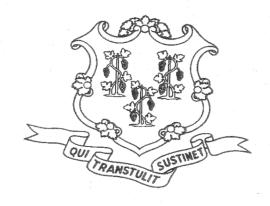
# **State of Connecticut**



# **Annual Report of Long-Term Care Facility**Cost Year 2017

Name of Facility (as l	licensed)							
Bristol Crossings LL	C							
Address (No. & Stree	et, City, State, Z	(ip Code)						
61 Bellevue Ave, Bris	stol, CT 06010							
Type of Facility								
I pronic and Convalescent				Rest Home with Nursing Supervision only  (RHNS)				
Report for Year Begin 10/1/2016	nning		Report for Yea 9/30/2017	r Ending				
License Numbers:		CCNH 2329	(-F : 5)			Medicare Provider 075221		
Medicaid Provider No	umbers:	CC 9043	CNH	RHNS		]	ICF-IID	
For Department Use	Only		•					
Sequence Number	Signed and	Date	Sequence Number		Signed o	nd Notorizad	Date Received	
Assigned	Notarized	Received	Assigned		Signed and Notarized		Date Received	

# **Table of Contents**

Gene	eral Information - Administrator's/Owner's Certification	1
Gene	eral Information and Questionnaire - Data Required for Real Wage Adjustment	1A
Gene	eral Information and Questionnaire - Type of Facility - Organization Structure	2
Gene	eral Information and Questionnaire - Partners/Members	3
Gene	eral Information and Questionnaire - Corporate Owners	3A
Gene	eral Information and Questionnaire - Individual Proprietorship	3B
Gene	eral Information and Questionnaire - Related Parties	4
Gene	eral Information and Questionnaire - Basis for Allocation of Costs	5
Gene	eral Information and Questionnaire - Leases	6
Gene	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.	Expenditures Other than Salaries (Cont'd) - Administrative and General	16
	Schedule C-1 - Management Services	17
C. C.	Expenditures Other than Salaries (Cont'd) - Dietary	18
C.	Expenditures Other than Salaries (Cont'd) - Laundry	19
C.	Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
	Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C.	Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
	Depreciation Schedule	23
	Amortization Schedule	24
C.	Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C.	Expenditures Other than Salaries (Cont'd) - Interest	26
C.	Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D.	Adjustments to Statement of Expenditures	28
D.	Adjustments to Statement of Expenditures (Cont'd)	29
F.	Statement of Revenue	30
G.	Balance Sheet	31
G.	Balance Sheet (Cont'd)	32
G.	Balance Sheet (Cont'd)	33
G.	Balance Sheet (Cont'd)	34
G.	Balance Sheet (Cont'd) - Reserves and Net Worth	35
H.	Changes in Total Net Worth	36
I.	Preparer's/Reviewer's Certification	37

#### **General Information**

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Bristol Crossings LLC	2329	9/30/2017	1	37

#### Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Bristol Crossings LLC [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)	Date	
Printed Name (Administrator)			Printed Name (Owner)		
Raymond L Wilkens			Marvin J. Ostreicher		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires	
A 11 CN				/ /	

Address of Notary Public

(Notary Seal)

# State of Connecticut **Department of Social Services**

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	Page	of		
			1A	37
Name of Facility	From	То		
Bristol Crossings LLC	10/1/2016	9/30/2017		
Address of Facility				
61 Bellevue Ave, Bristol, CT 06010	Phone Num			
Report Prepared By	Date			
Blum Shapiro & Co.	203-944-21	.00	2/1/2018	
•	m . 1	COM	DIDIG	(9 :0)
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 Ye	ar Ended	Page	of
		860-	-589-1682	-	9/30/2017		2	37
Name of Facility (as shown on license)			Address (No	o. & S	Street, City, Sto	ite, Zip)		
Bristol Crossings LLC			61 Bellevue	Ave,	Bristol, CT 06	010		
C	CNH		RHNS		(Specify)		Medicare F	rovider No
License Numbers:	2329						075221	
Type of Facility (Check appropriate box(es))								
Chronic and Convalescent Nursing Home only (CCNH)			t Home with I ervision only			(Specify)		
Type of Ownership (Check appropriate box)		- up		(1111				
					-			
O Proprietorship • LLC O Partn	ership	0	Profit Corp.	0	Non-Profit Cor	р. О	Government	O Trus
				Date	Opened	Date Clo	sed	
If this facility opened or closed during report year	ar provide	e:						
Has there been any change in ownership				_				
or operation during this report year?		0	Yes	<u> </u>	No	If "Yes,"	explain full	y.
Administrator								
Name of Administrator					Nursing Ho	ome		
Raymond L Wilkens				Administrator's 001841				
					License 1	No.:		
Other Operators/Owners who are assistant admi	nistrators	s (ful	l or part time	) of tl				
Name					License 1	No.:		

CSP-3 Rev. 10/2005

# **General Information and Questionnaire Partners/Members**

Name of Facility Bristol Crossings LLC		License No. 2329	Report for Y 9/30/2017	ear Ended	Page of 3 37
Legal Name of Parti Bristol Crossings LLC		Business A 61 Bellevue Ave 06010	Address	or Town(s) in egistered	
Name of Partners/Members	Business Ad	ldress	,	<u>Γ</u> itle	% Owned
See attached					

	State Facility	CT Bristol
	Owner	% Ownership
1	Agnes Zitter	2.08%
2	Albert David	1.67%
3	Barry Bokow	1.00%
4	BNB Healthcare Funds LLC	6.67%
5	Chaim Goldenberg	5.00%
6	David Cohen	6.67%
7	Gerald Neuman	3.33%
8	Ira Geffner	1.00%
9	Josef Skoczylas	2.00%
10	Tzivy Roberts	6.67%
11	Magda Manela	5.00%
12	Michael Lipman	5.00%
13	Mordechai Eisen	2.50%
14	Morris Fuchs	8.33%
15	Mosge Shaya-Mograby	1.67%
16	MSO Associates, LLC	30.75%
17	Nathan Pollack	4.17%
18	Shmuel Rubenstein	2.50%
19	Tali Skoczylas	4.00%
		100%

# **General Information and Questionnaire Corporate Owners**

Name of Facility	License No.	Report for Year	r Ended	Page	01
Bristol Crossings LLC	2329	9/30/2017		3A	37
If this facility is owned or operated as a corpor					
Legal Name of Corporation	Busi	ness Address	State(s) in V	Vhich Incorp	orated
				No. Sl	narec
Name of Directors, Officers	Busi	ness Address	Title	Held by	
				Tield by	Lacii
Names of Stockholders Owning at Least 10%					
of Shares					
	1		I	1	

CSP-3B Rev. 10/2005

## General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Bristol Crossings LLC	2329	9/30/2017	3B	37
If this facility is owned or operated as an individual	proprietorship, pro	vide the following information	:	
Ow	ner(s) of Facility			
	•			

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

Name of Facility		License			Report for Year Ended		Page	of
Bristol Crossings LLC			2329		9/30/2017		4	37
Are any individuals recei	ving compensation from the fac	cility rela	ated thro	ough		If "Yes," provide th	e Name/Ado	dress and
marriage, ability to contr	ol, ownership, family or busine	ss assoc	iation?	0	Yes	complete the inform		
Are any individuals or co	ompanies which provide goods	or servic	es,					
including the rental of pr	operty or the loaning of funds to	this fac	cility,					
related through family as	sociation, common ownership,	control,	or busin	iess	• Yes • No			
association to any of the	owners, operators, or officials of	of this fa	cility?			If "Yes," provide th	e following	information:
		Als	so Provi	des		Indicate Where		
		Good	ls/Servi	ces to		Costs are Included		
Name of Related	Business	Non-F	Related 1		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					

<sup>\*</sup> Use additional sheets if necessary.

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

CSP-4 Rev. 10/2005

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

Name of Facility License No.  Report for Year Ended 2329 9/30/2017	Page of
<u>Bristol Crossings, LLC</u>   2329   9/30/2017	4 37
Are any individuals receiving compensation from the facility related through	If "Yes," provide the Name/Address and
marriage, ability to control, ownership, family or business association?	
Are any individuals or companies which provide goods or services,	
including the rental of property or the loaning of funds to this facility,	
related through family association, common ownership, control, or business	
association to any of the owners, operators, or officials of this facility?	No If "Yes," provide the following information:
	7.1
Also Provides	
Goods/Services to	Indicate Where Costs are Actual Cost to th
Name of Related Business Non-Related Parties Description of Go	ods/Services Included in Annual Report Cost Related
Individual or Company Address Yes No %** Provide	
850 Silas Deane Highway,	a ruge # Pane # Reported rusty
Preferred Therapy Solutions   Wethersfield, Ct 06109   \Boxed \Bo	ting 13 5a,9a,10a,12 762,648 753,38
6851 Jericho Turnpike, Suite 150	
NOA Diagnostics Syosset, NY 11791	20 5f 19,496 18,00
National Health Care 850 Silas Deane Highway,	
Associates - Aetna Wethersfield, Ct 06109	15 1a5 636,696 636,69
61 Bellevue Avenue, Bristol, CT  EP Bristol Realty 06010	12(0,000
100 I CON 1 AMA	22 9 1,260,000 1,260,00
VK Newburyport, LLC 01950 Shared Expenses	16 12 261 26
National Health Care 20 East Sunrise Highway, Valley	10 12 201 20
Associates Stream, NY 11581 Shared Expenses	16 12/m13 555,325 555,32
850 Silas Deane Highway.	
850 Silas Deane Realty Wethersfield, Ct 06109	16 12 1,915 1,91
20 Sunrise Highway, Valley Stream	
20Sunrise NY 11581	16 12 10,522 10,52
Procare LTC Pharmacy Of 155 Northboro Rd STE 4  MA Southborough MA 01772   92% Drugs	
D V TO DI	20 5a2 35,045 31,34
Procare LTC Pharmacy of 1492 Highland Ave Cheshire CT	sult/Fees 20/13 5a2.b.j/b3.12 347.108 310.47

<sup>\*</sup> Use additional sheets if necessary.

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

\*\*\* Consolidated for all National Healthcare CT Facilities, control and ownership pass upon transfer of funds to insurance company manager. Information required by previous state auditor.

CSP-4 Rev. 10/2005

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

Name of Facility Bristol Crossings, LLC		License 2329	No.		Report for Year Ended 9/30/2017			Page 4	of 37
A i 1i i 1 1 i		1 - 4 - 4 4 1 - 4	l.			If "Vag " pro	ovide the Name/	Addraga and	
Are any individuals receiving comarriage, ability to control, own			ougn			, 1			
marriage, admity to control, own	ership, family of business assoc	iation!			☐ Yes ☑ No	complete the	e information or	Page II of t	he report.
Are any individuals or companie	es which provide goods or servi	ces,							
including the rental of property or related through family association			ness						
association to any of the owners,	operators, or officials of this f	acility?			✓ Yes □ No	If "Yes," prov	vide the following	g information:	
		Al	so Provi	des					1
			ds/Servic			Indicate W	here Costs are		Actual Cost to the
Name of Related	Business		Related I		Description of Goods/Services	Included in	Annual Report	Cost	Related
Individual or Company	Address	Yes	No	%**	Provided		# / Line #	Reported	Party
	20 East Sunrise Highway, Valley	ÌП	7					•	
National Health Care Associates	Stream, NY 11581		_		Due from Related	31	A8	50,341	50,341
	2428 Easton Turnpike,		7						
Cambridge Manor of Fairfield, LLC	Fairfield, CT 06824				Due from Related	31	A8	1,470	1,470
EP Bristol Realty	61 Bellevue Avenue, Bristol, CT 06010		<b>4</b>		Due to Realty	33	A12	2,307,626	2,307,626
EF Bristor Rearry	20 East Sunrise Highway, Valley				Due to Realty	33	A12	2,307,020	2,307,020
National Health Care Associates	Stream, NY 11581		<b>V</b>		Due to Related (Debt)	33	A12	131,334	131,334
	850 Silas Deane Highway,				(= 000)			,	
Preferred Therapy Solutions	Wethersfield, Ct 06109	7		37%	Due to Related	33	A12	10,139	10,139
	6851 Jericho Turnpike, Suite 150								
NOA Diagnostics	Syosset, NY 11791	7		82%	Due to Related	33	A12	3,526	3,526
Milford Health Care Center, Inc.	195 Platt St Milford CT 06460		7		Due to Related	33	A12	6,752	6,752
Cold Spring Hills Center for Nursing	378 Syosset-Woodbury Rd,								
& Rehabilitation	Woodbury, NY 11797		7		Due to Related	33	A12	12,743	12,743
New Milford Crossings LLC	19 Poplar St., New Milford, CT 06776		<b>4</b>		Due to Related	33	A12	3,624	3,624
	155 Northboro Rd STE 4							- , = -	2,021
Procare LTC Pharmacy Of MA	Southborough MA 01772	7		92%	Due to Related	33	A12	33,464	33,464
Procare LTC Pharmacy of CT	1492 Highland Ave Cheshire CT 06410	7		92%	Due to Related	33	A12	107,446	107,446

<sup>\*</sup> Use additional sheets if necessary.

<sup>\*\*</sup> Provide the percentage amount of revenue received from non-related parties.

\*\*\* Consolidated for all National Healthcare CT Facilities, control and ownership pass upon transfer of funds to insurance company manager. Information required by previous state auditor.

CSP-5 Rev. 9/2002

# **General Information and Questionnaire Basis for Allocation of Costs**

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:    Item	Name of Facility	License No.		Report for Year Ended	Page	of
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 employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants  Direct Resident Care Consultants Number of hours of resident care provided by EACH specialist (See listing page 13)  Maintenance and operation of plant Square feet  Property costs (depreciation) Square feet  Employee health and welfare Gross salaries  Management services Appropriate cost center involved  All other General Administrative expenses Total of Direct and Allocated Costs  The preparer of this report must answer the following questions applicable to the cost information provided.  1. In the preparation of this Report, were all costs allocated as required?  N/A  2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.  Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.  3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  9 Yes O No If "No," explain fully why such allocation was not made.	Bristol Crossings LLC	2329		9/30/2017	5	37
Dietary  Laundry  Number of meals served to residents  Laundry  Number of square feet serviced  Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants  Direct Resident Care Consultants  Number of hours of resident care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants  Direct Resident Care Consultants  Number of hours of resident care provided by EACH specialist (See listing page 13)  Maintenance and operation of plant  Square feet  Property costs (depreciation)  Square feet  Bemployee health and welfare  Management services  Appropriate cost center involved  All other General Administrative expenses  Total of Direct and Allocated Costs  The preparer of this report must answer the following questions applicable to the cost information provided.  1. In the preparation of this Report, were all     Yes O No If "No," explain fully why such allocation was not made.  2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.  Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.	If the facility is licensed as CDH and/or RCH or p	provides AII	OS or TBI	services with special Medicaid	rates, costs	
Dietary Laundry Number of meals served to residents Number of pounds processed Number of square feet serviced Nursing Number of square feet serviced Nursing Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants Number of hours of resident care provided by EACH specialist (See listing page 13)  Maintenance and operation of plant Square feet Property costs (depreciation) Square feet Gross salaries Management services Appropriate cost center involved All other General Administrative expenses The preparer of this report must answer the following questions applicable to the cost information provided.  1. In the preparation of this Report, were all costs allocated as required? N/A  2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.  Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.  3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  O Yes O No If "No," explain fully why such allocation was not made.	must be allocated to CCNH and RHNS as follows	s:		-		
Laundry	Item			Method of Allocatio	n	
Housekeeping  Number of square feet serviced  Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants  Direct Resident Care Consultants  Number of hours of resident care provided by EACH specialist (See listing page 13)  Maintenance and operation of plant  Square feet  Property costs (depreciation)  Employee health and welfare  Management services  Appropriate cost center involved  All other General Administrative expenses  Total of Direct and Allocated Costs  The preparer of this report must answer the following questions applicable to the cost information provided.  1. In the preparation of this Report, were all of Person of this report must answer the following applicable to the cost information provided.  1. In the preparation of this Report, were all of Person of this report must answer the following applicable to the cost information provided.  1. In the preparation of this Report, were all of Person of this report must answer the following applicable to the cost information provided.  1. In the preparation of this Report, were all of Person of this report must answer the following applicable to the cost information provided.  1. In the preparation of this Report, were all of Person of this report must answer the following appropriate supporting data.  2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.  3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  O Yes O No If "No," explain fully why such allocation was not made.	Dietary		Number o	of meals served to residents		
Nursing    Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants    Number of hours of resident care provided by EACH specialist (See listing page 13)   Maintenance and operation of plant   Square feet	Laundry		Number o	of pounds processed		
Nursing employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants  Direct Resident Care Consultants  Number of hours of resident care provided by EACH specialist (See listing page 13)  Maintenance and operation of plant  Property costs (depreciation)  Employee health and welfare  Management services  All other General Administrative expenses  Total of Direct and Allocated Costs  The preparer of this report must answer the following questions applicable to the cost information provided.  I. In the preparation of this Report, were all costs allocated as required?  N/A  2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.  Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.  3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  Per Yes O No If "No," explain fully why such allocation was not made.	Housekeeping		Number o	of square feet serviced		
Registered Nurses, Licensed Practical Nurses, Aides and Attendants  Direct Resident Care Consultants  Number of hours of resident care provided by EACH specialist (See listing page 13)  Maintenance and operation of plant  Square feet  Property costs (depreciation)  Employee health and welfare  Management services  Appropriate cost center involved  All other General Administrative expenses  Total of Direct and Allocated Costs  The preparer of this report must answer the following questions applicable to the cost information provided.  I. In the preparation of this Report, were all vest and in the preparation of the Report, were all vest and attach copy of appropriate supporting data.  N/A  2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.  Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.  3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  O Yes O No If "No," explain fully why such allocation was not made.			Number o	of hours of routine care provided	d by EACH	
Direct Resident Care Consultants  Number of hours of resident care provided by EACH specialist (See listing page 13)  Maintenance and operation of plant  Property costs (depreciation)  Employee health and welfare  Management services  Appropriate cost center involved  All other General Administrative expenses  Total of Direct and Allocated Costs  The preparer of this report must answer the following questions applicable to the cost information provided.  I. In the preparation of this Report, were all costs allocated as required?  N/A  2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.  Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.  3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  O Yes O No If "No," explain fully why such allocation was not made.	Nursing		employee	classification, i.e., Director (or	Charge Nurse	e),
Direct Resident Care Consultants    Number of hours of resident care provided by EACH specialist (See listing page 13)			Registere	d Nurses, Licensed Practical Nu	urses, Aides aı	nd
Sepecialist (See listing page 13)   Maintenance and operation of plant   Square feet			Attendant	S		
Maintenance and operation of plant Property costs (depreciation) Employee health and welfare Gross salaries Management services Appropriate cost center involved All other General Administrative expenses Total of Direct and Allocated Costs The preparer of this report must answer the following questions applicable to the cost information provided.  1. In the preparation of this Report, were all rosts allocated as required?  N/A  2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.  Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.  3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  Pres No No If "No," explain fully why such allocation was not made.	Direct Resident Care Consultants		Number o	f hours of resident care provide	ed by EACH	
Property costs (depreciation)  Employee health and welfare  Management services  Appropriate cost center involved  All other General Administrative expenses  Total of Direct and Allocated Costs  The preparer of this report must answer the following questions applicable to the cost information provided.  I. In the preparation of this Report, were all costs allocated as required?  N/A  Pres  No No If "No," explain fully why such allocation was not made.  Property costs (degree and allocated Costs)  Total of Direct and Allocated Costs  If "No," explain fully why such allocation was not made.  The preparer of this report must answer the following questions applicable to the cost information provided.  If "No," explain fully why such allocation was not made.  Total of Direct and Allocated Costs  If "No," explain fully why such allocation was not indirect costs to non-nursing home cost centers?  (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  Yes  No No If "No," explain fully why such allocation was not made.			specialist	(See listing page 13)		
Employee health and welfare  Management services  All other General Administrative expenses  Total of Direct and Allocated Costs  The preparer of this report must answer the following questions applicable to the cost information provided.  I. In the preparation of this Report, were all costs allocated as required?  N/A  2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.  Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.  3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  Yes  No  No  If "No," explain fully why such allocation was not made.	Maintenance and operation of plant		Square fe	et		
Management services All other General Administrative expenses Total of Direct and Allocated Costs The preparer of this report must answer the following questions applicable to the cost information provided.  1. In the preparation of this Report, were all costs allocated as required?  N/A  2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.  Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.  3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  • Yes • No  If "No," explain fully why such allocation was not made.	Property costs (depreciation)		Square fe	et		
All other General Administrative expenses  The preparer of this report must answer the following questions applicable to the cost information provided.  I. In the preparation of this Report, were all costs allocated as required?  N/A  Person No If "No," explain fully why such allocation was not made.  If "No," explain fully why such allocation was not made.  Person No If "No," explain fully why such allocation was not made.  If "No," explain fully why such allocation was not made.  Person No If "No," explain fully why such allocation was not made.	Employee health and welfare					
The preparer of this report must answer the following questions applicable to the cost information provided.  1. In the preparation of this Report, were all costs allocated as required?  N/A  2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.  Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.  3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  Yes O No If "No," explain fully why such allocation was not made.	Management services					
1. In the preparation of this Report, were all costs allocated as required?  N/A  2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.  Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.  3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  • Yes O No If "No," explain fully why such allocation was not made.	All other General Administrative expenses		Total of I	Direct and Allocated Costs		
2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.  Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.  3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)   • Yes O No If "No," explain fully why such allocation was not made.	The preparer of this report must answer the follow	wing question	ns applica	ble to the cost information prov	vided.	
2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.  Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.  3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)   • Yes O No If "No," explain fully why such allocation was not made.	1. In the preparation of this Report, were all	O Vos	O No	If "No," explain fully why su	ich allocation	was not
<ol> <li>Explain the allocation of related company expenses and attach copy of appropriate supporting data.</li> <li>Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.</li> <li>Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers?         <ul> <li>(e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)</li> <li>Yes</li> <li>No</li> <li>If "No," explain fully why such allocation was not made.</li> </ul> </li> </ol>	costs allocated as required?	O 1Cs	0 110	made.		
Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.  3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers?  (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  • Yes O No If "No," explain fully why such allocation was not made.	N/A					
Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.  3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers?  (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  • Yes O No If "No," explain fully why such allocation was not made.						
Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.  3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers?  (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  • Yes O No If "No," explain fully why such allocation was not made.						
Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.  3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers?  (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  • Yes O No If "No," explain fully why such allocation was not made.						
Shared expenses, allocated by bed size or geographic territory. See page 17 attachment.  3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers?  (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  • Yes O No If "No," explain fully why such allocation was not made.						
<ul> <li>3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers?         <ul> <li>(e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)</li> <li>Yes</li> <li>No</li> <li>If "No," explain fully why such allocation was not made.</li> </ul> </li> </ul>						
(e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  • Yes O No If "No," explain fully why such allocation was not made.	Shared expenses, allocated by bed size or geograp	phic territory	. See page	e 17 attachment.		
(e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  • Yes O No If "No," explain fully why such allocation was not made.						
(e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  • Yes O No If "No," explain fully why such allocation was not made.						
(e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  • Yes O No If "No," explain fully why such allocation was not made.						
(e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  • Yes O No If "No," explain fully why such allocation was not made.						
• Yes O No If "No," explain fully why such allocation was not made.	2 11 1			•	ne cost centers	s?
made.	(e.g., Assisted Living, Home Health, Outpatien	nt Services, A	Adult Day	Care Services, etc.)		
made.		O Vac	O No	If "No," explain fully why su	ich allocation	was not
N/A		0 163	0 110	made.		
	N/A				<del></del>	_

## **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	ear Ended		Page	of
Bristol Crossings LLC			2329	9/30/2017	i		6	37
		ed * to						
		ners,						
	_	ators,		Data	Т С	Annual	<b>A</b>	
N 1 1 1 CT		icers	D : .: CI I I	Date of	Term of	Amount		ount
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	of Lease	Clai	med
Reliable - 2610 Norstrand Ave, Brooklyn, NY 11210	0	•	Computer Equipment	03/01/08	60 Months	4,925	4,925	
Wescom Solutions, P.O. Box 674802, Detroit, MI 48267	0	•	Software	03/07/12	Ongoing	22,549	22,549	
Leaf, P.O. Box 644006, Cincinnatti, OH 45264	0	•	Copier	04/01/14	39 months	4,509	3,758	
Leaf, P.O. Box 644006, Cincinnatti, OH 45264	0	•	Copier	10/01/15	39 months	1,824	1,824	
Leaf, P.O. Box 644006, Cincinnatti, OH 45264	0	•	Copier	07/01/17	39 months	7,292	1,822	
	0	0						
	0	0						
	0	0						
	0	0						
	0	0						
Is a Mileage Log Book Maintained for All Le	eased Ve	ehicles S	O Yes	0	No	Total ***	34.878	

Is a Mileage Log Book Maintained for All Leased Vehicles?

<sup>\*</sup> Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

<sup>\*\*</sup> Attach copies of newly acquired leases.

<sup>\*\*\*</sup> Amount should agree to Page 22, Line 6e.

# **OLEAF**

SIGNED X

Accepted by: LEAF Capital Funding, LLC By:

### LEASE AGREEMENT

1720A Crete Street, Moberly, MO 65270

LESSEE LEGAL	NAME:					Phone: 800-66	52-3759, F	ex: 800-426-262
The Pines At				Tax ID#: 2087207	733	Telephone No; 8605891682	2	
61 Bellevue A	Avenue, Bristol, CT 06010		Equipment Location (if of 61 Bellvue Avenu	e Bristal	CT 06010			
EQUIPMENT I	DESCRIPTION: (indicate quantity, new or )	ised and include make, model, se	rial # and all attachment	s - see belo	wand/or attach	d Schedule A)		<del></del>
Unit Quantity	Description of Equipme	IN LARSON	Make and Typ	¢		Number	Se	rial Number
	* PLEASE REFER TO S	CHEDULE A						
BASE TERM IN MONTHS	TOTAL NUMBER OF LEASE PAYMENTS		EASE PURCHASE O	PTION		(a) Advance Pa	yment:	\$0.00
<u>39</u>	39 @ \$571.40 (plus taxes)	10% of Equipment cost, \$1.00, plus taxes	plus taxes			(b) Scenity De	posit:	\$0.00
	*	(PMV unless another option is	selected. You may not	exercise a p	urchase option	(c) Documenta	tion Foo:	\$95.00
**!************************************		if you are in default. If you ex right, title and interest in such I warranty.)	Equipment to you on an	AS-IS WHI	ERE IS without	Total due a + b		\$95.00
Your obligation	nc lease payment is required as an Advan to pay all amounts and perform all oth TERMS AND CONDITIONS	AL ADMENDARY OF MORT CHINCENS	e applied to lease payu ible, absolute, uncond	ients in inv	erse order, start I not subject to	ing with the las abatement, se	t lease pay t-off or d	ment. efense.
cost and your following terms is L. LEASE PAY execution. The execution the remaining Le Payment Date") prior to the first period from the Rent"). The Inter 15% if the actual 2. DELIVERY, delivery and inst your oral or wrighten consent are not responsible. 3. INDEMNIFIC against any loss expenses related possession, delived 4. LEASE EXPE expiration of the will renew on a either exercise ti the Equipment, you are responsible to the Equipment of th	(MENTS AND TERM: The Lease is a string of the Lease shall commence on the da memocrament Date."). The first Lease Payment his following the Lease Commencement Date are Payment before the same day of until paid in full. The Base Term shall corpayment Date. We may charge you a portic Lease Commencement Date until the first ment shall be due as invoiced. We may costs are different than the estimate used to ACCEPTANCE, USE AND REPAIR: You allation. You unconditionally accept the Exitten acceptance of the Equipment, or (b) authorize us to fill in the Lease Commence and are responsible for materialing the let for Equipment from and are responsible for materialing the let for Equipment or vendor failures. CATION: You agree to indemnify, defend as, damages, penalties, claims and suits, to the ordering, manufacture, installation, only or return of Equipment.  RATION, RENEWAL: Unless you notify Lease of your election to return or purel months to-month basis at the same mon are purchase option or provide us with a public for all return costs and we may charge and (ii) you must securely remove all data dior to returning the Equipment.	to lease the Equipment upon the enforceable on you upon you to the Equipment is delivered to cent shall be due on the date we te as set forth in our invoice, and feach subsequent month (each, a mmence on the date one month on of one Lease Payment for the day of the Baso Term ("Interim adjust the Lease Payments up to calculate the Lease Payments. In are responsible for Equipment upon the earlier of (a) 10 days after delivery of the sment Date, serial numbers and the above location without our Equipment in good repair. We and hold us harmless from and including attorneys' fees and hold us harmless from the carrier of the sment Date, serial numbers the same hold us harmless from and including attorneys' fees and hold us harmless from the same the Equipment, this Lease the Equipment, this Lease the Equipment, this Lease the Up Lease Payment until you east 90 days notice and return to the location we designate and a Rectacking Fee equal to one from any and all disk drives or subely repossible for eleastics.	our interests (and or additional amount for may be more than the b. 8. OWNERSHIP AI you are deemed to ove to file UCC financing fines and penalties real I we pay any taxes, it we pay any taxes, it is the amount we pai specified above or if cost. If we require an agree to reimburse out 9. DEFAULT: If you due date, or breach Equipment, you will to five following: (a) remaining Lease Pays by us, discounted at repossess the Equipm law. If you default, yous. In addition to a a penalty, we may react penaltic income and private sale, and apply disposition of the Equi is required by law, 10 for any amounts that security deposits to y without interest.	oly our interest of the cost o	exests). If we of such insurance in your own instruction in your characteristic inspection, rantor do not particularly pay all amore in Real and resident in your all amore in Real and resident in your and all pay the cost of 3%; (b) ruse any and all pay the cost or servicing of or servicing of or servicing of the exhall constituter we have apposed and if your and your a	bhain such insus and an administ and an administ unrance and on w Zquipment (exolor interest. You w leasing and/or or ess or penalties o You agree to pur of either \$125 or you requies to y us any amount by guaranty or we may require nts then due, plutual value of the larender of the remedies avail of repossession is entire the phone calls this Lease for yu bave deducted al you owe us. You can some of the control of the control of the control of the phone calls this Lease for yu bave deducted al you owe us. You can some of the control of	rance, you rate, you his on the control of the cont	will pay us an the cost of which the cost of which as make a profit. I stated software). If you will pay the Equipment alt, you will pay commentation fee of the Equipment ive services, you in (10) days of its e relating to the any combination tent value of the n, as determined any combination tent value of the n, as determined to the compared and not as and any additional ke possession of the case of the case of the sale or tif notice of sale main responsible may apply any will be retunded
is accordance we exercise a purcha AS-IS WHERE IS S. LATE FEES 2 due, you sgree to maximum legal as interest at 1.5% p. \$25 for each pay legolument and it INCLUDING TAND ARE NO DAMAGES.  7. INSURANCE from its order uperiod"). During Period"). During Equipment accep	moval standard that meets your business not ay us for any loss in value resulting from fi this Lease or for damages incurred in se option we will convey all of our interest S basis without representation or warranty. AND CHARGES: If any amount is not pai pay us a late charge equal to the leaser of 16 mount. Amounts which are not paid within 3 to mount. Amounts which are not paid within 3 to mount or if less, the maximum legal representation of the serious of the common of \$35 for each returned payment NTY: We do not manufacture the Equipm to supplier. WE MAKE NO EXPRESS OF MERCHANTABILITY OR TRESPONSIBLE FOR CONSEQUIPMENT OF LOSS: You bear all risk of lottli it is returned in the required condition the Risk Period you will maintain proper table to us, naming us loss payee and ad LESSEE: The Pines At Bristol	illure to maintain the Equipment is shipping and handling. If you in such Equipment to you on an and within three (3) days of when 19% of the amount past due or the 10 days of when due shall accrue the) until paid. You agree to pay the table of the 19% of the amount past of the 19% of	sell or assign our right shut will not be:  11. ARTICLE 2A: Y Uniform Commercial Article 2A (598-522) informed of the ident and may contact the 3 12. CREDIT INFOOD bureau reports, and m 13. CHOICE OF L/L LAW, YOU CONSEL IN PENNSYLVANI/A MISCELLANED only in writing signed or by electronic mes purposes. This Lease to the enforcement o means. You will use to rhousehold use.	its in the Les and the Les and the Les and the Code. You of the UCC ity of the St. upplier for a WMATION: aske other craw: TRIS NT TO JUR AND WAI DUS: This I is possible to the Les and, we is not binding the Equipment of the Lease th	ase and/or Equipy claim or defei is Lease is a "fu warve all rights is Lease is a "fu warve all rights and you a description of." You authorize edit inquiries the LEASE WILL USDICTION I EVE ANY RIGHEATH CAN THE LEASE THE LEASE THE LEASE HOLD THE LEASE IS THE PART OF THE LEASE IS THE PART OF THE LEASE IS THE PART OF THE LEASE HOLD THE	procurt and the n ase you have aga nance lease? as of and remedies of and remedies of vived a copy of it may have rights those rights. Us or any of ou at we deem neces BE GOVERNI N THE STATE HTTO A TRIAL tles' entire agree may be execute to us shall be e sign it. You agu executed or trans iness purposes a	cw owner instrus. Isfined in a conferred in the Supply under the raffiliates sary. ED BY PF OR FEDE LEY JURY ment and d in counter binding uncertainty in the same of the same	will have all our Article 2A of the open a lessee by Contract or been Supply Contract to obtain credit CNNSXLVANIA GRAL COURTS' & can be amended sparts (manually pon you for all alies as a defense us by electronic personal, family
Lessee Authori	zed Signature	E-Mail Addre			NOW.	Title: P-Re Date: 7/1-	سااد	
dictyship defende ees) we becur in e is and our affilian expressly waive an	ANANTY: Undersigned Suurantees that Le mat and not of collection, and that we can support the Lessessie in default indorcing our rights beganst undersigned or I as to obtain exedit bureau reports and make by right to a triabby jury.	and consents to any extensions	of modifications grante	d to Lessee	Undersigned w	ill pay us all ex	Indersigned perses (inc	d also waives all adding attoracys
IGNED X / /		J /		1	_	1	\	1

Title:

E-Mail Address

Date:



# SCHEDULE A TO LEASE AGREEMENT (EQUIPMENT DESCRIPTION)

Lease Application No.: 412185

QNT Equipment Description	New/Used	Make	Model	Serial Number
Location: 61 Bellvue Avenue, Bristol, CT 060	10			
1 Toshiba E-Studio 6570C	New		E-Studio 6570C	
Toshiba E-Studio 5508A			2 44400 00100	•
Toshiba E-Studio 3505AC				

LESSEE: The Pines At Bristol	LEAF CAPITAL FUNDING, LLC
PRINT NAME: MICHAET BOKOW.  TITLE: PURCHASING  DATE: 7/17/17	BY:

CSP-7 Rev. 6/95

# General Information and Questionnaire Accounting Basis

Name of Facility	License No.	Report for Year Ended		Page	of
Bristol Crossings LLC	2329	9/30/2017		7	37
The records of this facility for the p	period covered by this report	were maintained on the following basis:			
	Modified Cash				
Is the accounting basis for this					
F	Yes	If "No," explain.			
previous period?	No				
Independent Accounting Firm					
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)			
1 Blum Shapiro		2 Enterprise Drive, Shelton, CT 06484			
2					
3					
4					
Services Provided by This Firm (de	escribe fully )				
1 Review, preparation of Medicare and	Medicaid cost reports, and year end	I tax services	\$	26,640	
2			\$		
3			\$		
4			\$		
			Charge for	r Services Pı	rovided
			\$	26,640	
Are These Charges Reflected in the Expend	liture Portion of This Report? If Ye	s, Specify Expense Classification and Line No.		==,===	
	Page 15, line 1 d	, 1 J 1			
<b>Legal Services Information</b>	<u> </u>				
Name of Legal Firm or Independent	t Attorney		Telephone	Number	
1 Rogin Nassau	,		(860) 256		
2 Berchem Moses & Devlin PC			(203) 783		
3 Amerassist AR Solutions Inc			(877) 770		
4 Atlas Global Trade Solutions I	nc		(800) 509		
5 Goldman Gruder & Wood			(203) 899		
Address (No. & Street, City, State,	Zip Code)		(===)		
1 185 Asylum Street 22nd Floor	Hartford CT 06103-3460				
2 75 Broad Street Milford, CT 0					
3 PO Box 26095, Columbus, OH	I 43226				
4 PO Box 1389, Kenner, LA 700	063				
5 200 Connecticut Ave, Norwalk	CT 06854				
Services Provided by This Firm (de	escribe fully )				
1 Revaluation - Disallow			\$	7,256	
2 Labor			\$	14,675	
3 Collections - Disallow			\$	53	
4 Collections - Disallow			\$	3	
5 Collections - Disallow			\$	19,913	
			Charge fo	r Services Pi	rovided
			\$	41,900	
Are These Charges Reflected in the Expend	•	s, Specify Expense Classification and Line No.	•	^	
⊙ Yes O No	Page 15, line 1 e				

## **Schedule of Resident Statistics**

Name of Facility		License No. Report for Year					r Year Ende	ed		Page	of	
Bristol Crossings LLC			2	329			9/30/2017	7			8	37
					]	Period 10	/1 Thru 6/	30		Period 7/	1 Thru 9/3	30
		Total	Total									
	Total All	CCNH	RHNS	Total								
	Levels	Level	Level	(Specify)	Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
Certified Bed Capacity												
A. On last day of PREVIOUS report period	132	132			132	132			132	132		
B. On last day of THIS report period	132	132			132	132			132	132		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	122	122			122	122			121	121		
B. As of midnight of THIS report period	122	122			121	121			122	122		
3. Total Number of Days Care Provided During Period												
A. Medicare	6,435	6,435			4,736	4,736			1,699	1,699		
B. Medicaid (Conn.)	34,183	34,183			25,754	25,754			8,429	8,429		
C. Medicaid (other states)												
D. Private Pay	3,394	3,394			2,428	2,428			966	966		
E. State SSI for RCH												
F. Other (Specify) Managed Care	421	421			383	383			38	38		
G. Total Care Days During Period (3A thru F)	44,433	44,433			33,301	33,301			11,132	11,132		
Total Number of Days Not Included in Figures in 4. 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	23	23			23	23						
B. Other Bed Reserve Days	35	35			33	33			2	2		
5. Total Resident Days (3G + 4A + 4B)	44,491	44,491			33,357	33,357			11,134	11,134		

CSP-9 Rev. 9/2002

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

Name of Faci	lity			Licer	ise No.				Report	for Year	Ended		Page	of
Bristol Crossi	-	,			2329				кероп	9/30/201			9	37
BIISTOI CIUSSI	iigs LLC				2329					9/30/201	/		9	31
4 Were the	ere any c	hanges	in the certified b	ed car	nacity du	ing th	ne reno	rt vear	.9	0	Yes	•	No	
	-	_	lowing informat		pacity au	mg u	Стеро	it your	•	Ū		· ·	110	
11 1123	, provid			1011.	CI		· D 1				·	CI		
			f Change		Ci	nange	in Bed			Ca	pacity Afte	er Change		
Date of	CCNH	RHNS	(Specify)		Lost		(	Gaine	d					
Change														
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	Reason for	or Change
5 If there :		ahanaa i	n cortified had a		tr. durina	tha ra	n art	or (oc	ranarta	d in itam	4 abarra) n	warida tha mum	har of	
	-	-	n certified bed c	-	-	tne re	роп уе	ar (as	героги	a in item	4 above) p	provide the num	ber of	
RESIDE	ENT DA	YS for 9	00 days following	g the o	change.					1				
			Change in Ro	esider	nt Days					CC	NH	RHNS	(Spe	cify)
1st chang	ge													
2nd chan	ige													
3rd chan	ge													
4th chan	ge													
6. Number	of Resid	lents and	d Rates on Septe	mber	30 of Cos	st Yea	ır						_	
			Medicare		Medi					Se	lf-Pay		Other Stat	e Assisted
	Item		CCNH		CNH	RI	HNS	CC	CNH	RE	INS	(Specify)	R.C.H.	ICF-MR
No. of R			16		88	1(1	1110		18		1110	(Specify)	10.0.11.	TCT WITE
Per Dien			10		88				10					
a. One b			PPS		238.13				450/525					
b. Two			PPS		238.13				422/500					
c. Three			113		230.13				422/300					
bed 1	ms.		PPS											
7 T ( 1 N	1 (	· DI ·	1.TT T							TO	TAI	COMI	DIDIG	(C :C)
		-	l Therapy Treat	ments						10	TAL	CCNH	RHNS	(Specify)
		re - Part									2,478	2,478		
		,	usive of Part B)											
			e Treatments								266	266		
		torative	Treatments								366	366		
	Other Total I	Dhusiaal	Therapy Treatn	n amts							14,870	14,870		
											17,714	17,714		
		speecn re - Part	Therapy Treatm	ients							224	224		
											321	321		
В.			usive of Part B)											
			e Treatments								1.6	16		
		torative	Treatments								16	16		
	Other Total S	nacal. T	Though. To and	ande						-	1,567	1,567		
			Therapy Treatme		a ont~						1,904	1,904		
			tional Therapy	reatn	ients						2 422	2.422		
		re - Part									2,432	2,432		
В.			usive of Part B)											
			e Treatments								440	**		
		torative	Treatments							-	410	410		
	Other	Dagum ad	ional Therapy T	wac-tr-	ante						15,854	15,854		
D.	rotat C	лссирии	onai inerapy i	reuim	ienis					1	18,696	18,696		

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Report of Ex	License No.	Dalaire				C
Name of Facility			Report for Year	Ended	Page	of
Bristol Crossings LLC	2329		9/30/2017		10	37
Are time records maintained by all individuals receiving com	pensation?	•	Yes	0	No	
			Total Cost a	ind Hours		
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I						
of Schedule A1)  2. Administrator(s) (Complete also Sec. III						
	127.769	2.000				
of Schedule A1)  3. Assistant Administrator (Complete also Sec. IV	127,768	2,080				
of Schedule A1)						
4. Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)	217,215	9,788				
5. Dietary Service		2,7,00				
a. Head Dietitian	27,417	832				
b. Food Service Supervisor	70,442	2,080				
c. Dietary Workers	360,137	24,696				
Housekeeping Service     a. Head Housekeeper	45,148	2,080				
b. Other Housekeeping Workers	265,880	19,504				
7. Repairs & Maintenance Services	203,000	17,504				
a. Engineer or Chief of Maintenance	70,229	2,100				
b. Other Maintenance Workers	66,038	3,482				
8. Laundry Service						
a. Supervisor	45 476	2 227				
b. Other Laundry Workers     9. Barber and Beautician Services	45,476	3,327				
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
Directors and Assistant Director of Nurses	191,472	4,151				
b. RN	(55,000	17.740				
Direct Care     Administrative**	655,900 238,895	17,740 6,215				
c. LPN	230,073	0,213				
1. Direct Care	1,223,646	43,402				
2. Administrative**						
d. Aides and Attendants	1,854,703	118,651				
e. Physical Therapists						
f. Speech Therapists g. Occupational Therapists	+					
g. Occupational Therapists h. Recreation Workers	134,473	6,195				
i. Physicians	13 1, 173	0,173				
Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists					1	
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	283,150	9,713				
n. Marketing						
o. Other (Specify)						
See Attached Schedule  A-13. Total Salary Expenditures	5,877,989	276,036				
л-15. 16ші заші у Ехрепаниres	3,011,909	2/0,030	ļ	ļ	<u> </u>	<u> </u>

<sup>\*</sup> 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.

<sup>\*\*</sup> 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.

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

#### Schedule of Other Salaries and Wages (Page 10)

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

#### Schedule of Other Fees (Page 13)

		CC	NH	RH	NS	(Spe	cify)
Service	\$		Hours	\$	Hours	\$	Hours
Consulting Fees - Nursing	\$	6,474	Disallowed				
Consulting Fees - Rehabilitation Therapy and Ancillary	\$	4,264	Disallowed				
Fees - Respiratory	\$	2,275	Disallowed				
Total	\$	13,013	Disallowed	\$ -	-	\$ -	=

CSP-11 Rev. 10/2005

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

Name of Facility				License No.		Report for	Year Ended		Page	of
Bristol Crossings LLC				2329		9/30/2017			11	37
Name	CCNH	Salary Paid	(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			(~p****)	(20000000000000000000000000000000000000		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 1184 14	0 11101 =111p101y111011	1, 00000	
Marvin J. Ostreicher, 184 Wildacre Ave, Lawrence, NY 11559				Same as employees	Supervises operations, deals with DNS & other patient care,		p. 16 / m13 - \$31,200	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).										

<sup>\*</sup> No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

<sup>\*\*</sup> Include all employment worked during the cost year.

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

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

Vacation Sick Personal

Holiday

Total Hours

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 Y	ear Ended		Page	of
Bristol Crossings LLC				2329		9/30/2017	9/30/2017		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***			(1 )/	37			- č	1 3		
Raymond L Wilkens	127,768			Same as employees	Management & supervision of healthcare facility	2,080	a2			
Section IV - Assistant Administrators										

<sup>\*</sup>No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

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

<sup>\*\*\*</sup> If more than one Administrator is reported, include dates of employment for each.

CSP-13 Rev. 9/2002

**B.** Report of Expenditures - Professional Fees

Name of Facility	License No.		Report for Y		Page	of
Bristol Crossings LLC	23		9/30/2017		13	37
			Total Cost	and Hours		
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee						
for service basis in lieu of salary						
(For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	7,860	Disallowed				
3. Pharmacist	14,186	Disallowed				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	333,948	6,472				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	72,000	325				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**	2,197	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	74,565	1,135				
b. Other						
10. Occupational Therapist						
a. Resident Care	350,591	6,483				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	19,642	160				
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	13,013	Disallowed				
B-13 Total Fees Paid in Lieu of Salaries	888,002	14,575				

<sup>\*</sup> 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.

<sup>\*\*</sup> 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.

<sup>\*\*\*</sup> 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.		License No.		Report for '	Year Ended	Page	of
Bristol Crossings LLC		2329		9/30/2017		14	37
				to Owners,			
Name & Address of Individual	Full Expla	nation of Service		s, Officers	Expla	nation of Re	elationship
G il a dalai po p. 200520 Walang Il		D. C.	Yes	No			
Gerident Solutions, PO Box 290539, Wethersfield, CT		Dentist	0	•			
Procare LTC of CT, 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist,	Consulting Nursing	•	0	Common Own	ership	
Preferred Therapy, 850 Silas Deane Hwy, Wethersfield, CT 06109	PT/OT/ST, Co	nsulting Rehab Therapy	•	0	Common Own	ership	
In Patient Consulting, The Hospitalist Company P.O. Box 92284, Los Angeles, CA 90009	Med	lical Director	0	•			
Swalling Diagnostic, P.O. Box 484, Avon, CT 06001	Spe	ech Therapy	0	•			
Bristol Hospital PO Box 977, Bristol CT, 06010 Respiratory		piratory Fees	0	•			
360Healthcare Staffing. PO Box 674009. Dallas, TX 75267-4009		RN	0	•			
Litchfield Hills Surgery, 245 Alvord Park Rd Torrington, CT 06790-3493	Re	sident Care	0	•			
			0	0			
			0	0			
			0	0			
			0	0			
			0	0			
			0	0			
			0	0			
			0	0			
			0	0			
			0	0			
			0	0			
			0	0			
			0	0			
			0	0			

<sup>\*</sup> 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	
Bristol Crossings LLC	2329		9/30/2017		15	37	
Item			Total	CCNH	RHNS	(Specify)	
1. Administrative and General							
a. Employee Health & Welfare Benefits							
1. Workmen's Compensation		\$	288,998	288,998			
2. Disability Insurance		\$					
3. Unemployment Insurance		\$	95,324	95,324			
4. Social Security (F.I.C.A.)		\$	440,871	440,871			
5. Health Insurance		\$	638,642	638,642			
6. Life Insurance (employees only)							
(not-owners and not-operators)		\$					
7. Pensions (Non-Discriminatory)		\$	15,353	15,353			
(not-owners and not-operators)							
8. Uniform Allowance		\$					
9. Other ( <i>Specify</i> )		\$					
See Attached Schedule							
b. Personal Retirement Plans, Pensions, and		\$					
Profit Sharing Plans for Owners and							
Operators (Discriminatory)*							
c. Bad Debts*		\$					
d. Accounting and Auditing		\$	26,640	26,640			
e. Legal (Services should be fully described	on Page 7)	\$	41,900	41,900			
f. Insurance on Lives of Owners and		\$					
Operators (Specify )*							
g. Office Supplies		\$	27,424	27,424			
h. Telephone and Cellular Phones							
1. Telephone & Pagers		\$	26,012	26,012			
2. Cellular Phones		\$	3,390	3,390			
i. Appraisal (Specify purpose and		\$					
attach copy )*							
j. Corporation Business Taxes (franchise ta.	x)	\$	449	449			
k. Other Taxes (Not related to property - Se	e Page 22)						
1. Income*		\$					
2. Other ( <i>Specify</i> )		\$					
See Attached Schedule							
3. Resident Day User Fee		\$	801,683	801,683			
Subtotal		\$	2,406,686	2,406,686			

<sup>\*</sup> 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

Bristol Crossings LLC 9/30/2017

Attachment Page 15

### **Schedule of Other Employee Benefits**

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

#### **Schedule of Other Taxes**

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

.....

CSP-16 Rev. 9/2002

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

Name of Facility	License No.		Report for Y	Year Ended	Page	of
Bristol Crossings LLC	2329		9/30/2017		16	37
Item			Total	CCNH	RHNS	(Specify)
Subtotal	ls Brought Forwar	d:	2,406,686	2,406,686		
Travel and Entertainment						
1. Resident Travel and Entertainment		\$				
2. Holiday Parties for Staff		\$	5,484	5,484		
3. Gifts to Staff and Residents		\$	5,738	5,738		
4. Employee Travel		\$	3,235	3,235		
5. Education Expenses Related to Seminars and	d Conventions	\$	470	470		
6. Automobile Expense (not purchase or depre	eciation)	\$				
7. Other ( <i>Specify</i> )		\$				
See Attached Schedule						
m. Other Administrative and General Expenses						
1. Advertising Help Wanted (all such expenses	1)	\$				
2. Advertising Telephone Directory (all such ex	xpenses )***	\$				
3. Advertising Other (Specify)***		\$	46,033	46,033		
See Attached Schedule						
4. Fund-Raising***		\$				
5. Medical Records		\$				
6. Barber and Beauty Supplies (if this service i	s supplied	\$				
directly and not by contract or fee for service	e)***					
7. Postage		\$	2,657	2,657		
* 8. Dues and Membership Fees to Professional		\$	9,418	9,418		
Associations (Specify)						
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other Non-A	llowable Org.***	\$				
9. Subscriptions		\$	2,424	2,424		
10. Contributions***		\$	1,500	1,500		
See Attached Schedule						
11. Services Provided by Contract (Specify and	Complete	\$				
Schedule C-2, Page 21 for each firm or ind	ividual)					
12. Administrative Management Services**		\$	560,296	560,296		
13. Other (Specify)		\$	378,789	378,789		
See Attached Schedule						
C-14 Total Administrative & General Expenditures		\$	3,422,730	3,422,730		

<sup>\*</sup> Do not include Subscriptions, which should go in item 9.

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*\*</sup> 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	C	CNH	RHN	S	(Specify	y)
Advertising Promotional - Administration	\$	2,814				
Advertising Promotional - Marketing	\$	43,219				
Total Other Advertising	\$	46,033	\$	-	\$	-

#### **Schedule of Dues**

Description	(	CCNH	RHNS	(Specify)
CAHCF	\$	9,333		
ALTCFM	\$	85		
Total Dues	\$	9,418	\$ -	\$ -

#### Schedule of Contributions

Description	 CNH	RHN	NS	(Spec	ify)
Political Contributions - Administration - Disallowed	\$ 1,500				
Total Contributions	\$ 1,500	\$	-	\$	-

#### Schedule of Other Administrative and General

Description	(	CCNH	RHNS	(Specify)
IT Services - Administration	\$	57,115		
Consulting Fees- Administration - Disallowed via Management Fee	\$	7,727		
Consulting Fees - Fiscal Operations	\$	882		
Penalties - Administration - Disallowed	\$	12		
Purchased Services - Administration Staff	\$	31,200		
Purchased Services - Fiscal Operations	\$	35,511		
Licenses and Permits - Administration	\$	1,550		
Bank Charges - Administration - Disallowed	\$	19,027		
Background Check - Administration	\$	9,834		
Crime Insurance - Administration - Disallowed	\$	1,047		
Miscellaneous Expense - Administration - Disallowed	\$	15,945		
Amortization of Goodwill-Disallowed	\$	198,939		
Total Other Administrative and General	\$	378,789	\$ -	\$ -

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

Name of Facility Bristol Crossings LLC	License No. 2329	Report for Year Ended 9/30/2017	Page of 17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
National Healthcare	560,296		Page 16, Line M12

<sup>\*</sup> In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.

#### National Health Care Profit and Loss Allocated by GL Account

Start Date: 10/1/2016 End Date: 9/30/2017		0101 Bloomfield	0102 Bristol	0103 Cambridge	0104 Ludlowe	0105 Maple View	0106 Marlborough	0107 Milford	0108 New Milford	0109 Regency	0110 Riverside	0112 Water's Edge	0113 Bethel Health and	0114 HERREW HOME
	_			_		Manor						-	Rehabilitation	
300001-0000-00-000-0	TROY Shared Cost	(3,082.11)	(3,390.21)	(4,109.29)	(3,698.60)	(3,082.11)	(3,082.11)	(3,082.11)	(2,439.75)	(3,338.75)	(8,861.25)	(3,852.66)	(5,214.41)	(4,920.43)
391500-0000-00-000-0	Misc. Other Income-Nat. Mgmt	(230.77)	(253.85)	(307.69)	(276.93)	(230.77)	(230.77)	(230.77)	(182.66)	(249.96)	(663.47)	(288.48)	(390.42)	(494.21) 510,738.73
400000-0000-00-000-0 401000-0000-04-000-0	Salary-National Healthcare Management FICA-National Healthcare Management-Fiscal Ope	315,626.39 20.604.17	347,189.87 22,664.72	416,571.18 27,084.42	378,754.68 24,725.44	315,626.39 20,604.17	315,626.39 20,604.17	315,626.39 20,604.17	251,580.28 16,511.41	344,284.39 22,595.70	907,444.85 59,238.55	394,532.95 25,755.42	539,945.39 35.585.87	35,056.66
401100-0000-04-000-0	FUI-National Healthcare Management-Fiscal Oper -	91.21	100.31	120.44	109.45	91.21	91.21	91.21	72.19	98.81	262.25	114.01	156.06	184.12
401200-0000-04-000-0	SUI-National Healthcare Management-Fiscal Oper	1.334.59	1,468.09	1,754.79	1,601.56	1,334.59	1,334.59	1,334.59	1,055.97	1,445.10	3,837.06	1,668.31	2,274.74	2,740.85
401201-0000-00-000-0	SUI - NY-National Healthcare Management	(102.24)	(112.46)	(136.33)	(122.72)	(102.24)	(102.24)	(102.24)	(80.96)	(110.78)	(293.99)	(127.83)	(172.98)	(109.49)
401250-0000-00-000-0	NY MTA Tax-Nat. Mgmt	596.40	656.05	779.98	715.79	596.40	596.40	596.40	480.35	657.42	1,714.83	745.53	1,039.96	964.66
401300-0000-04-000-0	Health Insurance-National Healthcare-Fiscal Op	33,107.00	36,417.24	44,141.92	39,730.92	33,107.00	33,107.00	33,107.00	26,207.09	35,864.31	95,186.98	41,386.05	56,027.91	57,068.30
401400-0000-04-000-0	Workers Compensation-National Health-Fiscal Op	2,355.62	2,591.29	3,140.82	2,826.94	2,355.62	2,355.62	2,355.62	1,864.50	2,551.68	6,772.78	2,944.77	3,985.43	5,044.92
401500-0000-04-000-0	Medical Benefits-National Healthcare-Fiscal Op	(7.67)	(8.44)	(10.23)	(9.20)	(7.67)	(7.67)	(7.67)	(6.07)	(8.31)	(22.05)	(9.59)	(12.98)	(16.43)
401600-0000-04-000-0	Disability Expense-National Healthca-Fiscal Op-	(91.06) 6.418.84	(100.12)	(121.39)	(109.29)	(91.06)	(91.06)	(91.06)	(72.05)	(98.64)	(261.82)	(113.84)	(154.04) 10.859.59	(133.07)
401700-0000-04-000-0	Pension-National Healthcare Manageme-Fiscal Op-	6,418.84 708.47	7,060.44 779.27	8,558.00 944.60	7,702.73 850.19	6,418.84 708.47	6,418.84 708.47	6,418.84 708.47	5,081.06 560.82	6,953.32	18,454.51	8,023.53 885.57	10,859.59	10,007.07
401800-0000-04-000-0	Employee Benefits - Other-National H-Fiscal Op - Holiday Expense-National Healthcare -Fiscal Op -	106.86	117.55	142.46	128.21	106.86	106.86	106.86	84.59	767.42 115.76	2,036.84 307.20	133.55	1,198.07	1,118.67 74.55
410000-0000-04-000-0	Supplies-National Healthcare Managem-Fiscal Op	2.856.68	3,142.36	3,808.96	3,428.12	2.856.68	2,856.68	2,856.68	2,261.43	3.094.65	8,213.37	3,570.94	4,791.09	5,014.89
410000-0000-04-000-0	Supplies-National Healthcare Managem-Maintenan	10.69	11.75	14.25	12.82	10.69	10.69	10.69	8.47	11.60	30.73	13.35	18.09	0.70
410000-0000-09-000-0	Supplies-National Healthcare Managem-Housekeep	22.52	24.76	30.00	27.01	22.52	22.52	22.52	17.84	24.36	64.72	28.15	40.42	42.47
411000-0000-04-000-0	Food-National Healthcare Management-Fiscal Ope	27.76	30.52	37.01	33.33	27.76	27.76	27.76	21.96	30.08	79.83	34.69	46.97	35.88
431000-0000-03-000-0	Consulting Fees-National Healthcare -Administr	18.03	19.84	24.04	21.64	18.03	18.03	18.03	14.27	19.53	51.84	22.54	30.51	38.62
431000-0000-04-000-0	Consulting Fees-National Healthcare -Fiscal Op	8,620.19	9,481.77	11,493.28	10,344.69	8,620.19	8,620.19	8,620.19	6,823.93	9,338.21	24,783.91	10,775.60	14,401.14	12,800.60
432000-0000-03-000-0	Accounting Fees-National Healthcare -Administr	541.16	595.30	721.49	649.41	541.16	541.16	541.16	428.36	586.30	1,555.96	676.47	915.53	749.23
433000-0000-03-000-0	Legal Fees-National Healthcare Manag-Administr -	8,472.34	9,319.49	11,296.21	10,167.38	8,472.34	8,472.34	8,472.34	6,706.49	9,177.86	24,359.05	10,590.96	14,331.19	14,974.30
440000-0000-03-000-0	Purch Services-National Healthcare M-Administr Purch Services-National Healthcare M-Maintenan	11,050.58	12,155.52 4,466.78	14,733.60 5,414.06	13,261.53 4.872.98	11,050.58 4.060.58	11,050.58 4,060.58	11,050.58 4,060.58	8,747.49 3,214.16	11,970.89 4.398.65	31,771.33 11.674.64	13,813.66 5.076.06	18,696.03 6,869.97	18,753.34 7,797.89
440000-0000-08-000-0	Purch Services-National Healthcare M-Maintenan  Purch Services-National Healthcare M-Housekeep	1,489.60	1,466.78	1,986.19	1,787.73	1,489.60	1,489.60	1,489.60	1,179.29	1,613.64	4,282.82	1,862.18	2.520.33	2,368.28
440000-0000-07-000-0	Purch Services-National Healthcare Ma-Security -	3.49	3.83	4.65	4.18	3.49	3.49	3.49	2.76	3.78	10.03	4.36	5.90	7.47
440001-0000-08-000-0	Ground Services-Nat. MamtMaintenance-	18.25	20.07	24.33	21.89	18.25	18.25	18.25	14.42	19.77	52.43	22.81	30.84	27.68
441000-0000-03-000-0	Computer Expense-National Healthcare-Administr	12,976.69	14,274.04	17,301.36	15,572.95	12,976.69	12,976.69	12,976.69	10,272.48	14,057.75	37,308.86	16,221.30	21,685.61	18,439.19
442000-0000-08-000-0	Pest Control-Nat. MgmtMaintenance	8.17	8.98	10.89	9.80	8.17	8.17	8.17	6.47	8.85	23.49	10.21	13.82	
452000-0000-25-000-0	Equipment Rental-National Healthcare-Fiscal Op	2,879.22	3,166.92	3,838.70	3,455.18	2,879.22	2,879.22	2,879.22	2,279.21	3,119.01	8,277.99	3,599.21	4,871.10	4,482.71
461000-0000-03-000-0	Telephone-National Healthcare Manage-Administr	3,831.96	4,215.02	5,109.25	4,598.59	3,831.96	3,831.96	3,831.96	3,033.57	4,151.25	11,017.47	4,790.27	6,483.10	5,691.40
461100-0000-03-000-0	Telephone - Cell-National Healthcare-Administr	1,779.85	1,957.75	2,373.00	2,135.85	1,779.85	1,779.85	1,779.85	1,408.86	1,928.03	5,117.10	2,224.80	3,004.55	2,866.05
462000-0000-25-000-0	Electric-National Healthcare Manageme-Property-	2,842.62	3,126.81	3,790.05	3,411.30	2,842.62	2,842.62	2,842.62	2,250.29	3,079.44	8,172.84	3,553.35	4,809.26	4,075.05
463000-0000-25-000-0 466000-0000-25-000-0	Gas-National Healthcare Management-Property-	286.27 125.39	314.91 137.94	381.68 167.19	343.56 150.50	286.27 125.39	286.27 125.39	286.27 125.39	226.63 99.25	310.10 135.83	823.08 360.51	357.86 156.75	484.34 212.16	512.52 197.85
471000-0000-25-000-0	Water-National Healthcare Management-Property  Rent-National Healthcare Management-Property	11.904.14	137.94	15,871.29	14.285.51	11,904.14	11.904.14	11.904.14	9,424,58	12.896.53	34,225.14	14.880.11	20.139.49	12,476.79
472000-0000-25-000-0	Personal Property Taxes-National Hea-Fiscal Op	1.061.56	1,167,79	1.415.52	1,273.89	1.061.56	1,061.56	1.061.56	840.35	1,150.01	3,052.09	1,326,90	1,795.85	2,207.16
473000-0000-25-000-0	Real Estate Taxes-National Healthcar-Fiscal Op-	3,443,49	3.788.25	4,591,57	4,132.72	3.443.49	3,443,49	3,443,49	2,725.32	3,729,98	9,900.97	4,305.09	5.826.20	9,261.26
484000-0000-04-000-0	Amort Exp - LHI-National Healthcare -Fiscal Op	2,516.86	2,768.45	3,355.70	3,020.36	2,516.86	2,516.86	2,516.86	1,992.36	2,726.52	7,236.24	3,146.16	4,258.13	3,941.29
486000-0000-04-000-0	Dep Exp - Moveable Equip-National He-Fiscal Op	11,227.34	12,349.82	14,969.42	13,473.47	11,227.34	11,227.34	11,227.34	8,887.35	12,162.26	32,279.85	14,034.76	18,994.98	19,585.47
491000-0000-03-000-0	Dues and Subscriptions-National Heal-Administr	923.05	1,015.35	1,230.71	1,107.72	923.05	923.05	923.05	730.65	999.93	2,653.89	1,153.87	1,561.71	1,636.89
500000-0000-03-000-0	Licenses and Permits-National Health-Administr	581.40	639.59	775.21	697.74	581.40	581.40	581.40	460.20	629.82	1,671.67	726.81	983.64	1,079.59
501000-0000-03-000-0	Advertising Employment-National Heal-Administr	5,904.90	6,494.59	7,872.45	7,085.66	5,904.90	5,904.90	5,904.90	4,674.72	6,396.87	16,976.31	7,380.55	9,989.70	5,795.97
501100-0000-03-000-0	Advertising Promotional-National Hea-Administr-	6,751.42	7,426.73	9,002.04	8,102.13	6,751.42	6,751.42	6,751.42	5,344.56	7,313.87	19,411.29	8,439.87	11,380.63	10,816.81
503000-0000-03-000-0	Interest-National Healthcare Managem-Administr -	2,273.15	2,500.56	3,030.81	2,728.05	2,273.15	2,273.15	2,273.15	1,799.44	2,462.54	6,535.70	2,841.61	3,846.98	3,787.91
503500-0000-03-000-0	Penalties-National Healthcare Manage-Administr  Bank Charges-Nat. MgmtAdministration	1.390.29	1.529.34	1.853.69	1.668.44	1.390.29	1.390.29	1.390.29	1.100.51	1.506.09	3.997.26	1.737.92	2.352.16	2.304.72
504000-0000-03-000-0	Postage-National Healthcare Manageme-Administr-	1,390.29	1,131.09	1,370.92	1,233.97	1,028.24	1,028.24	1,028.24	813.92	1,508.09	2,956.35	1,285.36	1,739.60	1,917.74
509000-0000-03-000-0	Seminars-National Healthcare Managem-Administr-	580.46	638.51	773.95	696.66	580.46	580.46	580.46	459.55	628.81	1.668.93	725.66	981.20	904.13
510000-0000-03-000-0	Liability Insurance-National Healthc-Administr-	2,222.62	2,444.82	2,963.43	2,667.30	2,222.62	2,222.62	2,222.62	1,759.39	2,407.73	6,390.26	2,778.40	3,760.36	3,648.18
511000-0000-03-000-0	Auto Insurance-National Healthcare M-Administr	1,464.24	1,610.68	1,952.30	1,757.20	1,464.24	1,464.24	1,464.24	1,159.11	1,586.22	4,209.98	1,830.43	2,477.33	2,517.47
512000-0000-03-000-0	Umbrella Insurance-National Healthca-Administr	1,199.48	1,319.43	1,599.27	1,439.48	1,199.48	1,199.48	1,199.48	949.48	1,299.36	3,448.64	1,499.41	2,029.36	2,047.90
513000-0000-03-000-0	Crime Insurance-National Healthcare -Administr	67.24	73.99	89.66	80.71	67.24	67.24	67.24	53.23	72.86	193.35	84.07	113.74	125.48
517000-0000-03-000-0	Wor'kmans Comp Insurance-National	1,245.82	1,370.25	1,660.94	1,494.91	1,245.82	1,245.82	1,245.82	986.23	1,349.58	3,581.65	1,557.19	2,107.67	1,318.23
520000-0000-03-000-0	Auto Expense-National Healthcare Man-Administr-	1,940.32	2,134.10	2,586.87	2,328.27	1,940.32	1,940.32	1,940.32	1,536.21	2,102.07	5,578.30	2,425.16	3,282.49	1,300.95
520100-0000-03-000-0 521000-0000-00-000-0	Auto Lease Expense-National Healthca-Administr Travel Expense-Nat. Mgmt	3,326.39 11.04	3,658.73 12.14	4,434.78 14.72	3,991.57 13.24	3,326.39 11.04	3,326.39 11.04	3,326.39 11.04	2,633.34 8.74	3,603.08 11.95	9,563.31 31.74	4,157.82 13.79	5,641.63 18.67	4,606.91 23.63
521000-0000-00-000-0	Travel Expense-National Healthcare M-Administr	7,274.81	8.002.45	9.699.71	8,730.06	7,274.81	7,274.81	7,274.81	5,758.52	7,880.71	20,915.97	9,093.90	12,267.84	12,259.94
522000-0000-03-000-0	Hotel Expense-National Healthcare Ma-Administr -	6.265.22	6,891.68	8.353.42	7.518.61	6,265.22	6.265.22	6,265.22	4.959.41	6,786.92	18,013.18	7,831.80	10,599,82	10,784.74
541000-0000-03-000-0	Misc. Expense-Nat. MgmtAdministration-	117.75	129.52	157.02	141.31	117.75	117.75	117.75	93.18	127.51	338.47	147.19	199.22	370.50
541000-0000-31-000-0	Misc. Expense-National Healthcare Ma-Misc. Exp	(973.14)	(1,070.55)	(1,297.65)	(1,167.88)	(973.14)	(973.14)	(973.14)	(770.27)	(1,054.09)	(2,798.09)	(1,216.71)	(1,643.72)	(2,586.93)
541001-0000-03-000-0	Political Contributions-Nat. MgmtAdministrat-	12.21	13.43	16.28	14.65	12.21	12.21	12.21	9.67	13.23	35.10	15.26	20.65	13.07
542000-0000-31-000-0	Corporate Tax - State-National Healt-Misc. Exp	169.94	186.94	226.59	203.94	169.94	169.94	169.94	134.52	184.10	488.59	212.44	287.51	233.36
544000-0000-25-000-0	Sales Tax - ConnNational Healthcar-Fiscal Op	0.00	7,216.97	8,747.91	7,873.27	0.00	0.00	0.00	5,194.14	7,108.03	18,862.83	8,201.33	11,099.29	7,905.23
	Misc. variance	(2,449.44)	(3,807.40)	(2,941.05)	(4,154.98)	(2,449.44)	(2,449.44)	(2,449.44)	(3,092.88)	(7,341.25)		(4,327.62)	(8,341.42)	2,407.09
Total														
	Description and Description	510,838.54	568,023.13	685,491.35	619,677.59	510,838.54	510,838.54	510,838.54	410,359.93	558,462.11	1,494,604.24	645,491.34	877,341.62	838,892.50
	Page 16 line M12 Page 16 line M13	502,649.00 8,189.30	560,296.00 7,727.20	672,061.00 13,430.55	607,612.00 12,065.44	501,141.00 9,697.91	503,724.00 7,114.31	500,784.00 10,054.26	397,514.00 12,845.97	544,850.00 13,612.08	1,463,850.55 30,753.35	633,369.00 12,122.80	852,211.00 25,120.51	823,994.00 14,898.12
	roge to mic MID	0,103.30	7,727.20	13,430.33	12,005.44	3,037.91	7,114.31	10,034.20	12,043.97	13,012.00	30,733.33	12,122.00	23,120.31	14,030.12

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

		111	ott oi	1 Page 5)				
Nan	ne of Facility		License	e No.	Report for Y	ear Ended	Page	of
Bris	stol Crossings LLC			2329	9/30/2017	Ī	18	37
	Item			Total	CCNH	RHNS	(Sp	ecify)
2.	Dietary							
	a. In-House Preparation & Service							
	1. Raw Food		\$	308,300	308,300			
	2. Non-Food Supplies		\$		28,086			
	3. Other ( <i>Specify</i> )		\$					
	(1 00 /							
	b. Purchased Services (by contract other		\$					
	than through Management Services)		Ф					
	(Complete Schedule C-2 att. Page 21)							
<b>-</b>	c. Management Services**		\$					
	d. Other (Specify)		<u> </u>					
	u. Other (specify)		Ф					
2E.	<b>Total Dietary Expenditures</b> $(2a + b + c + d)$		\$	336,386	336,386			
<b>21</b> .	10.00 2 10.00 2 10 10 10 10 10 10 10 10 10 10 10 10 10		Ψ	330,300	330,300			
2F	Dietary Questionnaire			Total	CCNH	RHNS	(Sn	ecify)
	T T		.*	Total	CCIVII	KIIVS	(Sp	cciry)
G.	Resident Meals: Total no. of meals served per				N			
Н.	Is cost of employee meals included in 2E?	0	Yes	•	No			
I.	Did you receive revenue from employees?	0	Yes	•	No	If yes, specify amt.		
J.	Where is the revenue received reported in the	Cost	t Repor	t? (Page/Line	Item)			
	Is cost of meals provided to persons other					If yes, specify		
K.	than employees or residents (i.e., Board	0	Yes	•	No	cost.		
	Members, Guests) included in 2E?					COSt.		
L.	Is any revenue collected from these people?	0	Vec	0	No	If yes, specify		
L.	is any revenue conceted from these people:		1 03		110	amt.		
M.	Where is the revenue received reported in the	Cost	t Repor	t? (Page/Line	Item)			
	Is cost of food (other than meals, e.g.,							
N.	snacks at monthly staff meetings, board	$\circ$	Yes	•	No	If yes, specify		
14.	meetings) provided to employees included		103	9	110	cost.		
	in 2E?							
0	Is any revenue collected from employees?	$\cap$	Yes	9	No	If yes, specify		
O.	is any revenue confected from employees?	J	1 68	•	No	amt.		
P.	Where is the revenue received reported in the	Cost	t Repor	t? (Page/Line	Item)			
	<u> </u>		_	<u> </u>	-			

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

<sup>\*\*</sup> 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			No.	Report for Y		Page	of
Bris	tol Crossings LLC		2329	9/30/2017	1	19	37
	Item		Total	CCNH	RHNS	(S	pecify)
3.	Laundry  a. In-House Processing*  1. Bed linens, cubicle curtains, draperies, gowns and other resident care items	Lbs.	812	812			
	washed, ironed, and/or processed.***	Amt. \$	612	612			
	2. Employee items including uniforms, gowns, etc. washed, ironed and/or	Lbs.					
	processed.***	Amt. \$					
	3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.					
	washed, froned, and/or processed.	Amt. \$					
	4. Repair and/or purchase of linens.***	Lbs.					
		Amt. \$	240				
	b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$	132,072	132,072			-
	c. Management Services**	\$					
	d. Other (Specify ) Diapers	\$	43,276	43,276			
3E.	Total Laundry Expenditures $(3a + b + c + d)$	\$	176,400	176,400			
3F. G.	Laundry Questionnaire  Is cost of employee laundry included in 3E? C	) Yes	•	No	If yes,		
Н.		) Yes		No	specify cost.  If yes, specify amt.		
I.	Where is the revenue received reported in the Cost	Report?		(Page/Line			
J.	Is Cost of laundry provided to persons other	Yes	•	No	If yes, specify cost.		
K.	Did you receive revenue from these people?	) Yes	•	No	If yes, specify amt.		
L.	Where is the revenue received reported in the Cost	Report?		(Page/Line	Item)		

<sup>\*</sup> 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.

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*\*</sup> 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.	Rep	ort for Year E	Ended	Page	of
Bris	tol Crossings LLC	2329		9/30/2017		20	37
	Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced					
	a. In-House Care	by Personnel					
	1. Supplies - Cleaning ( <i>Mops</i> ,	Amt.	\$	29,318	29,318		
	pails, brooms, etc.)						
	b. Purchased Services (by contract other	Sq. Ft. Serviced					
	than through Management Services)	by Personnel					
	(Complete Schedule C-2 att.	Amt.	\$				
	Page 21)						
	c. Management Services*		\$				
	d. Other (Specify)		\$				
4E.	Total Housekeeping Expenditures (4a +	b+c+d)	\$	29,318	29,318		
5.	Resident Care (Supplies)**						
	a. Prescription Drugs***						
	1. Own Pharmacy		\$				
	2. Purchased from		\$	337,414	337,414		
	PCA						
	b. Medicine Cabinet Drugs		\$	25,232	25,232		
	c. Medical and Therapeutic Supplies		\$	130,146	130,146		
	d. Ambulance/Limousine***		\$	3,055	3,055		
	e. Oxygen						
	1. For Emergency Use		\$				
	2. Other***		\$	37,554	37,554		
	f. X-rays and Related Radiological		\$	20,798	20,798		
	Procedures***						
	g. Dental (Not dentists who should be inc	luded under	\$				
L	salaries or fees)						
	h. Laboratory***		\$	22,490	22,490		
	i. Recreation		\$	14,063	14,063		
	j. Other (Specify)****		\$	55,120	55,120		
	See Attached Schedule						
5K.	Total Resident Care Expenditures (5a - 5	5j)	\$	645,872	645,872		

<sup>\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

<sup>\*\*\*</sup> Facility should self-disallow the expense on Page 29 of the Cost Report.

<sup>\*\*\*\*</sup> ICFMR's should provide a detailed schedule of all Day Program Costs.

### **Schedule of Other Resident Care**

Description	(	CCNH	RHNS	(Specify)
Flu Vaccine - Medical Services	\$	4,725		
IV Expense - Rehabilitation Therapy and Ancillary	\$	8,261		
Purchased Services - Nursing	\$	5,880		
Equipment Rental - Nursing - Disallow	\$	9,567		
Equipment Rental - Rehabilitation Therapy and Ancillary - Disallow	\$	13,794		
Respiratory Therapy Fee	\$	12,893		
Total Other Resident Care	\$	55,120	\$ -	\$ -

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

Name of Facility Bristol Crossings LLC				License No. 2329	Report for Year Ende 9/30/2017	Report for Year Ended 9/30/2017				of 37
		Related ** Operators	,				Total Cost	/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	P.O. Box 842875, Boston, MA 02284	0	•	1	Waste Services/Monthly Recycling Services	27,388		7		6f
ADP	Mt Vernon, NY 10550	0	•		Payroll Processing	15,413			16	m13
Med- Apparel Services	Mt Vernon, NY 10550	0	•		Laundry/Linen	29,251			19	3b
Unitex Textile	111 Mines Road, Bristol, CT 06010	0	•		Laundry/Linen	102,821			19	3b
Custom Grounds	111 Mines Road, Bristol, CT 06010	0	•		Snow Landscaping	12,858			22	6f
M.J. Daly & Sons	110 Mattatuck HTS, Waterbury CT 06705	0	•		HVAC	18,508			22	6a
Integrated Health Systems	PO Box 23072 Overland Park, KS 66283	0	•		Computer Maintenance System	16,656			16	m13
Smartlinx	333 Thornall St. 4th Floor Edison, NJ 08837	0	•		Time & Attendance	11,269			16	m13
Iron Mountain	PO Box 27128 New York NY 10087	0	•		Record Management	19,228			16	m13
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							

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

<sup>\*\*</sup> Refer to Page 4 for definition of related.

<sup>\*\*\*</sup> 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 Fac	2	License No.	Report for Yo	ear Ended		Page	of
Bristol Cros	ssings LLC	2329	9/30/2017			22	37
	Item		Total	CCNH	RHNS	(Sne	ecify)
6. Mainter	nance & Operation of Plant		Total	CCIVII	Killyb	(Spt	city)
	pairs & Maintenance	\$	74,551	74,551			
b. Hea		\$	18,425	18,425			
	ht & Power	\$	145,984	145,984			
d. Wat		\$	19,150	19,150			
	sipment Lease ( <i>Provide detail on pe</i>		34,878	34,878			
_	er (itemize)	\$	44,393	44,393			
i. Oui	See Attached Schedule	Ψ	11,373	11,575			
6g. Total N	Maint. & Operating Expense (6a -	· 6f) \$	337,381	337,381			
	iation (complete schedule page 23		ĺ	,			
-	d Improvements	\$					
	lding & Building Improvements	\$					
	n-Movable Equipment	\$					
d. Mov	vable Equipment	\$	85,631	85,631			
*7e. <i>Total L</i>	Depreciation Costs $(7a + b + c + d)$	) \$	85,631	85,631			
	zation (Complete att. Schedule Pag						
a. Org	anization Expense	\$					
b. Moi	rtgage Expense	\$					
c. Lea	sehold Improvements	\$	12,063	12,063			
d. Oth	er (Specify)	\$					
*8e. <i>Total</i> A	<b>Amortization Costs</b> $(8a + b + c + d)$	l) \$	12,063	12,063			
9. Rental	payments on leased real property le	ess					
real est	ate taxes included in item 10b	\$	1,260,000	1,260,000			
10. Propert	ty Taxes						
a. Rea	l estate taxes paid by owner	\$					
b. Rea	l estate taxes paid by lessor	\$	213,117	213,117			
c. Pers	sonal property taxes	\$	17,028	17,028			
11. <i>Total P</i>	Property Expenses $(7e + 8e + 9 +$	10) \$	1,587,839	1,587,839			

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

### **Schedule of Other Repairs and Maintenance**

Description	CCNH	RHNS	(Specify)
Purchased Services - Security	\$ 280		
Ground Services - Maintenance	\$ 12,858		
Pest Control - Maintenance	\$ 1,313		
Carting - Maintenance	\$ 28,550		
Short Term Lease Pitney Bowes Mailing Machine	\$ 792		
IT Rentals	\$ 600		
Total Other Repairs and Maintenance	\$ 44,393	\$ -	\$ -

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

**Depreciation Schedule** 

Name of Facility					License No.	Janon Sci	iicuuic	Report for Year E	ndad		Page	of
Bristol Crossings LLC					232	20		9/30/2017	naca		23	37
Bristor Crossings ELC					1 232			Accumulated	I		23	31
					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					Land	value	Depreciated	Operations	Depreciation	LIIC	101 Tills Teal	Totals
Land Improvements     1. Acquired prior to this report period												
Acquired prior to this report period     Disposals (attach schedule)												
Acquired during this report period (attach schedule)												
A-4. Subtotal	ii schec	iuie)										
B. Building and Building Improvements												
Acquired prior to this report period					7,055,034		7,055,034	1,629,974	CI	Various		
Acquired prior to this report period     Disposals (attach schedule)					7,033,034	*Equity purpo	7,055,054	1,029,974	SL	various		
3. Acquired during this report period (attact	h cahad	hula)				Equity purpo						
B-4. Subtotal	ii schec	iuic)										
C. Non-Movable Equipment												
Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attact	h sched	hule)										
C-4. Subtotal	II SCIICC	iuic)										
C-4. Subtotal	1.	••	1									
		ileage										
		000k	D ( CA	,.	III:-4i1 C4	T		Accumulated	M-41 1 - 6			
	maint	ainea?	Date of A	cquisition	Historical Cost		C 44 D	Depreciation to	Method of	11 61	ъ	
	¥7	NI.	3.6.0	***	Exclusive of	Salvage Value	Cost to Be	Beginning of	Computing	Useful Life	Depreciation for This Year	T-4-1-
D. Marabla Englander	Yes	No	Month	Year	Land	value	Depreciated	Year's Operations	Depreciation	Life	for this year	Totals
D. Movable Equipment												
1. Motor Vehicles (Specify name, model												
and year of each vehicle)												
a. b.												
c.												
d.												
Movable Equipment												
a. Acquired prior to this report period					1,023,297		1,023,297	533,159	S/L	Various	72,484	
b. Disposals (attach schedule)							, ,	, , , ,				
c. Acquired during this report period												
(attach schedule)					162,441		162,441		S/L	Various	13,147	
D-3. Subtotal												85,631
E. Total Depreciation												85,631

#### Schedule of Land Improvements Acquired during this report period

_	_		Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
otal additions for Land Improv	ements	\$ -		\$ -
eletions:				
otal deletions for Land Improve	ements	\$ -		\$ -

<sup>\*</sup>Ties to Page 23, Line A3

#### Schedule of Building Improvements Acquired during this report period

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

<sup>\*</sup>Ties to Page 23, Line B3

#### Schedule of Non-Movable Equipment Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
Total additions for	Non-Movable Equipment	\$ -		\$ -
Deletions:				
Total deletions for I	Non-Movable Equipment	\$ -		\$ -

<sup>\*</sup>Ties to Page 23, Line C3
\*\*Ties to Page 23, Line C2

<sup>\*\*</sup>Ties to Page 23, Line A2

<sup>\*\*</sup>Ties to Page 23, Line B2

Acquisition Date	Description of Item	,	Cost	Useful Life	Dep	oreciation
Additions:						
12/31/2016		\$	3,336	5	\$	556
11/30/2016		\$	637	3	\$	194
	6 Healthcare grade TV's	\$	3,543	5	\$	295
	Mini PC desktop computer	\$	892	3	\$	99
6/30/2017	5 Mini PC Desktops	\$	5,735	3	\$	637
6/30/2017	Microsoft Software	\$	1,319	3	\$	147
6/30/2017	Top Freezer Fridge	\$	755	10	\$	25
6/30/2017	DynoPumps	\$	744	5	\$	50
5/31/2017	Integrated Health System - Chromebooks, Servers, Software	\$	131,560	5	\$	10,945
8/31/2017	10 HP Chromebooks	\$	3,371	5	\$	112
7/31/2017	Top Freezer Fridge	\$	636	10	\$	16
9/30/2017	Meridian Ice & Water Dispenser	\$	5,647	10	\$	47
9/30/2017	Thermaduke steam table	\$	4,266	15	\$	24
Total additions for N	Movable Equipment	\$	162,441		\$	13,147
Deletions:						
Total deletions for M	Novable Equipment	\$	-		\$	-

#### Schedule of Leasehold Improvements Acquired during this report period

			Useful		
Acquisition Date	Description of Item	Cost	Life	Der	oreciation
Additions:					
12/31/2016	4 Heat Pumps	\$ 2,982	10	\$	249
5/31/2017	Generator staires & landing	\$ 1,900	15	\$	53
8/31/2017	Zoneline heat pump	\$ 3,003	10	\$	50
Total additions for I	easehold Improvement	\$ 7,885		\$	352
Deletions:					
					•
Total deletions for L	easehold Improvement	\$ -		\$	-

<sup>\*</sup>Ties to Page 24, Line C3

<sup>\*</sup>Ties to Page 23, Line D2c \*\*Ties to Page 23, Line D2b

<sup>\*\*</sup>Ties to Page 24, Line C2

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

CSP-24 Rev. 10/2006

### **Amortization Schedule\***

Nam	e of Facility			License No.		Report for Yea	r Ended		Page	of
Brist	ol Crossings LLC			2329		9/30/2017			24	37
						Accumulated				
		Date	e of			Amort. to				
		Acqui	sition			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.	<b>Leasehold Improvements and Other</b>									
	1. Acquired prior to this report period			Various	116,474	43,030			11,711	
	2. Disposals (attach schedule)									
	3. Acquired during this report period									
	(attach schedule)			Various	7,885				352	
C-4.	Subtotal									12,063
D.	Total Amortization									12,063

<sup>\*</sup> Straight-line method must be 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.

<sup>\*\*</sup> Specify which of the following bases were used:

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

Name of Facility Bristol Crossings LLC	License No. 2329	Report for Year English 9/30/2017	ded		Page of 25   37
-					,
11. Property Questionnaire  Part A					
Is the property either owned by the or leased from a Related Party?*	e Facility	⊙ Yes	0	No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this fac business association to any person o related party transaction.					
Description		Total			
Date Land Purchased		06/16/66			
2. Date Structure Completed		09/01/72			
3. If <b>NOT</b> Original Owner, Date	e of Purchase				
4. Date of Initial Licensure		09/01/72			
5. Total Licensed Bed Capacity		132			
6. Square Footage		51,083			
7. Acquisition Cost					
a. Land		67,917			
b. Building		1,467,953			
Part B - Owner and Related Pa	rties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fi	ixed, variable)	Variable			
b. Date Mortgage Obtained	,	02/09/16			
c. Interest Rate for the Cost	Year	LIBOR + 275 basis p			
d. Term of Mortgage (number	er of years)	7			
e. Amount of Principal Borr	owed	10,469,500			
f. Principal balance outstand	ding as of 9/30/17	9,890,000			
Complete if Mortgage was I	Refinanced				
During Current Cost Ye	ear				
g. Type of Financing (e.g., fi	ixed, variable)				
h. Date of Refinancing	·				
i. New Interest Rate					
j. Term of Mortgage (number	er of years)				
k. Amount of Principal Borr	owed				
Principal Outstanding on	Note Paid-Off				
Part C - Arms-Length Leas	es for Real Property	y Improvements Only	,		
Name and Address of Lesso	or P	roperty Leased	Date of Lease	Term of Lease	Annual Amount of Lease
		-			
	<u> </u>		<u> </u>	<u> </u>	<u> </u>

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 Y	ear Ended		Page of
Bristol Crossings LLC	2329		9/30/2017			26   37
Ita			Total	CCNH	RHNS	(Specify)
12. Interest	<u>m</u>		Total	CCNH	KHNS	(Specify)
A. Building, Land Improv	vement & Non-Movahl	le				
Equipment						
1. First Mortgage		\$				
Name of Lender		Rate				
Address of Lender		<u> </u>	-			
2. Second Mortgage		\$				
Name of Lender		Rate				
Address of Lender			-			
3. Third Mortgage		\$				
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage		\$				
Name of Lender		Rate				
Address of Lender			-			
B. CHEFA Loan Informa	ntion					
1. Original Loan Amo	ount	\$				
2. Loan Origination I	Date					
3. Interest Rate %						
4. Term						
5. CHEFA Interest Ex	xpense					
12 B7. Total Building Interest E.	<b>xpense</b> (A1 - A4 + B5	() \$				
	,		(Car	rv Subtotals t	forward to v	ert nage)

(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		
Bristol Crossings LLC	2329		9/30/2017	car Ended		27	37
Distor Crossings DDC	1 232)		7/30/2017				31
Ite	em		Total	CCNH	RHNS	(Spec	ifv)
		Brought Forward:		001,11	101110	(Spec	<u> </u>
12. C. Movable Equipment							
Automotive Equipme	nt	\$					
A. Item	Rate	e Amount					
Lender			-				
Address of Lender			-				
2. Other ( <i>Specify</i> )							
A. Item	Rate	e Amount					
Lender	I	L	-				
Address of Lender		-					
B. Item	Rate	e Amount					
Lender			-				
Address of Lender			-				
12. C. 3. Total Movable Equip	ment Interest						
Expense (C1 + 2)		\$					
12. D. Other Interest Expense (		\$	1,915	1,915			
Administration \$812; Pro	operty \$1,103						
13. Total All Interest Expense (	12B7 + 12C3 + 12	2D) \$	1,915	1,915			
14. Insurance							
a. Insurance on Property (b	uildings only)	\$	68,617	68,617			
b. Insurance on Automobile	es	\$					
c. Insurance other than Pro	perty (as specified	above)					
1. Umbrella (Blanket Co		\$		10,826			
Fire and Extended Co	verage	\$					
3. Other ( <i>Specify</i> )		\$					
14d. Total Insurance Expenditur	es (14a + b + c)	\$	79,443	79,443			
15. Total All Expenditures (A-1	3 thru C-14)	\$		13,383,275			

# **D.** Adjustments to Statement of Expenditures

	e of Fa			Lic	ense No.	Report for Yea	r Ended	Page	of
Brist	ol Cro	ssings	LLC		2329	9/30/2017		28	37
	Page No.		Item Description		Total Amount of Decrease	CCNH	RHNS	(Spe	cify)
			es and Wages						
1.			Outpatient Service Costs	\$					
2.	10	12m	Salaries not related to Resident Care	\$	35,368	35,368			
3.			Occupational Therapy	\$					
4.			Other - See attached Schedule	\$					
Page			sional Fees						
5.	13	8e / 8	Resident Care Physicians **	\$	2,197	2,197			
6.	13	10a	Occupational Therapy	\$	350,591	350,591			
7.			Other - See attached Schedule	\$	53,447	53,447			
V	s 15 &	16 -	Administrative and General						
8.			Discriminatory Benefits	\$					
9.			Bad Debts	\$					
10.	15	1e	Accounting & Legal	\$	27,225	27,225			
11.			Telephone	\$					
12.	15	1h2	Cellular Telephone	\$	1,950	1,950			
13.			Life insurance premiums on the life	_					
1.4			of Owners, Partners, Operators	\$					
14.			Gifts, flowers and coffee shops	\$					
15.			Education expenditures to colleges or						
			universities for tuition and related costs	_					
1.0			for owners and employees	\$					
16.			Travel for purposes of attending						
			conferences or seminars outside the continental U.S. Other out-of-state						
				¢					
17.			travel in excess of one representative	\$ \$					
18.	1.6	m3	Automobile Expense (e.g. personal use) Unallowable Advertising *	\$	46,033	46,033			
19.	16		Income Tax / Corporate Business Tax	\$	40,033	46,033			
20.		,	Fund Raising / Contributions	\$	1,500	1,500			
			Unallowable Management Fees	\$	253,408	253,408			
22.	10 / 1.	11112/	Barber and Beauty	\$	233,400	233,400			
23.			Other - See attached Schedule	\$	249,608	249,608			
	18 - I	Dietar	y Expenditures	Ψ	2 17,000	217,000			
24.	10 - L		Meals to employees, guests and others	$\dashv$					
۵¬۰.			who are not residents	\$					
Page	19 - I	Laund	ry Expenditures	Ψ					
25.			Laundry services to employees, guests	$\dashv$					
			and others who are not residents	\$					
Page	20 - I	Touse	keeping Expenditures	-					
26.			Housekeeping services to employees, guests	$\neg$					
			and others who are not residents	\$					
		1	Subtotal (Items 1 - 26)		1,021,776	1,021,776			

<sup>\*</sup> All except "Help Wanted".

(Carry Subtotal forward to next page)

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

#### **Schedule of Other Salaries Adjustment**

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

\_\_\_\_\_

#### **Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	(	CCNH	RHNS	(Specify)
13	B2	Dentist	\$	7,860		
13	B3	Pharmacist	\$	14,186		
13	B12	Consulting Fees- Nursing	\$	6,474		
13	B12	Consulting Fees- Rehabilitation Therapy and Ancilliary	\$	4,264		
13	B12	Fees - Respiratory	\$	2,275		
13	B8a	Medical Director	\$	18,388		
<b>Total Othe</b>	otal Other Fees Adjustments		\$	53,447	\$ -	\$ -

\_\_\_\_\_\_

#### Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	(	CCNH	RHNS	(Specify)
15	1a1	Benefits on Salaries not Related to Resident Care	\$	8,900		
15	M13	Penalties	\$	12		
16	L3	Gifts to Residents and Staff	\$	5,738		
16	M13	Miscellaneous Expenses	\$	15,945		
16	M13	Bank Charges	\$	19,027		
16	M13	Crime Insurance	\$	1,047		
17	M13	Amortization of Goodwill	\$	198,939		
<b>Total Othe</b>	otal Other A&G Adjustments		\$	249,608	\$ -	\$ -

\_\_\_\_\_

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

Name of Facility  D. Adjustments to Statement of Expenditures (cont'd)  License No. Report for Year Ended Page of										
				Lic	ense No.		ear Ended	Page	of	
Bristo	ol Cro	ssings	LLC		2329	9/30/2017		29	37	
					Total					
	Page				Amount of					
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	(S <sub>1</sub>	pecify)	
			Subtotals Brought Forward	\$	1,021,776	1,021,776				
Page			ent Care Supplies***							
27.		5a2	Prescription Drugs	\$	337,414	337,414				
28.	20	5d	Ambulance/Limousine	\$	3,055	3,055				
29.	20	5f	X-rays, etc	\$	20,798	20,798				
30.	20	5h	Laboratory	\$	22,490	22,490				
31.	20	5c	Medical Supplies	\$	15,233	15,233				
32.	20	5e2	Oxygen (non emergency)	\$	37,554	37,554				
33.			Occupational Therapy	\$						
34.			Other - See Attached Schedule	\$	62,017	62,017				
Page	22 - N	Iainte	enance and Property							
<i>35</i> .			Excess Movable Equipment Depreciation							
			See Attached Schedule	\$	6,063	6,063				
36.			Depreciation on Unallowable							
			Motor Vehicles	\$						
37.	20	5i	Unallowable Property and Real							
			Estate Taxes	\$						
38.			Rental of Building Space or Rooms	\$						
39.			Other - See Attached Schedule	\$						
Page	27 - I	nsura	ince							
40.			Mortgage Insurance	\$						
41.			Property Insurance	\$						
Other	- 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	\$	4,517	4,517				
Not F	or Pr	ofit P	roviders Only							
50.			Building/Non Movable Eq. Depreciation							
			Unallowable Building Interest -							
			See Attached Schedule	\$						
51.	Total	Amo	unt of Decrease (Items 1 - 50)	\$	1,530,917	1,530,917				

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

#### **Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	(	CCNH	RHNS	(Specify)
20	5j	IV Expense - Rehabilitation Therapy and Ancillary	\$	8,261		
20	5j	Equipment Rental - Nursing - Disallow	\$	9,567		
20	5j	Equipment Rental - Rehaabilitation Therapy and Ancillary - Disallow	\$	13,794		
20	5a2/b	Procare LTC Pharmacy of CT (disallowance of markups)	\$	1,670		
20	5j	Flu Vaccine - Medical Services	\$	4,725		
20	5j	Purchased Services - Nursing	\$	2,338		
20	5i	Cable TV Expense - Resident Rooms	\$	8,769		
20	5j	Respiratory Therapy Fee	\$	12,893		
Total Other	otal Other Ancillary Costs		\$	62,017	\$ -	\$ -

#### **Schedule of Excess Movable Equipment Depreciation**

Page Ref	Line Ref	Description	C	CNH	RHNS	(Specify)
22	8c	Beauty Salon Disallowed Depreciation	\$	162		
22	7d	Mattress & TV Disallowed Depreciation	\$	5,901		
Total Exces	Total Excess Movable Equipment Depreciation		\$	6,063	\$ -	\$ -

### Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Othe</b>	r Property	Adjustments	\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	(	CCNH	RHNS	(Specify)
27	14b	Interest - Admin	\$	812		
30	IV8	Misc. Other income	\$	3,662		
30	IV5	Interest Income	\$	43		
				·		
<b>Total Othe</b>	r Adjustme	nts	\$	4,517	\$ -	\$ -

#### Schedule of Unallowable Building Interest

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

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

CSP-30 Rev.10/2005

### F. Statement of Revenue

Name of Facility Bristol Crossings LLC	License No. 2329		Report for Y 9/30/2017	ear Ended		Page of 30   37
	Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routin			1000	0 01 111	1411.15	(aprendy)
1. a. Medicaid Residents (CT or		\$	13,619,586	13,619,586		
b. Medicaid Room and Board	• .	\$	(6,063,765)	(6,063,765)		
2. a. Medicaid ( <i>All other states</i> )		\$	(0,005,705)	(0,005,705)		
b. Other States Room and Box		\$				
3. a. Medicare Residents (all inc		\$	3,053,989	3,053,989		
b. Medicare Room and Board	,	\$	225,900	225,900		
4. a. Private-Pay Residents and		\$	2,789,949	2,789,949		
b. Private-Pay Room and Boa		\$	(663,063)	(663,063)		
II. Other Resident Revenue	Tu Contractaar / mowanec	Ψ	(003,003)	(003,003)		
	anara	•	240.755	240.755		
1. a. Prescription Drugs - Medic		\$	240,755	240,755		
b. Prescription Drugs - Medic		\$	(237,821)	(237,821)		
c. Prescription Drugs - Non-N		\$	62,553	62,553		
	Medicare Contractual Allowance **	\$	(62,553)	(62,553)		
2. a. Medical Supplies - Medical		\$	667	667		
b. Medical Supplies - Medica		\$	(667)	(667)		
c. Medical Supplies - Non-Mo		\$				
• • • • • • • • • • • • • • • • • • • •	edicare Contractual Allowance **	\$				
3. <u>a. Physical Therapy - Medica</u>		\$	613,395	613,395		
b. Physical Therapy - Medica		\$	(540,883)	(540,883)		
c. Physical Therapy - Non-Mo		\$	51,413	51,413		
- 1	edicare Contractual Allowance **	\$	(44,889)	(44,889)		
4. <u>a. Speech Therapy - Medicare</u>		\$	165,148	165,148		
b. Speech Therapy - Medicare		\$	(130,743)	(130,743)		
c. Speech Therapy - Non-Med		\$	6,770	6,770		
1 1	dicare Contractual Allowance **	\$	(4,930)	(4,930)		
5. <u>a. Occupational Therapy - M</u>		\$	679,206	679,206		
	edicare Contractual Allowance **	\$	(607,329)	(607,329)		
c. Occupational Therapy - No		\$	72,208	72,208		
1 12	on-Medicare Contractual Allowance **	\$	(56,754)	(56,754)		
6. <u>a. Other (Specify)</u> - Medicare		\$	2,052	2,052		
b. Other (Specify) - Non-Med		\$	84	84		
III. Total Resident Revenue (Section	on I. thru Section II.)	\$	13,170,278	13,170,278		
IV. Other Revenue*						
Meals sold to guests, employe	es & others	\$				
2. Rental of rooms to non-resider	nts	\$				
3. Telephone		\$		_		
4. Rental of Television and Cable	e Services	\$				
5. Interest Income (Specify)		\$	43	43		
6. Private Duty Nurses' Fees		\$				
7. Barber, Coffee, Beauty and Gi	ift shops	\$				
8. Other ( <i>Specify</i> )		\$	20,628	20,628		
V. Total Other Revenue (1 thru 8)		\$	20,671	20,671		
VI. Total All Revenue (III+V)		\$	13,190,949	13,190,949		

<sup>\*</sup> Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

<sup>\*\*</sup> 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 II6	Medicare Part A Contra Other	\$	(36,925)		
30, line II6	Medicare Part A IV Therapy	\$	4,958		
30, line II6	Medicare Part A Lab	\$	17,123		
30, line II6	Medicare Part A X-Ray	\$	14,777		
30, line II6	Medicare Part A Oxygen	\$	2,769		
30, line II6	Medicare Part A Oxygen Contra	\$	(2,769)		
30, line II6	Medicare Part A Specialty Beds	\$	67		
30, line II6	Medicare Prior Period	\$	(2,447)		
30, line II6	Mgd Medicare Contra	\$	(10,619)		
30, line II6	Mgd Medicare IV Therapy	\$	225		
30, line II6	Mgd Medicare X-Ray	\$	3,835		
30, line II6	Mgd Medicare Pt A Lab	\$	5,049		
30, line II6	Mgd Medicare Ambulance	\$	1,509		
30, line II6	Mgd Medicare Oxygen	\$	2,277		
30, line II6	Mgd Medicare Oxygen Contra	\$	(2,277)		
30, line II6	Medicare Pt A Settlement	\$	4,500		
<b>Total Othe</b>	r Resident Revenue - Medicare	\$	2,052	\$ -	\$ -

#### Schedule of Other Non-Medicare Resident Revenue

#### Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30, line II6	Hospice Oxygen	\$ 470		
30, line II6	Hospice Oxygen Conta	\$ (470)		
30, line II6	Medicaid Contra Other	\$ (356)		
30, line II6	Medicaid Lab	\$ 99		
30, line II6	Medicaid Oxygen	\$ 7,078		
30, line II6	Medicaid Oxygen Contra	\$ (7,078)		
30, line II6	Medicaid X-Ray	\$ 256		
30, line II6	Private Speciality Beds	\$ 85		
30, line II6	Common Insurance Contra Other	\$ (7,193)		
30, line II6	Common Insurance Chargable Medical Supply	\$ 409		
30, line II6	Common Insurance Chargable Medical Supply Conta	\$ (409)		
30, line II6	Common Insurance IV Therapy	\$ 6,249		
30, line II6	Common Insurance Lab	\$ 22		
30, line II6	Common Insurance Oxygen	\$ 48		
30, line II6	Common Insurance Oxygen Contra	\$ (48)		
30, line II6	Common Insurance X-Ray	\$ 922		
Total Othe	r Resident Revenue	\$ 84	\$ -	\$ -

#### **Interest Income**

#### Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30, IV5	Interest Income		\$ 43		
Total Inter	otal Interest Income		\$ 43	\$ -	\$ -

#### Schedule of Other Revenue

Page Ref	Description		CCNH	RHNS	(Specify)
30, line IV8	Miscellaneous Other Income (UHC \$16,867; Bristol Hospital \$144, other income \$3,662)	\$	20,673		
30, line IV8	Prior Period Other	\$	(45)		
Total Othe	Total Other Revenue			\$ -	\$ -

### G. Balance Sheet

Name o	of Facility	License No.	Report for Year Ended	Page	of
Bristol	Crossings LLC	2329	9/30/2017	31	37
		Account		A	mount
Assets					
A. C	Current Assets				
1.	. Cash (on hand and in banks)	)		\$	1,449,482
2.	. Resident Accounts Receivabl	e (Less Allowance f	for Bad Debts)	\$	1,116,164
3.	. Other Accounts Receivable (1	Excluding Owners o	r Related Parties)	\$	
4	Inventories			\$	46,796
5.	. Prepaid Expenses			\$	195,945
	a. Worker's Compensation		35,517		
	b. Taxes (personal property,	real estate)	66,781		
	c. General Insurance		7,627		
	d. Other		86,020		
6.	. Interest Receivable			\$	
7.	. Medicare Final Settlement Re	eceivable		\$	
8.	. Other Current Assets (itemize	2)		\$	28,485
	Cash Patient Funds		28,485		
	Total Current Assets (Lines A1	thru 8)		\$	2,836,872
	ixed Assets				
	. Land			\$	225,000
2.	. Land Improvements	*Historical Cost		\$	
		Accum. Depreciat	ion Net		
3.	. Buildings	*Historical Cost		\$	
		Accum. Depreciat			
4.	. Leasehold Improvements	*Historical Cost	124,359	\$	69,266
		Accum. Depreciat	ion 55,093 Net		
5.	. Non-Movable Equipment	*Historical Cost		\$	
		Accum. Depreciat	ion Net		
6.	. Movable Equipment	*Historical Cost	1,185,738	\$	566,948
		Accum. Depreciat	ion 618,790 Net		
7.	. Motor Vehicles	*Historical Cost		\$	
		Accum. Depreciat	ion Net		
8.	. Minor Equipment-Not Depre	ciable		\$	
9.	. Other Fixed Assets (itemize)			\$	
B-10.	Total Fixed Assets (Lines B	1 thru 9)		\$	861,214

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

# G. Balance Sheet (cont'd)

Name of Facility		Facility	License No.	l *			Page	of
Brist	Bristol Crossings LLC		2329	9/30/2017			32   3	37
			Account				Amount	
				Total Brough	nt Forward:	\$	3,698,0	86
C.	Le	asehold or like property record	led for Equity Purposes.					
	1.	Land				\$		
	2.	Land Improvements	*Historical Cost					
			Accum. Depreciation		Net	\$		
	3.	Buildings	*Historical Cost	7,055,034				
			Accum. Depreciation	1,629,974	Net	\$	5,425,0	60
	4.	Non-Movable Equipment	*Historical Cost					
			Accum. Depreciation		Net	\$		
	5.	Movable Equipment	*Historical Cost					
			Accum. Depreciation		Net	\$		
	6.	Motor Vehicles	*Historical Cost					
			Accum. Depreciation		Net	\$		
	7.	Minor Equipment-Not Depre	ciable			\$		
C-8	To	tal Leasehold or Like Propert	ties (C1 thru 7)			\$	5,425,0	60
D.	Inv	vestment and Other Assets						
	1.	Deferred Deposits				\$		
	2.	Escrow Deposits				\$		
	3.	Organization Expense	*Historical Cost		_			
			Accum. Depreciation		Net	\$		
	4.	Goodwill (Purchased Only)				\$	1,790,4	50
	5.	Investments Related to Resid	ent Care (itemize)			\$		
				1		_		
	6.	Loans to Owners or Related l	,			\$		
		Name and Address	Amount	Loan Da	ate			
-	7	Other Assets (itemize)				\$	51,8	11
	, .	Due from Related		51,811		Ψ	31,0	
		Bue from Related		31,011				
D-8	To	tal Investments and Other As	ssets (Lines D1 thru 7)			\$	1,842,2	61
		tal All Assets (Lines A9 + B1	,			\$	10,965,4	
		`						

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

# G. Balance Sheet (cont'd)

Name of Facility		License No. Report for Year Ended			Pag	ge	of	
Bristol Cross	Bristol Crossings LLC		2329 9/30/2017		33		37	
	Account						Amount	
Liabilities								
A.	Cu	rrent Liabilities						
	1.	Trade Accounts Payable				\$	632,6	596
	2.	Notes Payable (itemize)				\$		
		I D 1.1. C E		(·, · )		Φ		
	3.	Loans Payable for Equipme		<del> </del>		\$		
		Name of Lender	Purpose	Amount	Date Due			
	4.	Accrued Payroll (Exclusive	of Owners and/or St	ockholders only)		\$	362,8	319
	5.	Accrued Payroll (Owners a	nd/or Stockholders o	nly)		\$		
	6.	Accrued Payroll Taxes Pay	able			\$		
	7.	Medicare Final Settlement	Payable		,	\$		
	8.	Medicare Current Financin	g Payable			\$		
	9.	Mortgage Payable (Curren	t Portion )			\$		
	10.	Interest Payable (Exclusive	of Owner and/or Rel	ated Parties)		\$		
11. Accrued Income Taxes*						\$		
	12. Other Current Liabilities ( <i>itemize</i> )				\$	2,919,8	340	
	Accrued Expenses 9,465 Revenue Assesment 198,324							
		Patient Funds		5 Accrued Pension	15,353			
		Due to Realty	2,307,62	6 Accrued Accounting Fee				
		Due to Related		8 Accrued Workers Compe		<b>.</b>		
A-13.	10	tal Current Liabilities (Line	es A1 thru 12)		ı	\$	3,915,3	355

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

## **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
Bristol Crossings LLC	Account 2329	9/30/2017	<u> </u>	34	37
	let Domonade	Amo			
Liabilities (cont'd)		Total Broug	nt Forward:		3,915,355
B. Long-Term Liabilities					
1. Loans Payable-Equipment (	itamiza)		\$		
Name of Lender	Purpose	Amount	Date Due		
Name of Echder	Turposc	Amount	Date Due		
2. Mortgages Payable			\$		
3. Loans from Owners or Rela	ted Parties (itemize)		\$		
Name and Address of Lender	Amount	Loan D			
Traine and Tradiess of Lender	Timount	Eoun D			
			_		
			_		
4. Other Long-Term Liabilities	\$				
B-5. Total Long-Term Liabilities (I			\$ \$		
C. Total All Liabilities (Lines A-		3,915,355			

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

	ne of Facility	License No.			ear Ended	Pag	
Bris	tol Crossings LLC	2329	9/3	30/2017		35	I
	<b>n</b>	Account					Amount
A.	Reserves						
	1. Reserve for value of leased	land				\$	
	2. Reserve for depreciation val	lue of leased building	ngs and	l appurten:	ances		
	to be amortized					\$	5,425,060
	3. Reserve for depreciation val	lua of lagged parger	nal proj	orty (Fau	ita)	\$	
	3. Reserve for depreciation va.	iue of leased persor	iai pioj	berty (Equ	ity)	Ф	
	4. Reserve for leasehold real p	roperties on which	fair rer	ıtal value i	s based	\$	
	5. Reserve for funds set aside:	as donor restricted				\$	
	3. Reserve for runus set uside (	dis donor restricted				Ψ	
	6. Total Reserves					\$	5,425,060
B.	Net Worth						
	1. Owner's Capital					\$	
	2. Capital Stock					\$	
	3. Paid-in Surplus					\$	
	4. Treasury Stock					\$	
	5. Cumulated Earnings					\$	1,817,318
	6. Gain or Loss for Period	10/1/20	016	thru	9/30/2017	\$	(192,326)
	7. Total Net Worth					\$	1,624,992
C.	Total Reserves and Net Worth					\$	7,050,052
D.	Total Liabilities, Reserves, and	Net Worth				\$	10,965,407

CSP-36 Rev. 6/95

# H. Changes in Total Net Worth

Nam	ne of Facility	License No.	Report for Year	Ended	Page	of
Brist	tol Crossings LLC	2329	9/30/2017		36	37
		Account			An	nount
A.	Balance at End of Prior Period as sl	\$	)	1,813,546		
B.	Total Revenue (From Statement of	\$	<b>)</b>	13,190,949		
C.	Total Expenditures (From Statemen	nt of Expenditures Pa	age 27)	\$		13,383,275
D.	Net Income or Deficit			\$		(192,326)
E.	Balance			\$	5	1,621,220
F.	Additions					
	1. Additional Capital Contributed					
	CT Dept of Revenue Refun	d	3,772			
	2. Other ( <i>itemize</i> )					
F-3.	Total Additions			\$	5	3,772
G.	Deductions					
	1. Drawings of Owners/Operators	/Partners ( <i>Specify</i> )		\$	5	
	Name and Address (No., City,	State, Zip)	Title	Amount		
	2. Other Withdrawings (Specify)		ļ.	\$	3	
	Purpose	ount				
	Turpose Turiount					
	2 Total Deductions			d	`	
Н.	3. Total Deductions  Balance at End of Period	09/30/1	7	\$ \$		1 624 002
П.	Duiance at Ena of Ferioa	09/30/1	1	1	)	1,624,992

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

Name of Facility	License No.	Report for Year Ended	Page	of							
Bristol Crossings LLC	2329	9/30/2017	9/30/2017 37								
	Check appropriate category										
Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)	□ (Specify)	☐ (Specify)								
Preparer/Reviewer Certification											
I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.											
Signature of Preparer	Signature of Preparer Title Date Signed										
Printed Name of Preparer	Printed Name of Preparer										
Blum Shapiro & Co											
Address	Phone Number										
2 Enterprise Drive, Shelton, CT 06484		203-944-2100									