: 12/22/15

LEAF CAPITAL FUNDING, LLC

BY:
PRINT NAME:
TITLE:
DATE:

Page 1 of 1

LEASESCHEDA 8-23-2012 App=336952

POINTCLICKCARE.COM SUBSCRIPTION SERVICE AGREEMENT

This agreement is made between Wescom Solutions Inc. ("Wescom"), 6975 Creditview Road, Unit 4, Mississauga, Ontario, L5N 8E9 AND National HealthCare Associates Inc, 46 Stauderman Ave., Lynbrook NY 11563 (Client)

Preamble

WHEREAS Wescom has developed PointClickCare.com ("PointClickCare"), a website designed, *inter alia*, to maintain patient/client records ("Records") for government entities and the private healthcare provider system;

AND WHEREAS PointClickCare consists of various applications, each of which offers various options to the Client ("Applications");

AND WHEREAS Wescom is the registered owner of PointClickCare and the Applications;

AND WHEREAS Wescom is prepared to grant a limited license for the use of the Applications to the Client.

1. **Description of Service**

1.1 Online Subscription Service. Wescom grants to the Client, during the term of this Agreement, a limited license to use those Applications of PointClickCare listed in Schedule 1 attached hereto, for a specified number of active Records ("Licensed Capacity"). The Licensed Capacity of the Client is set out in Schedule 1 hereto. The active Records shall be provided to the Client via an online service ("Online Service") through a data center established and maintained by Wescom ("Data Center"). Non-active (discharged or waiting list) Records are maintained by PointClickCare but are not included in the Licensed Capacity of the Client for the purposes of calculating the Subscription Charge (as hereinafter defined).

<u>1.2 Modifications</u>. The Client may, at any time, increase or decrease its Licensed Capacity and/or the number of Applications licensed. For each increase in the Licensed Capacity or number of Applications licensed, there shall be an additional Schedule 1 signed by both parties, which shall be subject to the terms of this Agreement.

<u>1.3 Client Responsibilities</u>. In order to use the Online Service, the Client must obtain access to the World Wide Web, either directly or through devices that access web-based content. The Client shall be responsible for any service fees associated with such access, including any carrier fees. In addition, the Client shall provide all equipment necessary to make such connection to the World Wide Web, including a computer and modem and/or a wireless access device.

<u>1.4 Transfer of limited license to use the Online Service</u>. The Client's usage rights to PointClickCare or any Application may not be transferred to another entity without the prior written consent of Wescom.

2. Eligibility

PointClickCare.com is available only to healthcare provider or government entities that have the capacity to enter into legally binding contracts under applicable law for legitimate business purposes. Any entity failing to fit the preceding description will not be able to enter into this Agreement.

3. Online Service Accessibility

<u>3.1 Database And Applications Accessibility</u>. The Data Center shall operate 24 hours a day, 365 days per year, subject to scheduled maintenance as described in section 3.2. The Client shall, subject to obtaining access to the World Wide Web, acquire access to the Client Database and acquire the ability to perform data processing with each Application, in accordance with the design of such Application, during not less than 99.6% of hours 24x7x365 for each calendar year.

3.2 Downtime Maintenance Periods. Wescom periodically adds, repairs, and upgrades the Data Center network, hardware and the Applications and shall use its best efforts to accomplish this without affecting the Client's access to PointClickCare or the Applications; however, repairs of an emergency or critical nature may result in the Online Service not being available for the Client's usage during the course of such repairs. In addition, Wescom has established periodic system maintenance windows on Tuesday and Friday mornings between the hours of 2am and 5am (EST). During this time, Wescom reserves the right to take down the server(s) at the Data Center hosting the Client Data in order to conduct routine maintenance to both software and hardware. Wescom shall advise the Client prior to any scheduled downtime. Wescom reserves the right to change its maintenance window upon prior notice to Client provided the maintenance occurs between the hours of 2 a.m. and 5 a.m. (EST).

<u>3.3 Database Back-up</u>. Tapes or other storage media shall be used at the Data Center for daily back-up of data for disaster protection purposes.

4. Subscription/License Fee

<u>4.1 Subscription Charge</u>. The Client shall be responsible for a subscription fee as set forth in Schedule 1 (the "Subscription Charge"), and shall be payable in full within 30-days from official start date.

<u>4.2 Price Protection</u>. We com may, at any time during the term of this Agreement, modify the Subscription Charge, upon ninety (90) days prior notice, subject to the following limitations:

a) no modification may occur within the twenty four

- b) -month period beginning with the first term for which the Subscription Charge is payable;
- c) Subscription Charge may not increase by more than 4% on any given year.

5. Non-Subscription Services

(a) Training & Professional Services. We com shall provide training & professional services to the Client's staff in the use of the Applications in accordance with the attached Schedule 2.

5.1 (b) Fixed Rate Training (If elected in Schedule 1). Wescom shall provide Fixed Rate training for as long as the client is subscribed to the Fixed Rate training subscription fee. This fee includes participation in all scheduled webinars, replacement training for designated PCC System Administrator, DON/DOC MDS Coordinator, or Office Coordinator and pre-scheduled training for 2 named clinical and 2 office contacts per centre. The client shall be required to purchase the published standard implementation fees in order for the on Fixed Rate training to take effect. The Client is committed for a period of 1 year. After one (1) year, the client may cancel the Fixed Rate training. The client shall not subscribe to Fixed Rate training for a period of one (1) year. If additional training is required or requested, the client shall pay the published rate of \$125/h.

5.2 Data Import Services. Except as expressly provided by this Agreement or an exhibit hereto, the Client shall be responsible for entering all Client Data, including data previously entered in a different software system. The Client may elect to purchase the Data Import service from Wescom for designated data sets, as offered by Wescom. If the data import service is elected, an exhibit will be attached hereto in Schedule 4 titled "Data Import Services"

5.3 Technical Support. TECHNICAL SUPPORT IS INCLUDED IN THE SUBSCRIPTION CHARGE. Technical support is defined as the provision of corrections for any reproducible material error in the Application. Technical support included in the Subscription Charge refers explicitly to maintaining or restoring the Application to operation in accordance with the system documentation. Support issues that arise through user error and Application training issues shall be referred to the Help Desk.

5.4 Help Desk. Wescom shall provide help desk ("Help Desk") support on an as-needed basis at no charge to the Client upon commencement of the Subscription Services and completion of client training. Help Desk services are available to the Client between 8am and 8pm EST Monday to Friday with off hour emergency support provided for urgent issues. An Urgent issue is defined by the Wescom "Service Level Agreement" found in Schedule 3 attached hereto.

6. Use Practices

<u>6.1 Security</u>. The Client shall receive one or more unique user identity and password combinations. In the event of turnover in the Client's staff or any other occurrence resulting in the Client's password(s) becoming known to any person not authorized to act for the Client, the Client shall immediately

notify Wescom. The Client shall be responsible for all security precautions at its site(s) and within its staff.

<u>6.2 Session Connection Limitations</u>. A connection session is the continuous block of time from the time the Client logs in to the Data Center until the moment the Client disconnects. In the event that the Client, after using an Application, omits to disconnect and leaves the connection idle for 15 minutes, Wescom shall automatically disconnect such connection. If disconnected, the Client is free to re-connect immediately to establish a new session.

<u>6.3 Suspension</u>. If the Client fails to make payment of any amount owing, including the Subscription Charge, under this Agreement within 45 days of such amount becoming due, the Client's right to utilize the Applications shall, at the discretion of Wescom, be subject to suspension. During the period of suspension, any attempt to access the Data Center by the Client will be blocked. An account that has been suspended for nonpayment will not be reactivated until the balance due on the account has been paid in full, or sufficient arrangements for payment acceptable to Wescom have been made. Reactivation of a suspended account requires, in addition to charges otherwise payable, a one-hundred-dollar (\$100.00) reactivation fee. Service fees shall continue to accrue during any period of suspension. Suspension of a Client account does not relieve the Client of his obligation to pay the outstanding account balance.

7. Term & Termination

<u>7.1 Term</u>. The Applications and live database shall be made available to the Client on a date determined by Wescom ("Official Subscription Start Date"). This Agreement constitutes an agreement for the Term outlined in Schedule 1, and shall be automatically renewable unless either party requests change or termination in writing to the other. Either party may terminate this Agreement, by notifying the other party thirty (30) days in advance.

<u>7.2 Termination.</u> Upon termination Wescom shall make available to the Client a file of the Client's data. The Client, if it requires such file, shall make such request when notifying Wescom of the termination of the Online Service. Wescom shall provide such file within 7 days of receipt of such request. Upon termination of the Online Service, the Client's right to use such Online Service immediately ceases. Wescom shall have no obligation to maintain any Data stored on behalf of the Client or to forward any Data to the Client or any third party. Wescom may, but is not obligated to, delete archived data, but will not do so until thirty (30) days following termination.

<u>7.3 Data Access on Insolvency</u>. In the event that Wescom threatens to or ceases operations, executes an assignment for the benefit of creditors, takes the benefit of any legislation for insolvent persons, or is subject to receivership or bankruptcy proceedings, the Client shall on written request by the Client to Wescom be provided with a disk copy of the Client's data within 7 business days.

8. Private Health Information Confidentiality - Wescom covenants and agrees;

- Not use or further disclose the Clients information other than as permitted or required to carry out its obligations pursuant to this Agreement or as required by law;
- b. To use reasonable safeguards to prevent use or disclosure of the Client's information other than as provided for in this Agreement;
- c. To report to the Client any use or disclosure of the Client's information not provided for by this Agreement of which it becomes aware;
- d. To ensure that any agents, including any subcontractors, to whom Wescom provides private health information ("PHI") received from, or created or received by Wescom on behalf of the Client, agrees to the same restrictions and conditions that apply to Wescom with respect to such information;
- e. To make available PHI in accordance with legislative requirements for access of individuals to PHI;
- f. To comply with all applicable legislation governing the confidentiality of the Client's data;
- g. To make available the information required to provide an accounting of disclosures in accordance with legislative requirements for accounting of disclosures of PHI;
- h. To make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by the Wescom on behalf of, the Client, available for purposes of determining Wescom's compliance its obligations pursuant to this section 8; and
- i. On termination of this Agreement to, destroy all PHI received from, or created or received by Wescom on behalf of the Client that Wescom still maintains in any form and Wescom covenants that it shall retain no copies of such information, or, if such return or destruction is not feasible, to extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible.

9. Additional Terms

<u>9.1 Warranty</u>. Wescom warrants that the Client shall have the right to utilize the Applications free and clear of all liens and encumbrances, subject to the terms hereof. Wescom warrants that the Applications shall function, as originally deployed and as modified by future releases, in accordance with its documentation, and that the Client shall have access to the Applications at the Data Center as described in this Agreement. NO OTHER WARRANTIES APPLY, EITHER EXPRESS OR IMPLIED, INCLUDING ANY WARRANTY OF MERCHANTABILITY OR FITNESS FOR PARTICULAR PURPOSE.

<u>9.2 Client Data</u>. Wescom does not own any data, information or material submitted by the Client to the Online Service ("Data"), unless Wescom specifically advises the Client otherwise. Wescom agrees not to disclose to any third party any information concerning the Client's operations, clients or patients except as expressly authorized herein. The Client shall allow Wescom to access and copy the Client Data provided that the portions of the Client Data to be copied by Wescom (the "Database") shall not include patient identification information, and further provided

that Wescom shall not provide the Database to any third party in any format – either by facility name or location – which enables such third party to identify Client Facility(ies) (individually or collectively) as the basis for the data reported. Subject to such restriction, Wescom may use or provide to third parties anonymous database information.

10. Limitation of Liability

IN NO EVENT SHALL WESCOM BE LIABLE FOR ANY DIRECT, INDIRECT, INCIDENTAL, SPECIAL OR CONSEQUENTIAL DAMAGES, OR DAMAGES FOR LOSS OF PROFITS, REVENUE, DATA OR USE, INCURRED BY THE CLIENT OR ANY THIRD PARTY, WHETHER IN AN ACTION IN CONTRACT OR TORT, ARISING FROM THE CLIENT'S ACCESS TO, OR USE OF, THE SITE OR THE ONLINE SERVICE UNLESS RESULTING FROM NEGLIGENT ACTS OR OMISSION BY WESCOM. SOME JURISDICTIONS DO NOT ALLOW THE EXCLUSION OF CERTAIN WARRANTIES OR THE LIMITATION OR EXCLUSION OF LIABILITY FOR INCIDENTAL OR CONSEQUENTIAL DAMAGES. ACCORDINGLY, SOME OF THE ABOVE LIMITATIONS MAY NOT APPLY TO THE CLIENT.

11. Indemnity

(a) The Client shall defend, indemnify and hold harmless Wescom, its officers, directors, employees and agents from and against any and all claims, liabilities, damages, losses or expenses, including reasonable attorneys' fees and costs, arising out of or in any way connected with the Client's access to or use of the Online Service or the site or the Applications UNLESS RESULTING FROM NEGLIGENT ACTS OR OMISSION BY WESCOM.

(b) Wescom shall defend, indemnify and hold harmless the Client, its officers, directors, employees and agents from and against any and all claims, liabilities, damages, losses or expenses, including reasonable attorneys' fees and costs, arising out of or in any way connected with the Client's access to or use of the Online Service or the site or the Applications.

12. General

<u>12.1 Notices.</u> All notices, requests, demands or other communications (collectively, "Notices") by the terms hereof required or permitted to be given by one party to any other party, or to any other person shall be given in writing by personal delivery or by registered mail, postage prepaid, or by facsimile transmission to such other party as follows:

- (a) To Wescom at: Wescom Solutions Inc.
 6975 Creditview Road, Unit 4 Mississauga, Ontario, L5N 8E9 Fax: (905) 858-2248
- (b) To Client at: National HealthCare Associates Inc 46 Stauderman Ave Lynbrook NY 11563

or at such other address as may be given by such person to the other parties hereto in writing from time to time.

All such Notices shall be deemed to have been received when delivered or transmitted, or, if mailed, 48 hours after 12:01 a.m. on the day following the day of the mailing thereof. If any Notice shall have been mailed and if regular mail service shall be interrupted by strikes or other irregularities, such Notice shall be deemed to have been received 5 days after 12:01 a.m. on the day following the resumption of normal mail service, provided that during the period that regular mail service shall be interrupted all Notices shall be given by personal delivery or by facsimile transmission.

<u>12.2 Governing Law.</u> This Agreement shall be governed by and construed in accordance with the State laws of New York and the federal laws of the United States of America applicable therein and each of the parties hereto agrees irrevocably to conform to the non-exclusive jurisdiction of the Courts of such State.

<u>12.3 Confidentiality</u>. Each party shall treat as confidential the terms of this Agreement and any information received concerning the other party which is not generally known to the public. Each party shall use reasonable precautions to prevent any confidential information from being acquired by an unauthorized person.

<u>12.4 Taxes</u>. The Client shall be responsible for payment of all taxes associated with this Agreement including, but not limited to, personal property taxes, sales taxes, use taxes, import taxes, taxes on telecommunication services, information services, data processing services or similar governmental charges that may be assessed by any jurisdiction, whether based on gross revenue or delivery of products or services.

12.5 Entire Agreement. This Agreement constitutes the entire Agreement between the parties with respect to all of the matters herein and its execution has not been induced by, nor do any of the parties rely upon or regard as material, any representations or writings whatever not incorporated herein and made a part hereof and may not be amended or modified in any respect except by written instrument signed by the parties hereto. Any schedules referred to herein are incorporated herein by reference and form part of the Agreement.

<u>12.6 Additional Considerations</u>. The parties shall sign such further and other documents, cause such meetings to be held, resolutions passed and by-laws enacted, exercise their vote and influence, do and perform and cause to be done and performed such further and other acts and things as may be necessary or desirable in order to give full effect to this Agreement and every part thereof. <u>12.7 Counterparts</u>. This Agreement may be executed in several counterparts, each of which so executed shall be deemed to be an original and such counterparts together shall be but one and the same instrument.

<u>12.8 Time of the Essence</u>. Time shall be of the essence of this Agreement and of every part hereof and no extension or variation of this Agreement shall operate as a waiver of this provision.

<u>12.9 Currency</u>. Unless otherwise provided for herein, all monetary amounts referred to herein shall refer to the lawful money of the United States of America.

<u>12.10 Headings for Convenience Only</u>. The division of this Agreement into articles and sections is for convenience of reference only and shall not affect the interpretation or construction of this Agreement.

<u>12.11</u> Gender. In this Agreement, words importing the singular number shall include the plural and vice versa, and words importing the use of any gender shall include the masculine, feminine and neuter genders and the word "person" shall include an individual, a trust, a partnership, a body corporate, an association or other incorporated or unincorporated organization or entity.

<u>12.12</u> Calculation of Time. When calculating the period of time within which or following which any act is to be done or step taken pursuant to this Agreement, the date which is the reference date in calculating such period shall be excluded. If the last day of such period is not a Business Day, then the time period in question shall end on the first business day following such non-business day.

<u>12.13 Severability</u>. If any Article, Section or any portion of any Section of this Agreement is determined to be unenforceable or invalid for any reason whatsoever that unenforceability or invalidity shall not affect the enforceability or validity of the remaining portions of this Agreement and such unenforceable or invalid Article, Section or portion thereof shall be severed from the remainder of this Agreement.

<u>12.14</u> Transmission by Facsimile. The parties hereto agree that this Agreement may be transmitted by facsimile or such similar device and that the reproduction of signatures by facsimile or such similar device will be treated as binding as if originals and each party hereto undertakes to provide each and every other party hereto with a copy of the Agreement bearing original signatures forthwith upon demand.

WESCOM SOLUTIONS INC.

By: _____C/S

Name: Angelo Papatheodorou Title: VP of Sales Date:

I have authority to bind the Corporation

National HealthCare Associates Inc

By:	C/S
Name: Yosef Daskal	
Title: Dir. of Procurement	
Date: 3-7-12	

I have authority to bind the Corporation

Schedule 1 PointClickCare Subscription Service

Applications: -EHR Advantage for Skilled -HL7 5 Pack -Replicated Reporting Data base	Clinical Bundled Applications Included Admission Discharge Transfer Medical Diagnosis (ICD 9/10) Care Plans Minimum Data Set (MDS 2.0/3.0) User Defined Assessments Progress Notes Physician Orders MARs/TARs (electronic) Communications Board Weights and Vitals Immunizations Risk Management Point of Care
	 Point of Care Intake Referral Management Resident Accounting Applications Included Census and Admissions Billing & Accounts Receivable Trust Accounts Collections HL7 5 Pack Interface (ROX)

Official Subscription Start Date:	April 1, 2012
Estimated Implementation Start Date:	April 1, 2012
Billing terms	Net 30
NT /	

Notes:

- 1. National has selected the Cold Springs facility for its pilot implementation. Prior to the implementation of the remaining facilities, National and PCC will mutually agree upon implementation fees that are needed for the remainder of the project.
- **2.** The term of this agreement is one year and as indicated in section 7.1 of the contract either party may cancel the agreement upon 30 days written notice for any reason.
- 3. Project Tentative start dates as noted above.
- 4. Training databases will be provided at an annual rate of \$1,200. DB refresh is \$300 per instance.
- **5.** Pharmacy Interface is not included in the listed fees and is subject to an additional subscription fee. Pharmacy participation is required. Pharmacy is responsible for incurring any charges if any are applicable.

Unit costs from Table 1.0 are based upon the following:

EHR Advantage Clinical & Financial Bundled Applications for SNF Residents \$0.48 Std Cost / Bed / Day – 38% Discount = \$0.2976/Resident/ Day HL7 Five Pack \$0.07 Std Cost / Bed / Day – 38% Discount = \$0.0435/Resident /Day Replicated Reporting DataBase \$0.03 std Cost/Bed/Day- 38% Discount= \$0.0187/Resident/Day

*The official subscription start date for the facility shall be the 1st day of the month for the facility based on the roll-out plan completed at the end of the discovery sessions. In the event that an alternative start date has been agreed upon with the Project Manager and Client, a written confirmation signed by both parties shall be required otherwise the above shall prevail as the official start date. Client also acknowledges that PointClickCare will invoice for the full (bundled) subscription fee per facility starting on the official subscription start date for that facility listed above. All of the above listed facilities will be billed on a separate invoice and sent to: National HealthCare Associates Inc, 46 Stauderman Ave Lynbrook NY 11563. During the rollout of PCC for the Pilot facility, both parties will agree to an implementation cost for the remainder of the facilities as well as an intended implementation schedule.

<u>Table 1.0</u>		PCC Pre- Disc.	Discount	Term	
Description	# of Beds	Cost/Bed/Day	Percentage	Monthly Sub. Fee	* Official Sub. Start Date
National Healthcare					
Associates Inc. 46 Stauderman Ave Lynbrook NY 11563					
EHR Advantage – clinical & financial bundled Application	4039	\$0.48	38%	\$36,661.20	TBD
HL7 Five Pack	4039	\$0.07	38%	\$5,358.95	TBD
Replicated Reporting data Base	4039	\$0.03	38%	\$2,291.33	TBD
Total Monthly Subscriptions				\$44,311.48	
Belair 2478 Jerusalem Ave. North Bellmore, NY 11710					
EHR Advantage – clinical & financial bundled Application	102	\$0.48	38%	\$925.83	TBD
HL7 Five Pack	102	\$0.07	38%	\$135.33	TBD
Replicated Reporting data Base	102	\$0.03	38%	\$57.87	TBD
Bloomfield					
355 Park Ave. Bloomfield, CT 06002					
EHR Advantage – clinical & financial bundled Application	120	\$0.48	38%	\$1089.22	TBD
HL7 Five Pack	120	\$0.07	38%	\$159.22	TBD
Replicated Reporting data Base	120	\$0.03	38%	\$68.08	TBD
Brattleboro (Pine					
Heights) 187 Oak Grove Avenue Brattleboro, VT 05301					
EHR Advantage – clinical & financial bundled Application	80	\$0.48	38%	\$726.14	TBD
HL7 Five Pack	80	\$0.07	38%	\$106.14	TBD
Replicated Reporting data Base	80	\$0.03	38%	\$45.38	TBD

Bristol (The Pines at) 61 Bellevue Avenue Bristol, CT 06010					
EHR Advantage – clinical & financial bundled Application	132	\$0.48	38%	\$1198.14	TBD
HL7 Five Pack	132	\$0.07	38%	\$175.14	TBD
Replicated Reporting data Base	132	\$0.03	38%	\$74.88	TBD
Cambridge 2428 Easton Turnpike Fairfield, CT 06825					
EHR Advantage – clinical & financial bundled Application	160	\$0.48	38%	\$1452.29	TBD
HL7 Five Pack	160	\$0.07	38%	\$212.29	TBD
Replicated Reporting data Base	160	\$0.03	38%	\$90.77	TBD
Catskill 154 Jefferson Plain Heights Catskill, NY 12414					
EHR Advantage – clinical & financial bundled Application	136	\$0.48	38%	\$1234.45	TBD
HL7 Five Pack	136	\$0.07	38%	\$180.45	TBD
Replicated Reporting data Base	136	\$0.03	38%	\$77.15	TBD
Cold Spring Hills- Pilot Facility 378 Syosset-Woodbury Rd Woodbury NY 11797					
EHR Advantage – clinical & financial bundled Application	606	\$0.48	38%	\$5,500.54	TBD
HL7 Five Pack	606	\$0.07	38%	\$804.04	TBD
Replicated Reporting data Base	606	\$0.03	38%	\$343.78	TBD
Glens Falls 170 Warren Street Glens Falls, NY 12801					
EHR Advantage – clinical & financial bundled Application	120	\$0.48	38%	\$1089.22	TBD
HL7 Five Pack	120	\$0.07	38%	\$159.22	TBD
Replicated Reporting data Base	120	\$0.03	38%	\$68.08	TBD

Hudson Pointe					
3220 Henry Hudson Pkwy Riverdale, NY 10463					
EHR Advantage – clinical &	167	\$0.48	38%	\$1515.83	TBD
financial bundled Application	107	ψ0.40	50%	φ1515.05	TDD
HL7 Five Pack	167	\$0.07	38%	\$221.58	TBD
Replicated Reporting data Base	167	\$0.03	38%	\$94.74	TBD
Huntington Hills 400 South Service Rd.					
Melville, NY 11747 EHR Advantage – clinical & financial hundled Application	320	\$0.48	38%	\$2904.58	TBD
financial bundled Application HL7 Five Pack	320	\$0.07	38%	\$424.58	TBD
Replicated Reporting data Base	320	\$0.03	38%	\$181.54	TBD
Duse					
Ludlowe Center 118 Jefferson Street Fairfield, CT 06825					
EHR Advantage – clinical & financial bundled Application	144	\$0.48	38%	\$1307.06	TBD
HL7 Five Pack	144	\$0.07	38%	\$191.06	TBD
Replicated Reporting data Base	144	\$0.03	38%	\$81.69	TBD
Maple View 856 Maple St. Rocky Hill, CT 06067					
EHR Advantage – clinical & financial bundled Application	120	\$0.48	38%	\$1089.22	TBD
HL7 Five Pack	120	\$0.07	38%	\$159.22	TBD
Replicated Reporting data Base	120	\$0.03	38%	\$68.08	TBD
Marlborough 85 Stage Harbor Rd. Marlborough, CT 06447					
EHR Advantage – clinical & financial bundled Application	120	\$0.48	38%	\$1089.22	TBD
HL7 Five Pack	120	\$0.07	38%	\$159.22	TBD
Replicated Reporting data Base	120	\$0.03	38%	\$68.08	TBD

Maywood 100 West Magnolia Avenue					
Maywood, NJ 07607					
EHR Advantage – clinical &	120	\$0.48	38%	\$1089.22	TBD
financial bundled Application	120	¢0.07	200/	¢150.22	TDD
HL7 Five Pack	120	\$0.07	38%	\$159.22	TBD
Replicated Reporting data Base	120	\$0.03	38%	\$68.08	TBD
Milford 195 Platt St. Milford, CT 06460					
EHR Advantage – clinical & financial bundled Application	120	\$0.48	38%	\$1089.22	TBD
HL7 Five Pack	120	\$0.07	38%	\$159.22	TBD
Replicated Reporting data Base	120	\$0.03	38%	\$68.08	TBD
Poughkeepsie					
100 Franklin Street Poughkeepsie, NY 12601					
EHR Advantage – clinical & financial bundled Application	200	\$0.48	38%	\$1815.36	TBD
HL7 Five Pack	200	\$0.07	38%	\$265.36	TBD
Replicated Reporting data Base	200	\$0.03	38%	\$113.46	TBD
Regency 181 East Main St.					
Wallingford, CT 06492EHR Advantage – clinical &financial bundled Application	130	\$0.48	38%	\$1179.98	TBD
HL7 Five Pack	130	\$0.07	38%	\$172.48	TBD
Replicated Reporting data Base	130	\$0.03	38%	\$73.75	TBD
Riverside 745 Main St.					
East Hartford, CT 06108					
EHR Advantage – clinical & financial bundled Application	345	\$0.48	38%	\$3131.50	TBD
HL7 Five Pack	345	\$0.07	38%	\$457.75	TBD
Replicated Reporting data Base	345	\$0.03	38%	\$195.72	TBD

135 135 135 135 135 120 120 120	\$0.48 \$0.07 \$0.03 \$0.48 \$0.48	38% 38% 38% 38%	\$1225.37 \$179.12 \$76.59 \$1089.22	TBD TBD TBD TBD
135 135 135 120 120	\$0.07 \$0.03 \$0.48	<u>38%</u> <u>38%</u>	\$179.12 \$76.59	TBD TBD
135 135 135 120 120	\$0.07 \$0.03 \$0.48	<u>38%</u> <u>38%</u>	\$179.12 \$76.59	TBD TBD
135 120 120	\$0.03	38%	\$76.59	TBD
120 120	\$0.48			
120 120	\$0.48			
120		38%	\$1089.22	TBD
120		38%	\$1089.22	TBD
120		38%	\$1089.22	TBD
	¢0.07			100
120	\$0.07	38%	\$159.22	TBD
120	\$0.03	38%	\$68.08	TBD
180	\$0.48	38%	\$1633.82	TBD
180	\$0.07	38%	\$238.82	TBD
180	\$0.03	38%	\$102.11	TBD
117	\$0.48	38%	\$1061.99	TBD
117	\$0.07	38%	\$155.24	TBD
117	\$0.03	38%	\$66.37	TBD
95	\$0.48	38%	\$862.30	TBD
95	\$0.07	38%	\$126.05	TBD
95	\$0.03	38%	\$53.89	TBD
	180 180 180 117 117 117 95 95 95	180 \$0.48 180 \$0.07 180 \$0.03 180 \$0.03 117 \$0.48 117 \$0.48 117 \$0.07 117 \$0.03 95 \$0.48 95 \$0.07	180 \$0.48 38% 180 \$0.07 38% 180 \$0.03 38% 180 \$0.03 38% 180 \$0.03 38% 117 \$0.48 38% 117 \$0.07 38% 117 \$0.03 38% 95 \$0.48 38% 95 \$0.07 38%	Image: second

Water's Edge 111 Church St. Middletown, CT 06457					
EHR Advantage – clinical & financial bundled Application	150	\$0.48	38%	\$1361.52	TBD
HL7 Five Pack	150	\$0.07	38%	\$199.02	TBD
Replicated Reporting data Base	150	\$0.03	38%	\$85.10	TBD

Schedule 2

PointClickCare Professional Services – Implementation Budget for the Pilot Facility

Item	Group Qty	Extended Rate	Amount
Enterprise Configuration	1	\$6000	\$6000
Clinical Training (Train the trainer)	1	\$39,750	\$39,750
Financial Training	<mark>1</mark>	<mark>\$TBD</mark>	<mark>\$TBD</mark>
Data Imports - Gold	1	\$1,250	1,250
Project MGMT	1	\$21,250	\$21,250
User defined assessment (UDA) Corporate Configuration	1	\$7,000	\$7000
IRM Training (with super user training)	1	\$600	\$600
Sandbox training database.	1	\$1200	\$1200
TOTAL			\$61,300

Terms:

- 1. Unless otherwise stated, all project coordination, configuration, implementation and data services are provided by consultants online and/or over the telephone. In the event that onsite services are required, the Client acknowledges that travel and accommodation fees are not included in the above noted fees. For clarification purposes, the Client will be solely responsible for all travel and accommodation expenses incurred by Wescom or its employees for any Onsite services required.
- 2. Cancellation Policy: All training sessions scheduled with a PointClickCare consultant require at least 24 hours notice when cancelling. Any sessions cancelled with less than 24 hours notice will be charged at their full rate. This policy also applies to fixed rate customers
- 3. Implementation fees are due within 30 days of signing.
- 4. Client will provide a fully equipped classroom with PCs, Internet connection and a PC projector (if possible).

Schedule 3 Service Level Agreement

Service Request Priorities:

Service priorities are identified by Help Desk service representatives based on the definitions below. Priorities that cannot be determined by the help desk representative are immediately escalated following Wescom's defined staff escalation process. The initial response time is the time in which the customer reporting the service request is provided with an initial diagnosis of the request and provided with a Service Request number (SR#) to track the request. The target resolution is the expected timeframe that the Service Request will be resolved.

Service Level Agreement:

Priority Level	Problem Description	Initial Response	Target Resolution Time	Commitment
Urgent	A condition that is stopping production with no economically feasible alternate method for running PointClickCare or prevents users from accessing or using a critical function of PointClickCare. Examples: - Users cannot login to the application (does not include Users forgetting or losing their password). - Data is corrupted in the PointClickCare database.	1 hour, 24 x 7 x 365	8 hours	The problem will be worked on until fixed or a reasonable workaround is applied.
High	A condition that is deterring user from meeting production processes/schedules, is seriously impacting the use of PointClickCare, is making production materially more difficult or costly for user, or results in material corruption of any of user's Data.	1 hour during primary support hours	Immediately to 5 Business Days	The problem will be worked on until fixed or a reasonable workaround is applied.
	Examples: - Charge generation process does not run. - MDS submission process does not run. - Interfaces to ERP, census, etc. do not run.			
Medium	A condition other than those described above in which PointClickCare is performing in an unpredictable manner or is producing incorrect results but is not materially impacting production or business processes/schedules.	1 hour during primary support hours	Immediately to 20 Business Days	The problem will be worked on until fixed or a reasonable workaround is applied.
	Examples: - Census reports do not accurately reflect			

	 census transactions entered into the system Quick ADT does not clear bed when a resident is discharged. 			
Low	A condition other than those described above in which inconsistencies, irregularities and/or limitations in PointClickCare or an Application that cause inconvenience to user.	1 hour during primary support hours	Mutually agreed to time	PCC will work with customer to mutually prioritize and schedule resolutions into regular release cycles.

Schedule 4 Data Import Services

Data Import Services (New Implementation):

Pricing is based on the provision that files are provided to PointClickCare in the format outlined by the PointClickCare Data Import Guide, and data integrity is of the highest quality. Data cleansing is subject to an additional cost.

Details:

Data Import Package	Included in Data Import Service	Pricing
Gold	Database Creation 18-Month MDS Import MDS Gap Import ADT AR Balances	** See Schedule 2**

**Data Import services charges shown here are already included in Schedule 2 **

General Information and Questionnaire Accounting Basis

Name of Facility License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of Q 913-C	9/30/2016	7 37
The records of this facility for the period covered by	y this report were maintained on the following basis:	
Accrual O Cash O Modified Cash		
Is the accounting basis for this		
period the same as for the • Yes	If "No," explain.	
previous period? O No		
<u> </u>		
Independent Accounting Firm		
Name of Accounting Firm	Address (No. & Street, City, State, Zip C	
1 Blum Shapiro	2 Enterprise Drive, Shelton, CT 0648	34
2		
3		
4		
Services Provided by This Firm (describe fully)		
1 Compilation, preparation of Medicare and Medicaid cost n	reports, and year end tax services	\$ 24,000
2		\$
3		\$
4		\$
		Charge for Services Provided
		\$ 24,000
Are These Charges Reflected in the Expenditure Portion of This	s Report? If Yes, Specify Expense Classification and Line No	φ 27,000
• Yes O No Page 15, line 10		
O Yes O No Page 15, line 10 Legal Services Information		Telephone Number
O Yes O No Page 15, line 10 Legal Services Information Name of Legal Firm or Independent Attorney		Telephone Number
• Yes • No Page 15, line 16 Legal Services Information Name of Legal Firm or Independent Attorney 1 See attachment.		Telephone Number
O Yes O No Page 15, line 16 Legal Services Information Name of Legal Firm or Independent Attorney 1 See attachment. 2		Telephone Number
O Yes O Page 15, line 16 Legal Services Information Name of Legal Firm or Independent Attorney 1 See attachment. 2 3		Telephone Number
O Yes O No Page 15, line 16 Legal Services Information Name of Legal Firm or Independent Attorney 1 See attachment. 2		Telephone Number
O Yes O Page 15, line 16 Legal Services Information Name of Legal Firm or Independent Attorney 1 See attachment. 2 3 4 5		Telephone Number
O Yes O Page 15, line 16 Legal Services Information Name of Legal Firm or Independent Attorney 1 See attachment. 2 3		Telephone Number
O Yes O Page 15, line 16 Legal Services Information Name of Legal Firm or Independent Attorney 1 See attachment. 2 3 4 5		Telephone Number
O Yes O Page 15, line 16 Legal Services Information Name of Legal Firm or Independent Attorney 1 See attachment. 2 3 4 5		Telephone Number
O Yes O No Page 15, line 16 Legal Services Information Name of Legal Firm or Independent Attorney 1 See attachment. 2 3 4 5 Address (No. & Street, City, State, Zip Code) 1 2		Telephone Number
O Yes O No Page 15, line 16 Legal Services Information Name of Legal Firm or Independent Attorney 1 See attachment. 2 3 4 5 Address (No. & Street, City, State, Zip Code) 1 2 3		Telephone Number
O Yes O No Page 15, line 16 Legal Services Information Name of Legal Firm or Independent Attorney 1 See attachment. 2 3 4 5 Address (No. & Street, City, State, Zip Code) 1 2 3 4 5 Address (No. & Street, City, State, Zip Code) 1 2 3 4		Telephone Number
O Yes O No Page 15, line 16 Legal Services Information Name of Legal Firm or Independent Attorney 1 See attachment. 2 3 4 5 Address (No. & Street, City, State, Zip Code) 1 2 3 4 5		Telephone Number
O Yes O No Page 15, line 16 Legal Services Information Name of Legal Firm or Independent Attorney 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)		
O Yes O No Page 15, line 16 Legal Services Information Name of Legal Firm or Independent Attorney 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.		\$ 34,525 \$
O Yes O No Page 15, line 10 Legal Services Information Name of Legal Firm or Independent Attorney 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 2 3 4 5		\$ 34,525 \$ \$ \$
O Yes O No Page 15, line 16 Legal Services Information Name of Legal Firm or Independent Attorney 1 1 See attachment. 2 3 4 5 Address (No. & Street, City, State, Zip Code) 1 2 3 3 4 5 Services Provided by This Firm (describe fully) 1 See attachment. 2 3 4 5 4 5 4 5 4 5 4 5 3 4 4 5		\$ 34,525 \$ \$ \$ \$ \$ \$
O Yes O No Page 15, line 16 Legal Services Information Name of Legal Firm or Independent Attorney 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. 2 3 3 4 5 3		\$ 34,525 \$ 34,525 \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
O Yes O No Page 15, line 16 Legal Services Information Name of Legal Firm or Independent Attorney 1 1 See attachment. 2 3 4 5 Address (No. & Street, City, State, Zip Code) 1 2 3 3 4 5 Services Provided by This Firm (describe fully) 1 See attachment. 2 3 4 5 4 5 4 5 4 5 4 5 3 4 4 5		\$ 34,525 \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
O Yes O No Page 15, line 10 Legal Services Information Name of Legal Firm or Independent Attorney 1 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. 2 3 4 5 5 1 2 3 4 5 5 1		\$ 34,525 \$ 34,525 \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
O Yes O Page 15, line 16 Legal Services Information Name of Legal Firm or Independent Attorney 1 Name of Legal Firm or Independent Attorney 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. 2 3 4 4 5 4	1 s Report? If Yes, Specify Expense Classification and Line No.	\$ 34,525 \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$

State of Connecticut Annual Report of Long-Term Care Facility CSP-7 Rev. 6/95

General Information and Questionnaire Accounting Basis

	of Facility	License No.	Report for Year Ended		Page	of	
Bloom	field Health Care Center of CT, LLC	9134	9/30/2016		7	37	
Legal	Services Information						
Name	of Legal Firm or Independent Attorney		Telephone Number				
1	Altus Global Trade Solutions Inc		(800)-509-6060				
2	Berchem & Moses, P.C.			(203)-783-	1200		
3	Treasurer State of Connecticut						
4	State Marshall						
5	Goldman Gruber & Wood			(203)-899-	8900		
6	Jackson Lewis PC			(631)-247-	0404		
7	Rogin Nassau, LLC			(860)-256-	6300		
Addre	ss (No. & Street, City, State, Zip Code)						
1	2400 Venterans Blvd, Suite 300, Kenner, LA 80062						
2	75 Broad Street Milford, CT. 06460						
3	Hartford, CT 06106						
4							
5	200 Connecticut Avenue, Norwalk, CT 06854						
6	58 South Service Rd Suite Melville, NY 11747						
7	185 Asylym Street - 22nd Floor Hartford, CT 06103-3460						
Servic	es Provided by This Firm (describe fully)						
1	Collections			\$	352		
2	Labor			\$	4,904		
3	Conservator			\$	750		
4	Conservator			\$	190		
5	Collections			\$	22,536		
6	Labor			\$	4,469		
7	Disallowed			\$	1,324		
					Services Pro	ovided	
				\$	34,525		
Are T	hese Charges Reflected in the Expenditure Portion of This Report? If Yes, Sp	5 1	fication and Line No.				
	• Yes O No	Page 15 line 1e					

State of Connecticut Annual Report of Long-Term Care Facility CSP-8 Rev. 9/2002

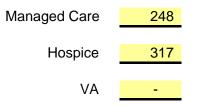
Schedule of Resident Statistics

Name of Facility			License No.			Report for Year Ended				Page	of	
Bloomfield Health Care Center of CT, LLC			913-C				9/30/2016				8	37
					Period 10/1 Thru 6/30			Period 7/1 Thru 9/30				
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
 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		
 Number of Residents A. As of midnight of PREVIOUS report period 	98	98			98	98			101	101		
B. As of midnight of THIS report period	102	102			98	98			102	102		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,663	4,663			3,759	3,759			904	904		
B. Medicaid (Conn.)	29,321	29,321			21,125	21,125			8,196	8,196		
C. Medicaid (other states)												
D. Private Pay	848	848			736	736			112	112		
E. State SSI for RCH												
F. Other (Specify)	560	560			392	392			168	168		
G. Total Care Days During Period (3A thru F)	35,392	35,392			26,012	26,012			9,380	9,380		
Total Number of Days Not Included in Figures in 4. 3G for Which Revenue Was Received for Reserved Beds A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days	5	5			5	5						ļ
5. Total Resident Days (3G + 4A + 4B)	35,397	35,397			26,017	26,017			9,380	9,380		<u> </u>

***OTHER DAYS BREAKOUT:

Bloomfield Health Care Center of CT, LLC 2016 Cost Report - Page 8 attachment

Page 8, Line 3F: Total Number of Other Days Care Provided During the Period



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

Name of Pacificity License No. Beport for Year Endes Page of 9302016 Page of 9302016 4. Were here ary change in formation 913-C 913-C 0 Vs 0 Vs 0 No 16 'YES' - provide the following information: France of Change Comment Page 0 No				Scl	hed	ule of	Re	sideı	nt S	tatis	stics (O	Cont'd)		
4. Were there any changes in the certified bed capacity during the report year? O Yes © No If "YES", provide the following information: COURT RINS (Specify) Lost Gained Capacity After Change (1) (2) (3) (1) (2)	Name of Facil	lity			Licer	nse No.				Report	t for Year	Ended		Page	of
If "YES". provide the following information: Change in Resident Counce in Resident	Bloomfield H	ealth Ca	are Cente	er of CT, LLC	9	13-C				-	9/30/201	6		9	37
Place of Change CNH RHNSPlace of Change Specify)Change is Beck LostCapacity After Change Reason for ChangeReason for Change(1)(2)(3)		-	-		-	pacity dur	ing th	ne repoi	t year	?	0	Yes	٥	No	
Date of ChangeCCNH (1)(2)(3)(1)(2)(3)(1)(2)(3)(1)(2)(3)(1)(2)(3)(1)(2)(3)(1)(2)(3)(1)(2)(3)(2)(3)(2)(3)(2)(3)(<u> </u>		-		Cł	nange	in Bed	s		Ca	nacity Afte	er Change		
Change (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (1) (2) (3) (3) (1) (2)	Data of		1	-			lunge			d	Cu	puerty Tite	er enange		
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$	Date of	cent	KIIII	(speeny)		LOSI			Jame	u	-				
RESIDENT DAYS for 90 days following the change. Change in Resident Days CCNH RHNS (Specify) 1st change -	Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	Reason f	or Change
RESIDENT DAYS for 90 days following the change. Change in Resident Days CCNH RHNS (Specify) 1st change -															
RESIDENT DAYS for 90 days following the change. Change in Resident Days CCNH RHNS (Specify) 1st change -															
RESIDENT DAYS for 90 days following the change. Change in Resident Days CCNH RHNS (Specify) 1st change -															
RESIDENT DAYS for 90 days following the change. Change in Resident Days CCNH RHNS (Specify) 1st change -															
It change Image of the state of the		-	-		-		the re	eport ye	ar (as	reporte	ed in item	4 above) p	provide the num	ber of	
2nd change Image Image <thimage< th=""> <thimage< th=""> Image</thimage<></thimage<>				Change in Re	esider	t Days					CC	CNH	RHNS	(Spe	cify)
3rd change model model 4th change Medicaid Self-Pay Other State Assisted 0 Medicaid Self-Pay Other State Assisted 1 1 Medicaid Self-Pay Other State Assisted No. of Residents 10 87 5 0 0 Per Diem Rate 10 87 5 0 0 0 a. One bed rm. Prs 246.46 404.00 0 0 0 0 b. Two bed rms. Prs 246.46 375.00 0															
4th change Image: Construct of Residents and Rates on September 30 of Cost Year Vector Year 6. Number of Residents and Rates on September 30 of Cost Year Self-Pay Other State Assisted Medicare Medicare Medicare Self-Pay Other State Assisted Item CCNH CCNH RHNS CSPerify) R.C.H. ICF-MR No. of Residents 10 87 5 September 30 September 30 Per Diem Rate 10 87 5 September 30 September 30 a. One bed rms. Prs 246.46 464.00 September 30 September 30<		0													
6. Number of Residents and Rates on September 30 of Cost Year Other State Assisted Medicare Medicaid Self-Pay Other State Assisted Item CCNH RHNS CCNH RHNS (Specify) R.C.H. ICF-MR No. of Residents 10 87 5 0 <td></td>															
MedicareMedicareMedicardSelf-PayOther State AssistedItemCCNHRHNSCCNHRHNS(Specify)R.C.H.ICF-MRNo. of Residents108156666Per Diem Rate108166666a. One bed rm.PPS246.46404.006666b. Two bed rms.PPS246.46375.006666c. Three or morePPS246.46N/A66666bed rms.PPS246.46N/A666 <td></td> <td></td> <td>lents and</td> <td>d Rates on Septe</td> <td>mber</td> <td>30 of Cos</td> <td>st Yea</td> <td>r</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>			lents and	d Rates on Septe	mber	30 of Cos	st Yea	r							
No. of Residents 10 87 5 11 Per Diem Rate 40 404.00											Se	elf-Pay		Other Sta	te Assisted
No. of Residents 10 87 5 11 Per Diem Rate 40 404.00															
No. of Residents 10 87 5 11 Per Diem Rate 40 404.00		Item		CCNH	C	CNH	RI	HNS	CO	CNH	RF	INS	(Specify)	R.C.H.	ICF-MR
a. One bed rm. PPS 246.46 404.00 Image: Constraint of the second	No. of R	esidents		10		87			5						
b. Two bed rms. PPS 246.46 375.00 Image: Constraint of Constraints of Constent of Constraints of Constent of Constraints of Constrai				-											
c. Three or more bed rms. PPS 246.46 NA 7. Total Number of Physical Therapy Treatments TOTAL CCNH RHNS (Specify) A. Medicare - Part B 2,042 2,042 2,042 2 B. Medicaid (Exclusive of Part B) 2,042 2,042 2 2 2. Restorative Treatments 1,456 1,456 2 2 2. Restorative Treatments 1,456 1,456 2 2 D. Total Physical Therapy Treatments 13,655 13,655 3															
bed rms. PFS 246.46 N/A Image: Constraint of the constraint of th				PPS		246.46				375.00					
7. Total Number of Physical Therapy Treatments TOTAL CCNH RHNS (Specify) A. Medicare - Part B 2,042 2,043 2,045<			e	DDC		246.46				NT/A					
A. Medicare - Part B2,0422,042B. Medicaid (Exclusive of Part B)1. Maintenance Treatments1,4561,456C. Other10,15710,157D. Total Physical Therapy Treatments13,6551,456S. Total Number of Speech Therapy Treatments391391A. Medicare - Part B391391B. Medicaid (Exclusive of Part B)1.1131. Maintenance Treatments158158C. Other1,1131,113D. Total Speech Therapy Treatments166216629. Total Number of Occupational Therapy Treatments1,6621,6629. Total Number of Occupational Therapy Treatments1,6621,6621. Maintenance Treatments1,6621,6621,6622. Restorative Treatments1,6621,6621,6623. Total Speech Therapy Treatments1,6621,6621,6624. Medicare - Part B2,0692,0691,6621,6625. Total Number of Occupational Therapy Treatments1,6621,6621,6626. Medicaid (Exclusive of Part B)1.1,1131,1131,1131. Maintenance Treatments1,6141,6141,6141. C. Other1,2,13612,13612,13612,136	Ded I	1115.		PPS		240.40				N/A					
A. Medicare - Part B2,0422,042B. Medicaid (Exclusive of Part B)1. Maintenance Treatments1,4561,456C. Other10,15710,157D. Total Physical Therapy Treatments13,6551,456S. Total Number of Speech Therapy Treatments391391A. Medicare - Part B391391B. Medicaid (Exclusive of Part B)1.1131. Maintenance Treatments158158C. Other1,1131,113D. Total Speech Therapy Treatments166216629. Total Number of Occupational Therapy Treatments1,6621,6629. Total Number of Occupational Therapy Treatments1,6621,6621. Maintenance Treatments1,6621,6621,6622. Restorative Treatments1,6621,6621,6623. Total Speech Therapy Treatments1,6621,6621,6624. Medicare - Part B2,0692,0691,6621,6625. Total Number of Occupational Therapy Treatments1,6621,6621,6626. Medicaid (Exclusive of Part B)1.1,1131,1131,1131. Maintenance Treatments1,6141,6141,6141. C. Other1,2,13612,13612,13612,136	7. Total Nu	mber of	Physica	al Therapy Treat	ments						то	TAL	CCNH	RHNS	(Specify)
1. Maintenance TreatmentsImage: constraint of the second seco			-									2,042	2,042		
2. Restorative Treatments1,4561,456C. Other10,15710,157D. Total Physical Therapy Treatments13,65513,6558. Total Number of Speech Therapy Treatments391391A. Medicare - Part B391391B. Medicaid (Exclusive of Part B)111. Maintenance Treatments158158C. Other1,1131,113D. Total Speech Therapy Treatments1.6621.6629. Total Number of Occupational Therapy Treatments2,0692,069B. Medicaid (Exclusive of Part B)1. Maintenance Treatments1.6141. Maintenance Treatments1.6141,614	B.			,											
C. Other10,15710,157D. Total Physical Therapy Treatments13,65513,6558. Total Number of Speech Therapy Treatments391391A. Medicare - Part B391391B. Medicaid (Exclusive of Part B)111. Maintenance Treatments1581582. Restorative Treatments158158D. Total Speech Therapy Treatments1,1131,113D. Total Speech Therapy Treatments1,6621,6629. Total Number of Occupational Therapy Treatments2,0692,0699. Total Number of Occupational Therapy Treatments2,0692,0691. Maintenance Treatments1112. Restorative Treatments1111. Maintenance Treatments1112. Restorative Treatments1113. Medicaid (Exclusive of Part B)1111. Maintenance Treatments1112. Restorative Treatments1111. C. Other11,213612,1361															
D. Total Physical Therapy Treatments13,65513,6558. Total Number of Speech Therapy Treatments391391A. Medicare - Part B391391B. Medicaid (Exclusive of Part B)111. Maintenance Treatments1581582. Restorative Treatments158158C. Other1,1131,113D. Total Speech Therapy Treatments1,66219. Total Number of Occupational Therapy Treatments2,0692A. Medicare - Part B2,0692,0691B. Medicaid (Exclusive of Part B)1111. Maintenance Treatments1612. Restorative Treatments161C. Other1,0141,6141C. Other1,213612,1361	C		torative	Treatments											
8. Total Number of Speech Therapy Treatments 391 391 A. Medicare - Part B 391 391 B. Medicaid (Exclusive of Part B) 1 1 1. Maintenance Treatments 158 158 2. Restorative Treatments 158 158 C. Other 1,113 1,113 D. Total Speech Therapy Treatments 1,662 1,662 9. Total Number of Occupational Therapy Treatments 2,069 2,069 B. Medicaid (Exclusive of Part B) 1 1 1. Maintenance Treatments 1,614 1,614 2. Restorative Treatments 1,614 1,614			Physical	Therapy Treatm	ients										
B. Medicaid (Exclusive of Part B)Image: mathematical systemImage: mathematical system1. Maintenance Treatments1581582. Restorative Treatments158158C. Other1,1131,113D. Total Speech Therapy Treatments1,6621,6629. Total Number of Occupational Therapy Treatments2,0692,069A. Medicare - Part B2,0692,0691B. Medicaid (Exclusive of Part B)1111. Maintenance Treatments1112. Restorative Treatments111C. Other12,13612,1361												- ,	- ,		
1. Maintenance TreatmentsImage: mail of the mail of t												391	391		
2. Restorative Treatments158158C. Other1,1131,1131,113D. Total Speech Therapy Treatments1,6621,66219. Total Number of Occupational Therapy Treatments2,0692,0691A. Medicare - Part B2,0692,0691B. Medicaid (Exclusive of Part B)11111. Maintenance Treatments1112. Restorative Treatments1,61411C. Other12,13612,1361	B.		-												
C. Other1,1131,113D. Total Speech Therapy Treatments1,6621,6629. Total Number of Occupational Therapy Treatments2,0692,069A. Medicare - Part B2,0692,069B. Medicaid (Exclusive of Part B)141. Maintenance Treatments142. Restorative Treatments1,6141,614C. Other12,13612,13612,136												150	150		
D. Total Speech Therapy Treatments1,6621,6629. Total Number of Occupational Therapy TreatmentsA. Medicare - Part B2,0692,069B. Medicaid (Exclusive of Part B)1. Maintenance Treatments2. Restorative Treatments1,614C. Other12,13612,136	C		torative	Treatments											
9. Total Number of Occupational Therapy Treatments 2,069 2,069 A. Medicare - Part B 2,069 2,069 B. Medicaid (Exclusive of Part B) 6 6 1. Maintenance Treatments 6 6 2. Restorative Treatments 1,614 1,614 C. Other 12,136 12,136															
B. Medicaid (Exclusive of Part B)Image: Constraint of the second sec												,	,		
1. Maintenance TreatmentsImage: Constraint of the second seco	A.	A. Medicare - Part B										2,069	2,069		
2. Restorative Treatments 1,614 1,614 C. Other 12,136 12,136	B.														
C. Other 12,136 12,136															
	C		orative	reatments							}		,		
			Dccupati	ional Therapy T	reatm	ents									

State of Connecticut Annual Report of Long-Term Care Facility CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

e of Facility	License No.	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	Report for Yea		Page	of
mfield Health Care Center of CT, LLC	913-C		9/30/2016	I Ended	10	37
ime records maintained by all individuals receiving com	ipensation?	٥	Yes		No	
	 г		Total Cost a	and Hours		1
Itom	CCNH	Hours	RHNS	Hours	(Specify)	Hours
Item Salaries and Wages*	CCNH	Hours	KIINS	Hours	(Specify)	Hours
 Operators/Owners (Complete also Sec. I of Schedule A1) 						
2. Administrator(s) (Complete also Sec. III						
of Schedule A1)	144,608	2,080				
3. Assistant Administrator (Complete also Sec. IV						
of Schedule A1)						
4. Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)	183,519	8,762				
5. Dietary Service	20.172	0.67				
a. Head Dietitian b. Food Service Supervisor	30,172 56,208	867 2,175				
c. Dietary Workers	358,707	2,175				
6. Housekeeping Service	338,707	20,003				
a. Head Housekeeper	57,286	2,091				
b. Other Housekeeping Workers	209,639	13,570				
7. Repairs & Maintenance Services		·				
a. Engineer or Chief of Maintenance	65,213	2,057				
b. Other Maintenance Workers	25,950	2,158				
8. Laundry Service						
a. Supervisor	1 10 000	0.071				
b. Other Laundry Workers	142,323	8,071				
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	196,995	4,209				
b. RN						
1. Direct Care	541,126	13,837				
2. Administrative**	181,060	4,541				
c. LPN						
1. Direct Care	883,859	30,980				
2. Administrative** d. Aides and Attendants	1,632,994	94,430				
d. Aides and Attendants e. Physical Therapists	1,032,994	94,430				
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	114,646	5,164				
i. Physicians						
1. Medical Director						
2. Utilization Review	<u> </u>					
3. Resident Care***						
4. Other (Specify)						
j. Dentists	╂────┤					
	╉────┤					
	+					
	141.777	4,712				
n. Marketing		.,=		1		1
o. Other (Specify)						
See Attached Schedule						
n. Marketing o. Other (Specify)	4,966,082	4,712				

* 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.

Bloomfield Health Care Center of CT, LLC 9/30/2016

Schedule of Other Salaries and Wages (Page 10)

	CC	NH	RH	NS	(Specify)		
Position	\$	Hours	\$	Hours	\$	Hours	
Total	\$-	-	\$-	-	\$-	-	

Schedule of Other Fees (Page 13)

	СС	NH	RH	NS	(Spe	cify)
Service	\$	Hours	\$	Hours	\$	Hours
Therapy Consulting - Nursing	\$ 26,396	Disallowed				
Therapy Consulting - Rehab Therapy and Ancillary	\$ 8,908	Disallowed				
Total	\$ 35,304	Disallowed	\$ -	-	\$ -	-

Attachment Page 10/13

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*

						1			D	c
Name of Facility				License No.		-	Year Ended		Page	of
Bloomfield Health Care Center of C	CT, LLC			913-C		9/30/2016			11	37
Name	ССИН	Salary Paie RHNS	d (Specify)	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
Section I - Operators/Owners										
Marvin J. Ostreicher, 184 Wildacre Ave, Lawrence, NY 11559					Supervises operations, deals with DNS & financial management		p.16/ m13 - \$21,200	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 TIME STUDY Y/E SEPTEMBER 2016

	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	TOTAL
Augusta	8.00	5.50	8.00	3.00	0.00	7.00	6.50	10.00	8.50	3.00	1.50	4.50	65.50
Belair	7.50	3.00	8.50	1.50	0.00	3.50	2.50	4.50	6.00	2.00	4.50	5.50	49.00
Bethel	0.00	0.00	0.00	0.00	0.00	6.00	4.00	1.00	0.00	3.50	3.50	12.50	30.50
Bloomfield	4.50	5.00	5.00	5.00	0.00	5.00	4.50	9.00	12.00	3.50	3.50	7.00	64.00
Brattleboro	4.00	4.50	10.00	5.00	1.50	4.00	1.50	8.50	4.00	5.50	7.00	5.50	61.00
Brentwood	3.50	4.00	4.00	3.00	0.00	6.00	4.00	1.00	3.00	3.50	4.00	2.50	38.50
Brewer	8.50	4.00	6.00	3.50	0.00	5.50	9.50	5.00	11.00	5.50	3.50	6.50	68.50
Bristol	4.00	0.50	6.50	4.50	0.00	6.00	5.00	7.00	3.00	2.50	6.50	7.00	52.50
Cambridge	3.00	4.00	6.00	4.00	0.00	3.50	8.00	4.00	4.50	7.00	7.00	2.00	53.00
Catskill	3.50	5.50	4.50	1.50	0.00	3.00	4.50	4.00	6.00	4.00	3.50	6.00	46.00
Cold Spring Hills	11.00	10.00	16.50	4.50	0.00	9.50	18.00	17.50	0.00	0.00	0.00	0.00	87.00
Colony	6.50	20.00	6.00	3.50	2.00	8.00	3.00	6.50	5.00	2.50	8.00	3.00	74.00
Country	6.50	7.50	3.00	9.00	0.00	2.00	1.50	12.50	5.00	2.50	2.00	3.00	54.50
Dover	6.50	1.50	2.50	3.00	0.00	7.00	1.00	4.50	2.00	2.50	3.50	5.50	39.50
Eastside	3.00	4.50	2.50	2.50	0.00	2.00	1.50	2.50	2.00	1.00	2.50	4.00	28.00
Eliot	0.50	4.50	1.50	1.50	1.50	6.00	1.00	3.50	3.50	2.00	2.50	6.50	34.50
Glen Falls	6.00	4.00	2.00	5.00	0.00	5.00	0.50	2.50	1.50	1.00	2.00	4.50	34.00
Hudson	2.50	8.50	7.00	2.50	0.00	4.50	5.50	9.00	0.00	0.00	0.00	0.00	39.50
Huntington	2.00	3.00	3.00	3.50	2.00	7.00	0.50	0.00	6.50	1.00	5.50	2.50	36.50
Kennebunk	2.50	5.00	1.50	2.50	0.50	3.00	0.00	1.00	2.50	1.00	2.00	4.50	26.00
Ludlowe	5.00	5.50	5.50	3.50	0.00	7.00	2.00	8.00	3.00	1.00	2.00	1.00	43.50
Maple View	5.50	1.00	7.00	3.00	0.00	7.50	2.50	4.00	7.00	3.50	1.00	6.50	48.50
Marlborough	1.50	2.00	1.00	1.50	0.00	3.50	0.00	4.00	4.00	5.00	5.00	4.00	31.50
Maywood	7.00	3.00	8.50	1.50	0.00	6.50	3.50	2.50	5.50	2.50	4.50	6.50	51.50
Milford	4.00	4.00	3.00	2.50	0.00	3.50	2.00	1.50	3.50	1.00	6.00	1.50	32.50
Newton Wellseley	0.50	5.50	5.00	0.00	0.00	1.50	1.50	0.50	5.50	4.50	4.00	3.50	32.00
Norway	2.50	5.50	1.50	12.00	1.00	4.50	2.00	3.50	2.50	3.00	4.00	6.00	48.00
Poughkeepsie	1.50	1.00	1.50	3.50	0.00	6.50	3.50	7.50	2.50	1.50	4.50	4.50	38.00
Regency	0.50	8.00	3.00	5.50	0.00	3.50	1.50	2.50	4.50	2.00	3.50	9.00	43.50
Reservoir	2.50	4.00	3.50	6.00	0.00	5.00	1.00	2.50	5.50	0.50	3.50	2.50	36.50
Riverside	6.50	5.00	1.00	0.50	0.00	1.00	3.50	2.00	6.50	3.50	4.50	0.00	34.00
Ross	5.00	7.50	11.00	2.50	0.00	5.50	4.50	10.00	0.00	0.00	0.00	0.00	46.00
Rutland	5.00 2.50	4.00 8.00	0.50	0.50	0.50	2.50	2.00	5.00	6.00 7.00	4.50	3.50	0.00	34.00
Sachem			2.50	1.50	0.00	5.50	1.00	4.50			3.50	3.00	40.00
Sands Point	0.00	3.00	4.50	0.00	0.00	1.00	0.00	0.50	7.00	4.00	5.00	2.50	27.50
Utica	8.50	2.50	3.50	1.50	0.00	2.00	1.50	1.00	3.50	3.00	3.50	10.00	40.50
Village Crest	4.00	1.50	2.00	4.50	0.00	5.50	2.00	5.50	4.00	1.50	1.00	2.50	34.00
Water's Edge Westgate	5.00 9.50	0.00 3.00	0.00	1.50 2.50	0.00	4.00 5.00	2.00	2.50 3.50	5.00 8.00	1.00	1.00 3.50	3.00 5.00	25.00 42.50
Winship	9.50 4.00	3.00	2.50	2.50	0.00	6.00	1.00	2.50	5.00	0.00	1.00	0.00	42.50
winship	4.00	10.50	2.30	1.00	0.00	0.00	1.00	2.30	5.00	0.50	1.00	0.00	34.00
Vacation	0.00	0.00	0.00	40.00	0.00	0.00	0.00	0.00	0.00	72.00	48.00	0.00	160.00
Sick	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Personal	0.00	0.00	8.00	0.00	0.00	0.00	0.00	8.00	8.00	0.00	0.00	11.00	35.00
Holiday	16.00	0.00	0.00	8.00	0.00	8.00	56.00	0.00	0.00	0.00	0.00	0.00	88.00
	10.00	0.00	0.00	0.00	0.00	0.00	50.00	0.00	0.00	0.00	0.00	0.00	00.00
	l		l	l	l	l	l	l	l	ļ	L	ļ	4

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				of		
Bloomfield Health Care Center of	CT, LLC			913-C		9/30/2016		12	37	
Name	ССИН	Salary Pai	d (Specify)	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
Section III - Administrators***										
Karen Chadderton (10/1/2015- 9/16/2016)	139,924			same as employees	Management and Supervision of a healthcare facility	2,018	a2			
Carol Green (9/17/2016- 9/30/2016)	4,684			same as employees	Management and Supervision of a healthcare facility	62	a2			
Section IV - Assistant Administrators										

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

** Include <u>all</u> other employment worked during the cost year.

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

State of Connecticut Annual Report of Long-Term Care Facility CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

D. Report of E2	-				D	C
5	License No.		Report for Y	ear Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913	3-C	9/30/2016		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	8,210	Disallowed				
3. Pharmacist	10,767	Disallowed				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	256,560	4,531				
b. Other						
6. Social Worker	21,951	394				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	36,300	84				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting	650	2				
c. Resident Care**	200	Disallowed				
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	68,171	1,119				
b. Other	00,171	1,117				
10. Occupational Therapist						
a. Resident Care	304,837	6,417				
b. Other	501,057	0,117				
11. Nurses and aides and attendants						
a. RN						
a. KN 1. Direct Care	25,241	267				
2. Administrative***	23,241	207				
b. LPN						
1. Direct Care	13,875	149				
2. Administrative***	13,073	149				
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	25 20 4	Discilla 1				
	35,304	Disallowed				
B-13 Total Fees Paid in Lieu of Salaries	782,066	12,963				

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

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

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

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

Name of Facility	License No.		Report for Y	ear Ended	Page	of	
Bloomfield Health Care Center of CT, LLC			9/30/2016		14	37	
Name & Address of Individual	Full Explanation of Service		* to Owners, ors, Officers No	Expla	nation of R	elationship	
Gerident Solutions, P.O. Box 290539, Wethersfield, CT 06129	Dentist	0					
Procare LTC of CT, 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist / Consulting Nursing	۲	0	Common Ownership Common Ownership			
Preferred Thearpy Solutions, 809 Main St., E. Hartford, CT, 06108	PT, OT, ST / Consulting Rehab	٥	0				
Dr Santo Buccheri, 357 Franklin Ave, Hartford, CT 06114	Medical Director	0	۲				
Arhim Akwasi, MD, 35 Jolley Drive, Suite 201, Bloomfield CT 06002	Medical Staff Meetings	0	۲				
Swallowing Diagnostics - PO Box 484, Avon, CT 06001	ST	0	۲				
Ready Nurse, 2602 Highland Blvd, N.Palm Harbor,FL 34684	RN	0	۲				
The Nurse Network, 653 Main St, Plantsville, CT 06479	RN	0	۲				
Milford Health & Rehabilitation Center, 195 Platt Street Milford, CT 06460	Social Worker	۲	0	Affiliated Enti	ty		
Valley Psychiatry, 558 Hopmeadow Street Simsbury, CT 06070	Medical Staff Meetings	0	۲				
Bloomfield Foot Specialists, LLC, One Northwestern Drive Bloomfield CT 0600-3062	Resident Care	0	۲				
MassTex Imaging LLC, 3 Electronics Avenue Suit # 201 Danvers, MA 01923-1099	PT, OT, ST / Consulting Rehab	0	۲				
Clinical Resources, LLC, 3338 Peachtree Road NE, Suite 102, Atlanta, GA, 30326	LPN	0	۲				
		0	0				
		0	0				
		0	0				
		0	0				
		0	0				
		0	0				
		0	0				
		0	0				
		0	0				

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	 Report for Ye	ear Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2016		15	37
	,100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation		\$ 251,607	251,607		
2. Disability Insurance		\$			
3. Unemployment Insurance		\$ 92,871	92,871		
4. Social Security (F.I.C.A.)		\$ 367,085	367,085		
5. Health Insurance		\$ 522,502	522,502		
6. Life Insurance (employees only)					
(not-owners and not-operators)		\$			
7. Pensions (Non-Discriminatory)		\$			
(not-owners and not-operators)					
8. Uniform Allowance		\$ 20,908	20,908		
9. Other (<i>Specify</i>)		\$			
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and	d	\$			
Profit Sharing Plans for Owners and					
Operators (Discriminatory)*					
c. Bad Debts*		\$			
d. Accounting and Auditing		\$ 24,000	24,000		
e. Legal (Services should be fully described	d on Page 7)	\$ 34,525	34,525		
f. Insurance on Lives of Owners and		\$			
Operators (Specify)*					
g. Office Supplies		\$ 27,918	27,918		
h. Telephone and Cellular Phones					
1. Telephone & Pagers		\$ 20,253	20,253		
2. Cellular Phones		\$ 2,355	2,355		
i. Appraisal (Specify purpose and		\$			
attach copy)*					
j. Corporation Business Taxes franchise to	ax)	\$			
k. Other Taxes (Not related to property - Second	ee Page 22)				
1. Income*		\$			
2. Other (<i>Specify</i>)		\$			
See Attached Schedule					
3. Resident Day User Fee		\$ 646,033	646,033		
Subtotal		\$ 2,010,057	2,010,057		

* 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

Bloomfield Health Care Center of CT, LLC 9/30/2016

Attachment Page 15

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

Name of Facility	License No.		Report for Y	Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C		9/30/2016		16	37
Item			Total	CCNH	RHNS	(Specify)
Subtota	ls Brought Forwa	rd:	2,010,057	2,010,057		
1. Travel and Entertainment						
1. Resident Travel and Entertainment	\$					
2. Holiday Parties for Staff	\$	4,269	4,269			
3. Gifts to Staff and Residents		\$	2,773	2,773		
4. Employee Travel		\$	2,431	2,431		
5. Education Expenses Related to Seminars an	nd Conventions	\$	5,531	5,531		
6. Automobile Expense (not purchase or depre	eciation)	\$	110	110		
7. Other (<i>Specify</i>)		\$				
See Attached Schedule						
m. Other Administrative and General Expenses						
1. Advertising Help Wanted (all such expenses	s)	\$	8,939	8,939		
2. Advertising Telephone Directory all such e	expenses)***	\$				
3. Advertising Other (Specify)***		\$	27,891	27,891		
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	ce)***					
7. Postage		\$	4,853	4,853		
* 8. Dues and Membership Fees to Professional	l	\$	8,539	8,539		
Associations (Specify)						
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other Non-A	Allowable Org.***	\$	375	375		
9. Subscriptions		\$				
10. Contributions***		\$	50	50		
See Attached Schedule						
11. Services Provided by Contract (Specify and	Complete	\$				
Schedule C-2, Page 21 for each firm or ind	lividual)					
12. Administrative Management Services**	\$	486,559	486,559			
13. Other (<i>Specify</i>)	\$	129,079	129,079			
See Attached Schedule						
C-14 Total Administrative & General Expenditures		\$	2,691,456	2,691,456		

* 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	С	CNH	RI	HNS	(Speci	fy)
Promotional Advertising	\$	27,891				
Total Other Advertising	\$	27,891	\$	-	\$	-

Schedule of Dues

Description	CCNH	R	HNS	(Spec	ify)
CAHCF	\$ 8,539				
Total Dues	\$ 8,539	\$	-	\$	

Schedule of Contributions

Description	CCI	NH	RH	NS	(Spec	ify)
Donations	\$	50				
Total Contributions	\$	50	\$	-	\$	-

Schedule of Other Administrative and General

Description	CCNH	RH	NS	(Specif	y)
Bank charges - disallowed	\$ 23,509				
Licenses & permits	\$ 1,990				
Miscellaneous expenses - disallowed	\$ (1,500)				
Financial Management	\$ 21,200				
Sales Tax	\$ 1,600				
Consulting Fees - Fiscal	\$ 25,815				
Background Check - Security	\$ 175				
Crime Insurance - disallowed	\$ 370				
Purchased Services - Fiscal Operations	\$ 22,455				
Background Check - Admin	\$ 1,173				
IT Services - Administration	\$ 27,431				
Consulting - Administration	\$ 4,861				
Total Other Administrative and General	\$ 129,079	\$	-	\$	-

......

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of CT, LI		9/30/2016	17 37
,,_,			
	Cost of		Indicate Where Costs
Name & Address of Individual or	Management	Full Description of Mgmt. Service	
Company Supplying Service	Service	Provided	Report Page #/Line #
National Healthcare Associates, Inc.	486,559	See Attached	page 16, line M12
		I	1

Schedule C-1 - Management Services*

* 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

Image: state	Start Date: 10/1/2015		0101	0102	0103	0104	0105	0106	0107	0108	0109	0110	0112	0113
	End Date: 9/30/2016		Bloomfield	Bristol		Ludlowe	Maple View Manor	Marlborough	Milford	New Milford	Regency	Riverside	Water's Edge	
UnitUn														
Description Description <thdescription< th=""> <thdescription< th=""></thdescription<></thdescription<>			eds 12	132	160	144	120	120	120	95	130	345	150	203
Description Description <thdescription< th=""> <thdescription< th=""></thdescription<></thdescription<>														
Description Lap Automation Management Dist of 10 mode Dist														
Introduction Production shows the subject for dyname Physical Physical <td></td>														
Display Display <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>														
Diff Diff <thdiff< th=""> Diff Diff <thd< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></thd<></thdiff<>														
UNIDED 00000 Nome Number														
Bit Sec 2004 And A														
Bit No. 0044000 Person hemole number number number. 104.00 104.00 104.00														
Between besides Program														
Biology Control Biology Control Table 1														
Integra September Integra														812.18
Integr Single Actional Integrie Manders () 1640 97.03 17.03 17.03 15.03														2,822.95
Integer Number														
11000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 000000 000000 000000 000000 0000000 000000000000000000000000000000000000														
1000000000000000000000000000000000000														20.32
Lapped Scale Lapped Scale<		······································												
11100.000.000.000.000 Log Part Survey Autional Mandama Amenian (0.77) (0.77) (0.77) (0.73) </td <td></td>														
140000 000 000 000 mm Perside Median Languar Mademan. 9978 mm 9978 mm <td></td> <td>3,129.33</td>														3,129.33
istance subsort														12,550.88
etembol between setuces i														
Labol: Labol: <thlabol:< th=""> <thlabol:< th=""> <thlabol:< td="" th<=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></thlabol:<></thlabol:<></thlabol:<>														
41000 Compart Latence Manual Mathema Administor 712.2 ml 712.2 ml 712.4 ml 744.2 ml 711.5 ml														
ctable instant stant, sta														
ist 0000 000 000 00000 00000 00000 00000 0000									24.29					
initios initios 1,46.70 1,46.70 1,46.70 1,46.70 1,46.70 1,46.70 1,46.70 1,46.70 1,46.70 1,46.70 1,46.70 1,46.70 1,46.70 1,46.70 1,21.70 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>														
accord - data or 3 - 0.00 - 10 (accord - data or 3 - 0.00 - 10 (accord - accord - 0.00 - 0.0														
isable 3:0000 3:5:000 Ges National Healthcare Management Programs Gar 7:00 Gar 7:00 <thgar 7:00<="" th=""> Gar 7:00 G</thgar>														
110000002-30:000 Peent Autional Headmany Membry Traces Stational Headmany Haws Trad Ope- 10,73.79 10,42.30 10,73.79 10,73.79 10,73.79 10,73.79 10,73.79 11,84.80 11,84.80 11,84.20 11,84.20 11,84.20 11,84.20 11,84.20 11,84.20 11,84.20 11,84.20 11,84.20 11,84.20 11,84.20 11,84.20 11,84.20 11,84.20 11,84.20 11,84.20 11,84.20 11,71.50 22,40.20 24.62 24.62 24.62 24.62 24.62 24.62 24.62 11,71.71 11,71.71 11,71.71 11,71.71 11,71.71 11,71.71 11,71.71 11,71.71 11,71.71 11,71.71 11,71.71 11,71.71 11,71.71 1								637.70		504.94				
ctropport pressond Property Taxes. National Nates Fiscal Op. 444.00 544.34 649.72 79.700 74.220 </td <td></td>														
171000 171000 171000 171000 171000 171000 171000 171000 171000 171000 171000 171000 1710000 1710000 1710000 1710000 1710000 1710000 1710000 1710000 1710000 1710000 1710000 1710000 1710000 1710000 1710000 17100000 17100000000000000000000000000000000000														
inition 0000-04.000 Amoritzation Eige- LH ALL-Nat. Mgmfinishop 1.20 2.20 2.20 2.26 2.26 2.26 1.78 2.46 0.42 2.28 (7.83) 64000 0000-0000 Deg Erg. Movanhe Eigen-Mattomi Hersization Hersizati														
i46000.0000-00000000000000000000000000000														
int 000000000000000000000000000000000000														
50000-000-000-000-000-000-000-000-000-0														
501100-0000-01-000-01 Advertising Promotional-National Heal-Administr- 6,944.52 7,649.58 6,944.20 6,944.20 6,944.20 5,499.79 7,524.62 19,970.22 8,681.81 7,444.00 50300-0000-03-000-0 Penatilies-Manigen-Administr- 1220.64 220.64 220.66 120.70 11,751.00 4,564.99 1,443.00 1,064.76 50300-0000-03-000-0 Ronk anges-National Healthcare Mangen-Administr- 10,84.76 1,144.10 1,101.63 1,084.76 1,085.77 1,085.78 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>														
502000-0000-00-00-00-00-00-00-00-00-00-00														
S035000000-000-000-000-0000 Penalties-National Healthcare Managene-Administr 220.68 242.70 224.21 224.22 220.68 220.08 174.73 220.00 644.44 277.83 S03000-0000-000-000-000-000-000-000-000-														
50360-0000-03-000-0 Bark Charges-Mat. Mgmt. Administration 998.58 1,098.26 999.58 1004.50 5.572.55 5.572.55 5.572.55 5.572.55 5.572.55 5.442.52 5.176.57 5.032.53 1.033.62 1.033.62 1.033.62 1.033.62 1.033.62 1.033.62 1.033.62 1.033.62 1.051.55 5.572.55 5.572.55 5.572.55 5.572.55 5.521.55 5.021 5.572.55														2,153.07
S04000-0000-03-000-0 Portage-Matinal Healthcare Manageme-Administr 10,04,76 1,04,76 1,04,76 1,04,76 1,04,76 1,04,76 1,04,76 1,04,76 1,04,76 1,04,76 1,04,76 1,04,76 1,04,76 1,04,76 1,04,76 1,04,76 1,04,76 1,04,76 1,04,76 5,0020 1,01,750 5,0020 1,01,750 5,0020 1,01,750 5,0020 1,01,750 5,0020 1,01,750 5,0020 1,01,750 5,0020 1,01,750 5,0020 1,01,750 5,0020 1,01,750 5,0020 1,01,750 5,0020 1,01,750 5,0020 1,01,750 5,0020 1,01,750 1,01,750 5,0021 1,01,750														1,086.24
51000-0000-300-00 Lability Insurance-National Healthce-Administri- 2.014.32 2.217.39 2.468.39 2.417.12 2.04.32 2.014.32 1.94.41 2.212.26 5.791.08 2.297.16 2.207.42 51000-0000.3-00-0 Umbrails nurrance-National Healthce-Administri- 1.033.62 1.747.82 1.742.02 1.033.62 1.123.53 1.123.53 1.123.53 1.123.53 1.123.53 1.123.53 1.123.53 1.123.53 1.123.53 1.123.54 1.132.55 5.501.50 5.521 5.60.97 5.63.31 5.021 5.52.7 5.651.97 5.63.14 5.531.45 5.531.45 5.531.55 5.531.55 5.531.55 5.531.55 5.531.55 5.531.55 5.531.55 5.241.96 5.333.45 5.433.55		Postage-National Healthcare Manageme-Administr									.,			
\$11000.0000.300.0 Auto Insurance-National Healthcare M-Administr 1,033.62 1,132.64 1,037.62 1,033.62 1,033.62 10.03.62 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>														
\$12000.0000-3.000-0 Umbrella Insurance-Mational Healthcar-Administr 1,123.59 1,247.20 1,124.59 1,122.53 1,122.55 1,502.1 5,521.55 5,501.55 5,521.55														
\$130000000-03-000-0 Crime Insurance-Mational Healthcare Administr 50.21 55.22 66.69 66.31 50.21 50.21 39.79 54.74 114.47 66.78 35.52 \$10000-0000-3000-0 Auto Expense-Mational Healthcare Administr 92.93 1,152.21 92.943 <td></td> <td></td> <td></td> <td>53 1,235.69</td> <td></td> <td>1,348.28</td> <td>3 1,123.53</td> <td>1,123.53</td> <td>1,123.53</td> <td>889.62</td> <td></td> <td></td> <td></td> <td>1,152.55</td>				53 1,235.69		1,348.28	3 1,123.53	1,123.53	1,123.53	889.62				1,152.55
52000-0000-3-00-0 Auto Expense-National Healthcare Man-daministr- 929.43 1,229 05 1,115.23 929.44 929.44 92.44 92						60.31	50.21	50.21	50.21		54.47			
520100-0000-3000-0 Auto Lasse Expense-National Healthca-Administr- 3,055.16 4,073.13 3,666.16 3,055.38 3,065.38 2,419.06 3,007.07 8,783.58 3,481.34 3,044.11 521000-0000-000-00 Hord Expense-National Healthcare Ma-Administr- 7,119.77 7,380.81 9,422.18 854.352 7,119.77 7,119.75 7,11														
521000-0000-03-000-0 Travel Expense-National Healthcare Ma-deministri- 7,119.77 7,380.81 9,492.18 8,543.52 7,119.77 7,119.77 7,119.77 7,119.77 7,279.12 20,409.28 8,898.96 7,633.49 522000-0000-03-000-0 Hotel Expense-National Healthcare Ma-duministri- 6,719.01 7,389.97 8,957.52 8,062.79 6,719.01 6,719.01 5,319.61 7,279.13 19,316.30 8,398.06 8,711.93 541000-0000-3-000-0 Misc. Expense-National Healthcare Ma-difinistration 4,061.32 4,466.51 5,414.45 4,273.58 4,061.32														
522000-0000-3-000-0 Hole Expense-National Healthcare Ma-Administrat- 6,71 90 7,389 97 8,957.52 8,062.79 6,71 901 5,71 91 5,71 91 19,31 601 8,398.06 8,671.19 521000-0000-300-0 Misc. Expense-National Healthcare Ma-Administrat- 4,061.32 4,465.1 54,145 4,061.32 1,155 1,015.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0														
\$\$1000-000-31-000-0 Misc. Expense-National Healthanze Ma-Misc. Exp 1,385.0 1,490.62 1,490.64 1,610.610.610.610.610		Hotel Expense-National Healthcare Ma-Administr	6,719.0	7,389.97	8,957.52	8,062.79	6,719.01	6,719.01	6,719.01	5,319.61	7,279.13	19,316.90	8,398.06	8,671.19
SA1001-0000-33-000-0 Political Contributions-Nat. Mgm:-Administrat- 0.00 <td></td>														
542000.0003-100-0 Corporate Tax - State-National Healt-Misc: Exp 114.55 125.27 137.46 114.55 114.55 90.70 128.09 329.33 144.16 166.05 542000-0000-3100-0 Corporate Tax - State-National Healt-Misc: Exp 18.80 225.66 18.80 18.80 14.99 20.37 54.05 22.56 33.81 542000-0000-3 Sales Tax - Conn-National Healt-Misc: Exp 116.00 52.07 22.56 18.80 18.80 14.99 20.37 54.05 22.56 33.81 542000-0000-2 Sales Tax - Conn-National Healt-Micar-Fiscal Op (15.01) 6.922.30 6.37.06.42 57.91.57 (15.01) (15.01) 4.98.174 6.817.49 18.091.92 7.866.00 52.92 51.818 01.95.07 (15.01) 4.98.174 6.817.49 14.091.92 7.866.00 52.92 11.415.91 90.202.24 53.95.02 1.416.961.05 52.911.63 Total Consulting-nation.20 Tatal 657.986.00 591.434.00 486.559.00 486.559.00 390.220.0 533.95.00 1.4														1,733.97
S44000-0000-25-000-0 Sales Tax - Conn-National Healthcar-Fiscal Op- (15.01) 6.922.30 8.390.48 7.551.57 (15.01) (15.01) 4.981.74 6.817.49 19.091.92 7.866.00 4.976.89 Total 0 645.590.00 657.086.42 591.434.35 486.559.04 486.559.04 533.950.21 1.416.981.92 7.866.00 612.747 522.911.63 Consulting-nation20														166.05
Total 486,559.04 542,087.48 657,086.42 591,434.35 486,559.04 486,559.04 390,220.24 533,950.21 1,416,981.50 616,041.57 522,911.63 Consulting-nation.20 Mngmnt-other old Page 16 line m12 on Cost Report 542,087.48 657,086.04 591,434.30 486,559.04 486,559.04 390,220.24 533,950.21 1,416,981.50 616,041.57 522,911.63 Magent-other old Page 16 line m12 on Cost Report 542,087.00 657,086.00 591,434.00 486,559.00 486,559.00 390,220.00 533,950.00 1,416,982.00 616,042.00														
Consulting-nation20 0 (17,747,79) Mngmmt-other old 71,580.20 71,580.20 Page 16 line m12 on Cost Report 486,559.00 591,434.00 486,559.00 390,220.00 533,950.00 1,416,982.00 616,0422.00		Sales Tax - ConnNational Healthcar-Fiscal Op											.,	.,
Mngmnt-other old 71,580.20 Page 16 line m12 on Cost Report 486,559.00 542,087.00 657,086.00 591,434.00 486,559.00 486,559.00 390,220.00 533,950.00 1,416,982.00 616,042.00	IOTAI	Consulting-pation20	486,559.0	542,087.48	657,086.42		486,559.04	486,559.04	486,559.04			1,416,981.50		
Page 16 line m12 on Cost Report 486,559.00 542,087.00 657,086.00 591,434.00 486,559.00 486,559.00 390,220.00 533,950.00 1,416,982.00 616,042.00			-	-	-	-	-	-	-	-	-	-	0	
Variances 0 0 0 0 0 0 0 0 0 0 0 0 (1) (0)		Page 16 line m12 on Cost Report												
		Variances		0 0	0	0	0	0	0	0	0	(1)	(0)	

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

		N	ote o	n Page 5)			
Nar	ne of Facility]	Licens	e No.	Report for	or Year Ended	Page of
Blo	Bloomfield Health Care Center of CT, LLC		913-C			2016	18 37
	Item			Total	CCN	H RHNS	(Specify)
2.	Dietary						
	a. In-House Preparation & Service						
	1. Raw Food		9	262,588	262,	588	
	2. Non-Food Supplies		5	6 16,626	16,	626	
	3. Other (<i>Specify</i>)		5	6			
	b. Purchased Services (by contract other		9	14,320	14,	320	
	than through Management Services)						
	(Complete Schedule C-2 att. Page 21)						
	 Management Services** 		5	6			
	d. Other (<i>Specify</i>)		5	6			
2E.	<i>Total Dietary Expenditures</i> (2a + b + c + d)		9	293,534	293,	534	
2F.	Dietary Questionnaire			Total	CCN	H RHNS	(Specify)
G.	Resident Meals: Total no. of meals served per	dav:	*				
H.	Is cost of employee meals included in 2E?	Ó Ì		0	No	I	
I.	Did you receive revenue from employees?	0	Yes	٥	No	If yes, specify amt.	/
J.	Where is the revenue received reported in the	Cost	Repor	t? (Page/Line	Item)		
	Is cost of meals provided to persons other					10 :0	
K.	than employees or residents (i.e., Board	0	Yes	\odot	No	If yes, specify	/
	Members, Guests) included in 2E?					cost.	
		0	x 7	0	ŊŢ	If yes, specify	ý
L.	Is any revenue collected from these people?	0	Yes	•	No	amt.	
M.	Where is the revenue received reported in the	Cost	Repor	t? (Page/Line	Item)		
	Is cost of food (other than meals, e.g.,	2200	r 01	(
	snacks at monthly staff meetings, board	_		_		If yes, specify	v
N.	meetings) provided to employees included	0	Yes	\odot	No	cost.	'
	in 2E?						
						If yes, specify	J
О.	Is any revenue collected from employees?	0	Yes	\odot	No	amt.	/
	XX71 1.1 1.1 1.1	0			τ	ann.	
P.	Where is the revenue received reported in the	Cost	Repor	t? (Page/Line	Item)		

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

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

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

Name of Facility	License	e No.	Report for Y	ear Ended	Page of
Bloomfield Health Care Center of CT, LLC	9	913-C	9/30/2016		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	Amt. \$	7,406	7,406		
washed, ironed, and/or processed.***					
2. Employee items including uniforms,	Lbs.				
gowns, etc. washed, ironed and/or					
processed.***	Amt. \$				
	Ann. 5				
3. Personal clothing of residents	Lbs.				
washed, ironed, and/or processed.***	Amt. \$				
	Ann. 9				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. \$				
b. Purchased Services (by contract other	\$				
than through Management Services)					
(Complete Schedule C-2 att. Page 21)					
c. Management Services**	\$				
d. Other (Specify)	\$	48,175	48,175		
Diapers \$8,080, Supplies \$40,095					
3E. Total Laundry Expenditures (3a + b + c + d)	\$	55,581	55,581		
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E? C) Yes	<u>م</u>	No	If yes,	
G. Is cost of employee faundry included in SE?	Jies	•	NO	specify cost.	
H. Did you receive revenue from employees? C) Yes		No	If yes,	
		0		specify amt.	
I. Where is the revenue received reported in the Cos	st Report?		(Page/Line	Item)	
J. Is Cost of laundry provided to persons other) Yes	•	No	If yes,	
than employees or residents included in 3E?	105	U	110	specify cost.	
K. Did you receive revenue from these people? C) Yes		No	If yes,	
K. Did you receive revenue from these people?	5 165	U		specify amt.	
L. Where is the revenue received reported in the Cos	st Report?		(Page/Line	Item)	

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

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

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

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

Name of Facility	License No.	Repo	ort for Year E	nded	Page	of
Bloomfield Health Care Center of CT, LLC	913-C		9/30/2016		20	37
Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced					
a. In-House Care	by Personnel					
1. Supplies - Cleaning (Mops,	Amt.	\$	26,646	26,646		
pails, brooms, etc.)						
b. Purchased Services (by contract other	r Sq. Ft. Serviced					
than through Management Services)	by Personnel					
(Complete Schedule C-2 att.	Amt.	\$				
Page 21)						
c. Management Services*		\$				
d. Other (<i>Specify</i>)		\$	1,185	1,185		
4E. Total Housekeeping Expenditures (4a	\$	27,831	27,831			
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		\$				
2. Purchased from		\$	256,415	256,415		
PCA						
b. Medicine Cabinet Drugs		\$	17,717	17,717		
c. Medical and Therapeutic Supplies		\$	121,940	121,940		
d. Ambulance/Limousine***		\$	11,146	11,146		
e. Oxygen		¢				
1. For Emergency Use		\$		10.1.10		
2. Other***		\$	19,163	19,163		
f. X-rays and Related Radiological		\$	10,687	10,687		
Procedures***	1 1 1 1	¢				
g. Dental (Not dentists who should be in	icluded under	\$				
salaries or fees)		<u>ф</u>	15 100	15 100		
h. Laboratory***		\$	17,130	17,130		
i. Recreation		\$	30,507	30,507		
j. Other (Specify)****		\$	65,061	65,061		
See Attached Schedule	5:)	¢	540 765	540 766		
5K. Total Resident Care Expenditures (5a -	· 5J)	\$	549,766	549,766		

* 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.

Bloomfield Health Care Center of CT, LLC 9/30/2016

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Equipment Rental - Nursing	\$ 25,529		
Equip Rental - Rehab/Therapy	\$ 16,513		
Flu Vaccine	\$ 8,247		
IV Thy Supplies - Rehab Therapy and Ancillary	\$ 11,564		
Nursing Purchased Services	\$ 3,208		
Total Other Resident Care	\$ 65,061	\$-	\$ -

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

Name of Facility				License No.	Report for Year Ende	d			Page	of	
Bloomfield Health Care Cent	er of CT, LLC			913-C	9/30/2016				21	37	
		Related ** Operators	,				Total Cost	/Page Ref.**	Page Ref.***		
Name of Individual or Company	Address	Yes	No	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	(Specify)	Pg	Line	
ADM Environmental Group	Avenue, Brooklyn, Ny 11230	0	•	Waste Service/ Monthly Recycling Service		24,518		(~)	22		
ADP	P.O. Box 842875, Boston, MA 02284 110 Mattatuck HTS,	0	٥	Payroll Processing		11,282			16	m13	
MJ Daly & Sons	Waterbury CT 06705 P.O Box 114 Granby,	0	۲	HVAC		20,747			22	6A	
AMSGG, LLC	CT 06035 15 Britton Drive	0	•	Plumbing Services		12,758				6A	
Eagle Rivet Roof Service	Bloomfield, CT 06002 P.O Box 13716 Newark,	0	• •	Roof Repair		15,121				6A	
Otis Elevator Omni Property Services, Inc.	NJ 07188-0716 8001 Castor Ave #115 Philadelphia, PA 19152	0	•	Elevator Repair Landscaping/ Snow Removal		12,086 10,600				6A 6F	
	-	0	0								
		0	0								
		0	0								
		0	0								
		0	0								
		0	0								

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

** Refer to Page 4 for definition of related.

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

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

Name of Facility	License No.	Report for Y	ear Ended		Page of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2016			22 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$	111,609	111,609		
b. Heat	\$	54,858	54,858		
c. Light & Power	\$	119,863	119,863		
d. Water	\$	22,289	22,289		
e. Equipment Lease (Provide detail on po	age 6) \$	32,415	32,415		
f. Other (<i>itemize</i>)	\$	64,996	64,996		
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a -	- 6f) \$	406,030	406,030		
7. Depreciation (complete schedule page 23	*)				
a. Land Improvements	\$				
b. Building & Building Improvements	\$				
c. Non-Movable Equipment	\$	1,155	1,155		
d. Movable Equipment	\$	29,005	29,005		
*7e. <i>Total Depreciation Costs</i> (7a + b + c + d) \$	30,160	30,160		
8. Amortization (Complete att. Schedule Pag	ge 24*)				
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$	67,837	67,837		
d. Other (<i>Specify</i>)	\$				
*8e. Total Amortization Costs (8a + b + c + d	l) \$	67,837	67,837		
9. Rental payments on leased real property l	less				
real estate taxes included in item 10b	\$	630,000	630,000		
10. Property Taxes					
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$	100,867	100,867		
c. Personal property taxes	\$	8,302	8,302		
11. Total Property Expenses (7e + 8e + 9 +	10) \$	837,166	837,166		

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

Bloomfield Health Care Center of CT, LLC 9/30/2016

Schedule of Other Repairs and Maintenance

Description	CC	NH	RHNS	(Specify)
Pest Control	\$	3,579		
Plowing/Landscaping	\$	16,630		
Security	\$	10,899		
Carting	\$	27,058		
Consulting Fees - Maintenance	\$	1,542		
IT Rentals	\$	4,165		
Short Term Lease - Pitney Bowes Mailing Machine	\$	771		
Short Term Lease - Neopost USA Inc. Mailing Machine	\$	352		
Total Other Repairs and Maintenance	\$	64,996	\$ -	\$ -

State of Connecticut Annual Report of Long-Term Care Facility CSP-23 Rev. 10/2006

					Deprec	iation Sc	chedule					
Name of Facility					License No.			Report for Year E	nded		Page	of
Bloomfield Health Care Center of CT, LLC					913-C			9/30/2016			23	37
								Accumulated				
					Historical Cost	Less		Depreciation to	Method of			
					Exclusive of	Salvage	Cost to Be	Beginning of Year's		Useful	Depreciation	
Property Item					Land	Value	Depreciated	Operations	Depreciation	Life	for This Year	Totals
A. Land Improvements												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attac	ch sche	dule)										
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	53,773	SL	30	1,155			
2. Disposals (attach schedule)												
3. Acquired during this report period (attac	ch sche	dule)										
C-4. Subtotal												1,155
	Is a m	nileage										
		book						Accumulated				
			Date of A	Acquisition	Historical Cost	Less		Depreciation to	Method of			
					Exclusive of	Salvage	Cost to Be	Beginning of	Computing	Useful	Depreciation	
	Yes	No	Month	Year	Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
D. Movable Equipment							1	1	1			
1. Motor Vehicles (Specify name, model												
and year of each vehicle)												
a.												
b.												
с.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					1,027,651		1,027,651	310,750	SL	Various	21,996	
b. Disposals (attach schedule)	4				(577,299)		(577,299))				
c. Acquired during this report period												
(attach schedule)					163,331		163,331		SL	Various	7,009	
D-3. Subtotal												29,005
E. Total Depreciation												30,160

Bloomfield Health Care Center of CT, LLC 9/30/2016

Schedule of Land Improvements Acquired during this report period

	ients Acquired during tins report period		Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
Fotal additions for Land Im	provement	\$ -		\$ -
Deletions:				
				ф
Total deletions for Land Imp	provement	\$ -		\$ -

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Schedule of Dunung	g miprovements Acquired during this report period			
			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:	-			
Fotal additions for 1	Building Improvemen	\$ -		\$ -
Deletions:				
Total deletions for H	Building Improvement	\$ -		\$ -
*Ties to Page 23, L	ine B3	•		

**Ties to Page 23, Line B3

1105 to 1 ugo 20, 2110 22

Schedule of Non-Movable Equipment Acquired during this report perio

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:	-			
	P •			¢
Fotal additions for Non-Movabl	e Equipmen	\$ -		\$ -
Deletions:				
Fotal deletions for Non-Movable	Equipmen	\$ -		\$ -
*Ties to Page 23, Line C3	Equipmen	Ψ -		Ψ

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report perio

Additions: Int/30/2015 PC Equipment 11/30/2015 PC Equipment Int/30/2015 PC's 11/30/2015 PC'S Int/30/2015 PC's 11/30/2015 Monitors Int/30/2015 Monitors 11/30/2015 Scale Int/30/2015 Scale 12/31/2015 Scale Int/30/2015 Scale 12/31/2015 Tv's Int/30/2016 Reclining Chair 2/29/2016 HyperSteam Convection Intraction 2/29/2016 Furniture Intraction 4/30/2016 Furniture Intraction 4/30/2016 Bed-Electric Rexx Intraction 5/31/2016 Rexx Hi/lo bed Intraction 5/31/2016 Rexx Hi/lo bed Intraction 5/31/2016 Chromebooks & Monitors S/31/2016 5/31/2016 Floor Lift S/31/2016 5/31/2016 Tri State - Bed 8/31/2016 8/31/2016 Direct Supply - Measurement entrapment tool	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	206 206 668 668 344 4,207 1,462 1,599 954 5,769 3,952 124,280 935 809 113	5 5 5 3 3 5 10 5 10 10 10 10 10 10 12	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	38 38 123 123 105 771 122 267 72 267 72 385 263
11/30/2015 PC Equipment 11/30/2015 PC's 11/30/2015 PC'S 11/30/2015 Monitors 11/30/2015 Monitors 11/30/2015 Carpet Care System 12/31/2015 Scale 12/31/2015 Scale 12/31/2016 Reclining Chair 2/29/2016 HyperSteam Convection 2/29/2016 Commercial Blender 4/30/2016 Bed-Electric Rexx 4/30/2016 Bed-Electric Rexx 4/30/2016 Bed-Electric Rexx 5/31/2016 Rexx Hi/lo bed 5/31/2016 PC Equipment 5/31/2016 Chromebooks & Monitors 5/31/2016 Floor Lift 5/31/2016 Tri State - Bed 8/31/2016 MJ Daly and Sons	\$ \$	206 668 668 344 4,207 1,462 1,599 954 5,769 3,952 124,280 935 809	5 5 3 10 5 10 10 10 10 10 10 12	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	38 123 105 771 122 267 72 385 263
11/30/2015 PC's 11/30/2015 PC'S 11/30/2015 Monitors 11/30/2015 Carpet Care System 12/31/2015 Scale 12/31/2015 Tv's 1/31/2016 Reclining Chair 2/29/2016 HyperSteam Convection 2/29/2016 Commercial Blender 4/30/2016 Furniture 4/30/2016 Bed-Electric Rexx 4/30/2016 Bed-Electric Rexx 5/31/2016 Rexx Hi/lo bed 5/31/2016 PC Equipment 5/31/2016 Floor Lift 5/31/2016 Tri State - Bed 8/31/2016 MJ Daly and Sons	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	668 668 344 4,207 1,462 1,599 954 5,769 3,952 124,280 935 809	5 5 3 5 10 5 10 10 10 10 10 15 12	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	123 123 105 771 122 267 72 385 263
11/30/2015 PC'S 11/30/2015 Monitors 11/30/2015 Carpet Care System 12/31/2015 Scale 12/31/2015 Tv's 1/31/2016 Reclining Chair 2/29/2016 HyperSteam Convection 2/29/2016 Commercial Blender 4/30/2016 Bed-Electric Rexx 4/30/2016 Bed-Electric Rexx 5/31/2016 Tax & Shipping #409 5/31/2016 Rexx Hi/lo bed 5/31/2016 Chromebooks & Monitors 5/31/2016 Floor Lift 5/31/2016 Tri State - Bed 8/31/2016 MJ Daly and Sons	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	668 344 4,207 1,462 1,599 954 5,769 3,952 124,280 935 809	5 3 5 10 5 10 10 10 10 15 12	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	123 105 771 122 267 72 385 263
11/30/2015 Monitors 11/30/2015 Carpet Care System 12/31/2015 Scale 12/31/2015 Tv's 1/31/2016 Reclining Chair 2/29/2016 HyperSteam Convection 2/29/2016 Commercial Blender 4/30/2016 Furniture 4/30/2016 Bed-Electric Rexx 4/30/2016 Bed-Electric Rexx 5/31/2016 Tax & Shipping #409 5/31/2016 Rexx Hi/lo bed 5/31/2016 PC Equipment 5/31/2016 Floor Lift 5/31/2016 Tri State - Bed 8/31/2016 MJ Daly and Sons	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	344 4,207 1,462 1,599 954 5,769 3,952 124,280 935 809	3 5 10 5 10 10 10 10 15 12	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	105 771 122 267 72 385 263
11/30/2015 Carpet Care System 12/31/2015 Scale 12/31/2015 Tv's 1/31/2016 Reclining Chair 2/29/2016 HyperSteam Convection 2/29/2016 Commercial Blender 4/30/2016 Furniture 4/30/2016 Bed-Electric Rexx 4/30/2016 Bed-Electric Rexx 5/31/2016 Tax & Shipping #409 5/31/2016 Rexx Hi/lo bed 5/31/2016 PC Equipment 5/31/2016 Floor Lift 5/31/2016 Tri State - Bed 8/31/2016 MJ Daly and Sons	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	4,207 1,462 1,599 954 5,769 3,952 124,280 935 809	5 10 5 10 10 10 10 15 12	\$ \$ \$ \$ \$ \$ \$ \$	771 122 267 72 385 263
12/31/2015 Scale 12/31/2015 Tv's 1/31/2016 Reclining Chair 2/29/2016 HyperSteam Convection 2/29/2016 Commercial Blender 4/30/2016 Furniture 4/30/2016 Bed-Electric Rexx 4/30/2016 Bed-Electric Rexx 5/31/2016 Bed-Electric Rexx 5/31/2016 Rexx Hi/lo bed 5/31/2016 PC Equipment 5/31/2016 Chromebooks & Monitors 5/31/2016 Floor Lift 5/31/2016 Tri State - Bed 8/31/2016 MJ Daly and Sons	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	1,462 1,599 954 5,769 3,952 124,280 935 809	10 5 10 10 10 15 12	\$ \$ \$ \$ \$ \$	122 267 72 385 263
12/31/2015 Tv's 1/31/2016 Reclining Chair 2/29/2016 HyperSteam Convection 2/29/2016 Commercial Blender 4/30/2016 Furniture 4/30/2016 Bed-Electric Rexx 4/30/2016 Bed-Electric Rexx 5/31/2016 Tax & Shipping #409 5/31/2016 Rexx Hi/lo bed 5/31/2016 PC Equipment 5/31/2016 Chromebooks & Monitors 5/31/2016 Floor Lift 5/31/2016 Tri State - Bed 8/31/2016 MJ Daly and Sons	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	1,599 954 5,769 3,952 124,280 935 809	5 10 10 10 15 12	\$ \$ \$ \$ \$	267 72 385 263
1/31/2016Reclining Chair2/29/2016HyperSteam Convection2/29/2016Commercial Blender4/30/2016Furniture4/30/2016Bed-Electric Rexx4/30/2016Bed-Electric Rexx5/31/2016Tax & Shipping #4095/31/2016Rexx Hi/lo bed5/31/2016PC Equipment5/31/2016Chromebooks & Monitors5/31/2016Floor Lift5/31/2016Tri State - Bed8/31/2016MJ Daly and Sons	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	954 5,769 3,952 124,280 935 809	10 10 10 15 12	\$ \$ \$ \$	72 385 263
2/29/2016 HyperSteam Convection 2/29/2016 Commercial Blender 4/30/2016 Furniture 4/30/2016 Bed-Electric Rexx 4/30/2016 Bed-Electric Rexx 4/30/2016 Bed-Electric Rexx 5/31/2016 Tax & Shipping #409 5/31/2016 Rexx Hi/lo bed 5/31/2016 PC Equipment 5/31/2016 Chromebooks & Monitors 5/31/2016 Floor Lift 5/31/2016 Tri State - Bed 8/31/2016 MJ Daly and Sons	\$ \$ \$ \$ \$ \$ \$ \$ \$	5,769 3,952 124,280 935 809	10 10 15 12	\$ \$ \$	385 263
2/29/2016 HyperSteam Convection 2/29/2016 Commercial Blender 4/30/2016 Furniture 4/30/2016 Bed-Electric Rexx 4/30/2016 Bed-Electric Rexx 4/30/2016 Bed-Electric Rexx 5/31/2016 Tax & Shipping #409 5/31/2016 Rexx Hi/lo bed 5/31/2016 PC Equipment 5/31/2016 Chromebooks & Monitors 5/31/2016 Floor Lift 5/31/2016 Tri State - Bed 8/31/2016 MJ Daly and Sons	\$ \$ \$ \$ \$ \$	3,952 124,280 935 809	10 15 12	\$ \$	263
4/30/2016 Furniture 4/30/2016 Bed-Electric Rexx 4/30/2016 Bed-Electric Rexx 5/31/2016 Tax & Shipping #409 5/31/2016 Rexx Hi/lo bed 5/31/2016 PC Equipment 5/31/2016 Chromebooks & Monitors 5/31/2016 Floor Lift 5/31/2016 Tri State - Bed 8/31/2016 MJ Daly and Sons	\$ \$ \$ \$ \$	124,280 935 809	15 12	\$	
4/30/2016 Bed-Electric Rexx 4/30/2016 Bed-Electric Rexx 5/31/2016 Tax & Shipping #409 5/31/2016 Rexx Hi/lo bed 5/31/2016 PC Equipment 5/31/2016 Chromebooks & Monitors 5/31/2016 Floor Lift 5/31/2016 Tri State - Bed 8/31/2016 MJ Daly and Sons	\$ \$ \$ \$	935 809	12	Ŧ	4.1.40
4/30/2016 Bed-Electric Rexx 5/31/2016 Tax & Shipping #409 5/31/2016 Rexx Hi/lo bed 5/31/2016 PC Equipment 5/31/2016 Chromebooks & Monitors 5/31/2016 Floor Lift 5/31/2016 Tri State - Bed 8/31/2016 MJ Daly and Sons	\$ \$ \$	809			4,143
5/31/2016 Tax & Shipping #409 5/31/2016 Rexx Hi/lo bed 5/31/2016 PC Equipment 5/31/2016 Chromebooks & Monitors 5/31/2016 Floor Lift 5/31/2016 Tri State - Bed 8/31/2016 MJ Daly and Sons	\$ \$			\$	39
5/31/2016 Rexx Hi/lo bed 5/31/2016 PC Equipment 5/31/2016 Chromebooks & Monitors 5/31/2016 Floor Lift 5/31/2016 Tri State - Bed 8/31/2016 MJ Daly and Sons	\$	113	12	\$	34
5/31/2016 Rexx Hi/lo bed 5/31/2016 PC Equipment 5/31/2016 Chromebooks & Monitors 5/31/2016 Floor Lift 5/31/2016 Tri State - Bed 8/31/2016 MJ Daly and Sons	-		12	\$	4
5/31/2016 Chromebooks & Monitors 5/31/2016 Floor Lift 5/31/2016 Tri State - Bed 8/31/2016 MJ Daly and Sons	\$	920	12	\$	32
5/31/2016 Chromebooks & Monitors 5/31/2016 Floor Lift 5/31/2016 Tri State - Bed 8/31/2016 MJ Daly and Sons		688	5	\$	57
5/31/2016 Floor Lift 5/31/2016 Tri State - Bed 8/31/2016 MJ Daly and Sons	\$	528	5	\$	44
5/31/2016 Tri State - Bed 8/31/2016 MJ Daly and Sons	\$	2,147	10	\$	89
8/31/2016 MJ Daly and Sons	\$	920	12	\$	32
	\$	2,869	5	\$	90
6/51/2010 Direct Supply Measurement entrapment tool	\$	1,443	5	\$	48
9/30/2016 Mckesson - Lift	\$	1,687	5	\$	28
9/30/2016 Direct Supply - Headboard	\$	481	10	\$	
9/30/2016 Tri State - 2 Beds	\$	1,840	10	\$	13
9/30/2016 600 pound scale	\$	1,477	10	\$	12
9/30/2016 Direct Supply - Measurement entrapment tool	\$	1,238	5	\$	21
9/30/2016 Tri State - Bed	\$	921	12	\$	
7/30/2010 In State - Ded	φ)21	12	ψ	
otal additions for Movable Equipmen	\$	163,331		\$	7,009
eletions:	-	,		-	.,50,
9/30/2016 Disposal of fully depreciated moveable equipment for equity purposes	\$	(577,299)			
7.50/2010 Disposa of rany depretated moveable equipment for equity purposes	φ	(377,277)			
Yotal deletions for Movable Equipmen *Ties to Page 23, Line D2c	\$	(577,299)		\$	-

Schedule of Leasehold Improvements Acquired during this report peri-

Scheuble of Leasend	nu improvements Acquireu during uns report peri				
Acquisition Date	Description of Item	Cost	Useful Life	Dor	reciation
Additions:		COSt	Life	Dep	reclation
10/31/2015	Condenser Fans	\$ 1,163	15	\$	78
10/31/2015	Buiilding Paving	\$ 10,007	10	\$	1,001
11/30/2015	Sidewalk	\$ 2,500	15	\$	153
12/31/2015	Shower Room Lights	\$ 1,022	10	\$	85
12/31/2015	Driveway Lighting	\$ 1,459	10	\$	122
1/31/2016	Building Paving	\$ 14,413	10	\$	1,081
3/31/2016	Eye Wash Station	\$ 1,079	10	\$	63
3/31/2016	Bathroom Painting	\$ 8,925	5	\$	1,041
3/31/2016	HVAC Chassis	\$ 2,552	15	\$	99
3/31/2016	Heat Exchanger	\$ 6,375	15	\$	248
3/31/2016	Toilet	\$ 1,015	10	\$	59
4/30/2016	Roof Resoration	\$ 44,555	10	\$	2,228
7/31/2016	C Mather - Fabricate and install three countertops	\$ 4,470	10	\$	112
8/31/2016	Eagle - Roof repair	\$ 2,310	10	\$	39
8/31/2016	Otis - Dumb Waiter	\$ 7,718	10	\$	129
Fotal additions for	Leasehold Improvemen	\$ 109,563		\$	6,538
Deletions:					

				ttachment Pages 23 24
	Leasehold Improvemen	\$ -	\$ -	**
*Ties to Page 24, L				

**Ties to Page 24, Line C2

Amortization Schedule*

Nam	Name of Facility				License No. Report for Year Ended				Page	of
	Bloomfield Health Care Center of CT, LLC			913	-C	9/30/2016			24	37
		Date Acqui				Accumulated Amort. to Beginning of	Basis for			
				Length of	Cost to Be	Year's	Computing	Rate	Amortization	
	Item	Month	Year	Amortization	Amortized	Operations	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			5-20	760,401	300,005	SL		61,299	
	2. Disposals (attach schedule)									
	3. Acquired during this report period									
	(attach schedule)			5-20	109,563		SL		6,538	
C-4.	Subtotal				· · ·					67,837
D.	Total Amortization									67,837

* 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 Lie Bloomfield Health Care Center of CT,	cense No. 913-C	Report for Year En 9/30/2016	ded		Page of 25 37
	913-C	9/30/2010			23 31
11. Property Questionnaire Part A					
Is the property either owned by the F	acility				If "Yes," complete Part B.
or leased from a Related Party?*	o O	Yes	\odot	No	If "No," complete Part C.
			<u> </u>		II NO, Complete I alt C.
*If any owner or operator of this facility business association to any person or or					
related party transaction.	8				
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		1.135.1	0.114	2.114	41.36
Part B - Owner and Related Partie	28	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing	d variable)	Fixed			
a. Type of Financing (e.g., fixed b. Date Mortgage Obtained	i, variable)	Fixed 07/01/02			
c. Interest Rate for the Cost Yea	ar	7.33%			
d. Term of Mortgage (number of		15			
e. Amount of Principal Borrow		8,226,480			
f. Principal balance outstanding		3,400,358			
Complete if Mortgage was Ref					
During Current Cost Year					
g. Type of Financing (e.g., fixed	d, variable)				
h. Date of Refinancing	/ /				
i. New Interest Rate					
j. Term of Mortgage (number of	of years)				
k. Amount of Principal Borrow					
l. Principal Outstanding on Not	te Paid-Off				
Part C - Arms-Length Leases f					
Name and Address of Lessor	Pro	perty 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 Ye	ear Ended		Page of	
Bloomfield Health Care Center of CT 913-C		9/30/2016	1		26 37
Item		Total	CCNH	RHNS	(Specify)
 12. Interest A. Building, Land Improvement & Non-Movable Equipment 1. First Mortgage 	e \$				
Name of Lender	Rate				
Address of Lender					
2. Second Mortgage	\$				
Name of Lender	Rate				
Address of Lender	<u> </u>				
3. Third Mortgage	\$				
Name of Lender	Rate				
Address of Lender	I				
4. Fourth Mortgage	\$				
Name of Lender	Rate				
Address of Lender	<u> </u>				
B. CHEFA Loan Information		-			
1. Original Loan Amount	\$				
2. Loan Origination Date					
3. Interest Rate %					
4. Term					
5. CHEFA Interest Expense					
12 B7. Total Building Interest Expense (A1 - A4 + B5)	\$				

(Carry Subtotals forward to next page)

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

Name of Facility License No.	Report for Ye		Page of	
Bloomfield Health Care Center of C 913-C	9/30/2016	1		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 (<i>Specify</i>) \$	10,186	10,186		
A. Item Rate Amount				
Equipment Loan - Multiple 4%-5% 10,186				
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 $(C1 + 2)$ \$	10,186	10,186		
12. D. Other Interest Expense (Specify) \$	3,280	3,280		
Admin. Interest \$3,292; Liability Insurance Financing \$575				
13. <i>Total All Interest Expense</i> (12B7 + 12C3 + 12D) \$	13,466	13,466		
14. Insurance				
a. Insurance on Property (buildings only) \$	9,640	9,640		
b. Insurance on Automobiles \$				
c. Insurance other than Property (as specified above)				
1. Umbrella (Blanket Coverage) \$	8,570	8,570		
2. Fire and Extended Coverage \$				
3. Other (<i>Specify</i>) \$	33,108	33,108		
Liability Insurance \$32,155; Boiler Insurance \$953				
14d. Total Insurance Expenditures (14a + b + c) \$	51,318	51,318		
15. Total All Expenditures (A-13 thru C-14) \$	10,674,296	10,674,296		

D. Adjustments to Statement of Expenditures

	e of Fa mfield		th Care Center of CT, LLC	Lic	cense No. 913-C	Report for Yea 9/30/2016	r Ended	Page 28	of 37
	Page No.	Line	Item Description	<u> </u>	Total Amount of Decrease	CCNH	RHNS	(Spe	
Page	10 - S	Salari	es and Wages						
1.			Outpatient Service Costs	\$					
2.	10	12M	Salaries not related to Resident Care	\$	14,348	14,348			
3.			Occupational Therapy	\$					
4.			Other - See attached Schedule	\$					
			sional Fees						
5.			Resident Care Physicians **	\$	200	200			
6.	13	B10a	Occupational Therapy	\$	304,837	304,837		_	
7.			Other - See attached Schedule	\$	77,009	77,009			
~	s 15 &	- 16	Administrative and General						
8.			Discriminatory Benefits	\$				-	
9.			Bad Debts	\$					
10.	15	1e	Accounting & Legal	\$	34,525	34,525			
11.			Telephone	\$					
12.	15	1h2	Cellular Telephone	\$	1,275	1,275			
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.	16		Automobile Expense (e.g. personal use)	\$	110	110			
18.	16	m3	Unallowable Advertising *	\$	27,891	27,891			
19.			Income Tax / Corporate Business Tax	\$					
20.			Fund Raising / Contributions	\$	50	50			
21.	16	m12	Unallowable Management Fees	\$	243,471	243,471			
22.			Barber and Beauty	\$	20.455	00.170		+	
23.	10 1		Other - See attached Schedule	\$	29,153	29,153			
	18 - L	netar	y Expenditures						
24.			Meals to employees, guests and others	٠					
D	10 -	L,	who are not residents	\$					
-	19 - L	aund	ry Expenditures						
25.			Laundry services to employees, guests	٠					
D.	20 7	7	and others who are not residents	\$					
-	20 - E	10USE	keeping Expenditures						
26.			Housekeeping services to employees, guests	ሱ					
			and others who are not residents	\$	700.000	700.040		+	
			Subtotal (Items 1 - 26)	\$	732,869	732,869			

* All except "Help Wanted".

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

⁽Carry Subtotal forward to next page)

Bloomfield Health Care Center of CT, LLC 9/30/2016

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Othe	r Salaries A	Adjustment	\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	0	CNH	RHNS	(Specify)
13	B2	Dentist	\$	8,210		
13	B3	Pharmacist	\$	10,767		
13	B12	Therapy Consulting - Nursing	\$	26,396		
13	B12	Therapy Consulting - Rehab Therapy and Ancillary	\$	8,908		
13	B8a	Excess Disallowed of Medical Director Salary	\$	22,728		
Total Othe	r Fees Adj	ustments	\$	77,009	\$-	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	C	CNH	RHNS	(Specify)
15		Benefits on Salaries not Related to Resident Care	\$	3,626		
16	M13	Misc. Exp	\$	(1,500)		
16	M13	Bank Charge	\$	23,509		
16	M13	Crime Insurance	\$	370		
16	M8	Chamber of Commerce Dues	\$	375		
16	L3	Gifts to Staff and Residents	\$	2,773		
Total Othe	r A&G Ad	justments	\$	29,153	\$-	\$ -

State of Connecticut Annual Report of Long-Term Care Facility CSP-29 Rev. 10/2006

	D. Adjustments to Statement of Expenditures (cont'd)									
Name	e of Fa	acility		Lic	ense No.	Report for Y	ear Ended	Page	of	
Bloo	nfield	Heal	th Care Center of CT, LLC		913-C	9/30/2016		29 3	37	
					Total					
Item	Page	Line			Amount of					
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	(Specify	')	
			Subtotals Brought Forward	\$	732,869	732,869			<u>.</u>	
Page	20 - K	Reside	ent Care Supplies***							
27.	20	5a2	Prescription Drugs	\$	256,415	256,415				
28.	20	5d	Ambulance/Limousine	\$	11,146	11,146				
29.	20	5f	X-rays, etc	\$	10,687	10,687				
30.	20	5h	Laboratory	\$	17,130	17,130				
31.	20	5c	Medical Supplies	\$	2,604	2,604				
32.	20	5e2	Oxygen (non emergency)	\$	19,163	19,163				
33.			Occupational Therapy	\$						
34.			Other - See Attached Schedule	\$	72,657	72,657				
Page	22 - N	Iainte	enance and Property							
35.			Excess Movable Equipment Depreciation							
			See Attached Schedule	\$	1,203	1,203				
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	\$	4,263	4,263				
Page	27 - I	nsura	ince							
40.			Mortgage Insurance	\$						
41.			Property Insurance	\$						
Other	r - Mis	scella	neous							
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	\$	5,015	5,015				
Not F	For Pr	ofit P	Providers Only							
50.			Building/Non Movable Eq. Depreciation							
			Unallowable Building Interest -							
			See Attached Schedule	\$						
51.	Total	Amo	unt of Decrease (Items 1 - 50)	\$	1,133,152	1,133,152				

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

*** 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.

Bloomfield Health Care Center of CT, LLC 9/30/2016

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	C	CNH	RHNS	(Specify)
20	5J	Equipment Rental - Nursing	\$	25,529		
20	5J	Equip Rental - Rehab/Therapy	\$	16,513		
20	5J	Flu Vaccine	\$	8,247		
20	5J	IV Thy Supplies - Rehab Therapy and Ancillary	\$	11,564		
20	5a2 / b	Procare Disallowance Price Markup	\$	1,039		
20	5i	Cable TV Expense - Resident Rooms	\$	9,765		
Total Othe	r Ancillary	Costs	\$	72,657	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH		RHNS	(Specify)
23	2a	TV and Mattress Disallowed Depreciation Expense	\$	1,203		
Total Exce	ss Movable	Equipment Depreciation	\$	1,203	\$-	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	С	CNH	RHN	S	(Specify)
22	бе	Auto Lease	\$	4,263			
Total Othe	r Property	Adjustments	\$	4,263	\$	-	\$-

Page Ref	Line Ref	Description	(CCNH	RHNS	(Specify)
27	12D	Interest Expense	\$	3,280		
30	IV5	Interest Income	\$	66		
30	8	Misc income - other	\$	1,669		
Total Othe	Total Other Adjustments				\$-	\$ -
-						

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unal	lowable Bui	lding Interest	\$-	\$-	\$ -

State of Connecticut Annual Report of Long-Term Care Facility CSP-30 Rev.10/2005

F. Statement of Revenue

F. Statement of Ke					D
Name of Facility License No. Bloomfield Health Care Center of CT, LL 913-C		Report for Y 9/30/2016	ear Ended		Page of 30 37
		7/30/2010			30 37
Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (CT only)	\$	10,868,725	10,868,725		
b. Medicaid Room and Board Contractual Allowance **	\$	(3,727,099)	(3,727,099)		
2. a. Medicaid (All other states)	\$	<u> </u>			
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (all inclusive)	\$	1,712,573	1,712,573		
b. Medicare Room and Board Contractual Allowance **	\$	602,465	602,465		
4. a. Private-Pay Residents and Other	\$	498,331	498,331		
b. Private-Pay Room and Board Contractual Allowance **	\$	(152,209)	(152,209)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$	131,335	131,335		
b. Prescription Drugs - Medicare Contractual Allowance **	\$	(131,335)	(131,335)		
c. Prescription Drugs - Non-Medicare	\$	123,600	123,600		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$	(123,005)	(123,005)		
2. a. Medical Supplies - Medicare	\$	930	930		
b. Medical Supplies - Medicare Contractual Allowance **	\$	(930)	(930)		
c. Medical Supplies - Non-Medicare	\$	(299)	(299)		
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$	287,348	287,348		
b. Physical Therapy - Medicare Contractual Allowance **	\$	(235,472)	(235,472)		
c. Physical Therapy - Non-Medicare	\$	195,112	195,112		
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$	(155,304)	(155,304)		
4. a. Speech Therapy - Medicare	\$	71,413	71,413		
b. Speech Therapy - Medicare Contractual Allowance **	\$	(47,467)	(47,467)		
c. Speech Therapy - Non-Medicare	\$	72,749	72,749		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$	(40,319)	(40,319)		
5. a. Occupational Therapy - Medicare	\$	357,313	357,313		
b. Occupational Therapy - Medicare Contractual Allowance **	\$	(310,773)	(310,773)		
c. Occupational Therapy - Non-Medicare	\$	244,783	244,783		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$	(176,201)	(176,201)		
6. a. Other (Specify) - Medicare	\$	(4,345)	(4,345)		
b. Other (Specify) - Non-Medicare	\$	80	80		
III. Total Resident Revenue (Section I. thru Section II.)	\$	10,061,999	10,061,999		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$	66	66		
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
	¢.	51,206	51,206		
8. Other (<i>Specify</i>)	\$	51,200	51,200		
8. Other (Specify) V. Total Other Revenue (1 thru 8)	\$ \$	51,200	51,272		

* 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	\$ 9,003		
30, line II6a	Medicare A X Ray	\$ 4,606		
30, line II6a	Medicare A Contra	\$ (17,943)		
30, line II6a	Medicare Pt B Prior Period	\$ (1,741)		
30, line II6a	Medicare A IV Therapy	\$ 1,730		
30, line II6a	Medicare A Oxygen	\$ 631		
30, line II6a	Medicare A Oxygen Contra	\$ (631)		
30, line II6a	Managed Medicare Contra Other	\$ (1,720)		
30, line II6a	Managed Medicare IV Therapy	\$ 225		
30, line II6a	Managed Medicare Lab	\$ 678		
30, line II6a	Managed Medicare X-Ray	\$ 817		
Total Other	Resident Revenue - Medicare	\$ (4,345)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	C	CNH	RHNS	(Specify)
30, line II6b	Commerical Insurance - LAB	\$	7,161		
30, line II6b	Commerical Insurance - X-RAY	\$	5,687		
30, line II6b	Commercial Insurance - Contra Other	\$	(14,003)		
30, line II6b	Medicaid Lab	\$	695		
30, line II6b	Medicaid Contra Other	\$	(695)		
30, line II6b	Commercial Insurance IV Therapy	\$	540		
30, line II6b	Hospice Pharmacy	\$	72		
30, line II6b	Hospice Pharmacy Contra	\$	(72)		
30, line II6b	Hospice Oxygen	\$	124		
30, line II6b	Hospice Oxygen Contra	\$	(124)		
30, line II6b	Medicaid Oxygen	\$	4,020		
30, line II6b	Medicaid Oxygen Contra	\$	(4,020)		
30, line II6b	Commercial Insurance Oxygen	\$	695		
Total Other	Resident Revenue	\$	80	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30, line IV5	Interest Income (Money Market)		\$ 66		
Total Interes	Total Interest Income		\$ 66	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30, line IV8	Prior Period	\$ 19,546		
30, line IV8	Misellaneous Other Income	\$ 31,660		
	(Insurance Claim (in excess of cost) \$22,802; United Health Care \$5,640;			
	U.S. Treasury 1,549; Frontier Refund 26; Verizon Refund 452; Copier			
	Lease Refund 400; Medical Records \$720; Other \$71)			
Total Other	Revenue	\$ 51,206	\$ -	\$ -

State of Connecticut Annual Report of Long-Term Care Facility CSP-31 Rev. 6/95

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Ce	nter of CT, I 913-C	9/30/2016	31	37
	Account		A	Amount
Assets				
A. Current Assets				
1. Cash (on hand an	,		\$	205,117
2. Resident Account	s Receivable (Less Allowanc	e for Bad Debts)	\$	2,541,550
3. Other Accounts R	eceivable (Excluding Owners	s or Related Parties)	\$	
4 Inventories			\$	34,052
5. Prepaid Expenses			\$	132,599
a. Workers Comp		41,051		
b. Taxes (persona	l property & real estate)	33,535		
c. Management F	ees	55,651		
d. Other		2,362		
6. Interest Receivable	e		\$	
7. Medicare Final Se	ttlement Receivable		\$	
8. Other Current Ass	sets (<i>itemize</i>)		\$	142,457
Patient Funds Due from Related		<u>32,614</u> 109.843	_	
		109,845	-	
			_	
A-9. Total Current Assets	(Lines A1 thru 8)		\$	3,055,775
B. Fixed Assets				
1. Land			\$	
2. Land Improvement	nts *Historical Cost		\$	
	Accum. Depreci			
3. Buildings	*Historical Cost		\$	
	Accum. Depreci	ation Net		
4. Leasehold Improv	rements *Historical Cost	892,303	\$	524,461
	Accum. Depreci	ation 367,842 Net		
5. Non-Movable Equ	ipment *Historical Cost	60,024	\$	5,096
	Accum. Depreci	ation 54,928 Net		
6. Movable Equipme	ent *Historical Cost	591,344	\$	251,589
	Accum. Depreci	ation 339,755 Net		
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreci	ation Net		
8. Minor Equipment	-Not Depreciable		\$	
9. Other Fixed Asset	s (itemize)		\$	
	$(\mathbf{L}_{ineq}, \mathbf{D}_{1}, \mathbf{d}_{1}, 0)$		ф.	7 01 1 4 4
B-10. Total Fixed Asset	s (Lines B1 thru 9)		\$	781,146

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

(Carry Total forward to next page)

State of Connecticut Annual Report of Long-Term Care Facility CSP-32 Rev. 6/95

G. Balance Sheet (cont'd)

		•	License No.	Report for Year Ended		Page		of
Bloo	mfie	eld Health Care Center of CT,	913-C	9/30/2016		32		37
			Account			An	nount	
				Total Brought Forward	1:\$		3,836	5,921
C.	Lea	asehold or like property record	ed for Equity Purpose	S.				
	Leasehold 1. Land 2. Land I 3. Buildin 4. Non-W 5. Movat 6. Motor 7. Minor 8 Total Leas Investmen 1. Deferr 2. Escrow 3. Organi 4. Goodw 5. Investr 6. Loans 7. Other	Land			\$			
	2.	Land Improvements	*Historical Cost					
			Accum. Depreciation	n Net	\$			
	3.	Buildings	*Historical Cost	5,657,365				
			Accum. Depreciation	n Net	\$		5,657	7,365
	4.	Non-Movable Equipment	*Historical Cost					
			Accum. Depreciation	n Net	\$			
	5.	Movable Equipment	*Historical Cost					
			Accum. Depreciation	n Net	\$			
	6.	Motor Vehicles	*Historical Cost					
			Accum. Depreciation	n Net	\$			
	7.	Minor Equipment-Not Deprec	ciable		\$			
C-8	To	tal Leasehold or Like Properti	es (C1 thru 7)		\$		5,657	7,365
D.	Inv	vestment and Other Assets						
	1.	Deferred Deposits			\$			
	2.	Escrow Deposits			\$			
	3.	Organization Expense	*Historical Cost					
			Accum. Depreciation	n Net	\$			
	4.	Goodwill (Purchased Only)	-		\$			
	5.	Investments Related to Reside	ent Care (temize)		\$			
	6.	Loans to Owners or Related P	arties (<i>itemize</i>)		\$			
		Name and Address	Amount	Loan Date				
	7.	Other Assets (itemize)			\$		11	,500
		Security Deposits		11,500				
D-8.	To	tal Investments and Other Ass	ets (Lines D1 thru 7)		\$		11	1,500
D-9.	To	tal All Assets (Lines A9 + B10	0 + C8 + D8)		\$		9,505	5,786

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

G. Balance Sheet (cont'd)

Name of Fac	cility		License No.	Report for Year E	nded	Page	of
		h Care Center of CT, LLC	913-C	9/30/2016		33	37
			Account			A	mount
Liabilities							
А.	Cu	rrent Liabilities					
	1.	Trade Accounts Payable			\$	3	2,543,454
	2.	Notes Payable (itemize)			\$	6	
	3.	Loans Payable for Equipm			\$	6	69,450
		Name of Lender	Purpose	Amount	Date Due		
			F · · ·	CO 450			
		M&T Bank	Equipment	69,450			
	4.	Accrued Payroll (Exclusiv	e of Owners and/or St	ockholders only)	\$	5	325,435
	5.	Accrued Payroll (Owners	and/or Stockholders o	nly)	\$	6	
	6.	Accrued Payroll Taxes Pa	yable		\$	6	
	7.	Medicare Final Settlement	t Payable		\$	5	
	8.	Medicare Current Financia	ng Payable		\$	5	
	9.	Mortgage Payable (Curren	nt Portion)		\$	5	
	10	. Interest Payable (Exclusive	e of Owner and/or Rel	ated Parties)	\$	5	
	11	. Accrued Income Taxes*			\$	5	
	12	. Other Current Liabilities (itemize)		\$	<u> </u>	2,395,581
		Accrued expenses	67,09	1			
		Revenue assessment	177,78	7			
		Patient personal funds	32,61	4			
		Due to related party	2,118,08	9			
A-13	<u> </u>	tal Current Liabilities (Lin	les A1 thru 12)		\$	5	5,333,920

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

(Carry Total forward to next page)

State of Connecticut Annual Report of Long-Term Care Facility CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year	Ended	Page	of
Bloomfield Health Care Center of CT, LLC		9/30/2016		34	37
	Account				Amount
		Total Broug	ht Forward:		5,333,920
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment				\$	215,486
Name of Lender	Purpose	Amount	Date Due		
M&T Bank	Equipment	215,486			
2. Mortgages Payable				\$	
3. Loans from Owners or Rel				\$	
Name and Address of Lender	Amount	Loan Da	ate		
4. Other Long-Term Liability	es (itemize)	11	5	\$	1,078,034
Due to related party	·	1,078,034			
		, , ,			
B-5. Total Long-Term Liabilities (Lines B1 thru 4)		5	5	1,293,520
C. Total All Liabilities (Lines A-				5	6,627,440

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

	ne of Facility License No. Report for Year Ended	Page	
Blo	omfield Health Care Center of CT,913-C9/30/2016	35	37
A.	Account Reserves		Amount
А.			
	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 (<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	\$	5,657,365
B.	Net Worth		
	1. Owner's Capital	\$	
	2. Capital Stock	\$	
	3. Paid-in Surplus	\$	
	4. Treasury Stock	\$	
	5. Cumulated Earnings	\$	(2,217,994)
	6. Gain or Loss for Period 10/1/2015 thru 9/30/2016	\$	(561,025)
	7. Total Net Worth	\$	(2,779,019)
C.	Total Reserves and Net Worth	\$	2,878,346
D.	Total Liabilities, Reserves, and Net Worth	\$	9,505,786

State of Connecticut Annual Report of Long-Term Care Facility CSP-36 Rev. 6/95

H. Changes in Total Net Worth

H.	Balance at End of Period 09	9/30/16		5	\$	(2,779	9,019)
	3. Total Deductions				\$		
	Purpose		Amou	int			
	2. Other Withdrawings (Specify)		A		\$		
	2. Other With dramin $g_{\alpha}(G) = (G)$				ħ		
	Name and Address (No., City, State, Zip)		Title	Amount			
	1. Drawings of Owners/Operators/Partners (Spec	ify)		5	5		
	Deductions				T		
F-3.	Total Additions				\$		
	2. Other (<i>itemize</i>)						
1.	1. Additional Capital Contributed (<i>itemize</i>)						
E. F.	Additions				þ	(2,115	,019)
D. E.	Net Income or Deficit Balance				\$ \$	(56)	1,025)
	Total Expenditures (From Statement of Expenditur	res Pag	ge 27)		5	10,674	
	Total Revenue (From Statement of Revenue Page				\$	10,113	
A.	Balance at End of Prior Period as shown on Report		/30/2015		\$	(2,217	
	Account					Amount	
	mfield Health Care Center of CT, L 913-C		9/30/2016		36		37
Name	e of Facility License No.		Report for Year	Ended	Page		of

Name of Facility	License No.	Report for Year Ended	Page	of	
Bloomfield Health Care Center of CT, LLC	913-С	9/30/2016	37	37	
	Check appropriate catego	ory			
Chronic and Convalescent Nursing Home only (CCNH)	□ Rest Home with Nursing Supervision only (RHNS)	□ (Specify)	□ (Specify)		
I	Preparer/Reviewer Cert	ification			
I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. 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	Title Date Signed			
Printed Name of Preparer					
Blum Shapiro & Company, P.C.					
Address		Phone Number	Phone Number		
2 Enterprise Drive, Shelton, CT 06484		(203) 944-2100	(203) 944-2100		

I. Preparer's/Reviewer's Certification