# State of Connecticut

# Annual Report of Long-Term Care Facility

Cost Year 2019

| | |
|---|---|
| Name of Facility (as licensed)<br>Bloomfield Health Care Center of CT, LLC | |
| Address (No. & Street, City, State, Zip Code)<br>335 Park Ave Bloomfield, CT 06002 | |
| Type of Facility<br>☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify) | |
| Report for Year Beginning<br>10/1/2018 | Report for Year Ending<br>9/30/2019 |

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

| Medicaid Provider Numbers: | CCNH | RHNS | ICF-IID |
|---|---|---|---|
| | 9134 | | |

**For Department Use Only**

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

# Table of Contents


| | | |
|---|---|---|
| | General Information - Administrator's/Owner's Certification | 1 |
| | General Information and Questionnaire - Data Required for Real Wage Adjustment | 1A |
| | General Information and Questionnaire - Type of Facility - Organization Structure | 2 |
| | General Information and Questionnaire - Partners/Members | 3 |
| | General Information and Questionnaire - Corporate Owners | 3A |
| | General Information and Questionnaire - Individual Proprietorship | 3B |
| | General Information and Questionnaire - Related Parties | 4 |
| | General Information and Questionnaire - Basis for Allocation of Costs | 5 |
| | General Information and Questionnaire - Leases | 6 |
| | General Information and Questionnaire - Accounting Basis | 7 |
| | Schedule of Resident Statistics | 8 |
| | Schedule 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. | 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 |

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-1 Rev.9/2002

# General Information

| Name of Facility (as licensed) | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 1 | 37 |

## Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Bloomfield Health Care Center of CT, LLC [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

{a} Subject to Desk Audit Review

| Signed (Administrator) | | Date | Signed (Owner) | Date |
|---|---|---|---|---|
| Printed Name (Administrator)<br>Kimberly Phulgence | | | Printed Name (Owner)<br>Marvin J. Ostreicher | |
| Subscribed and Sworn<br>to before me: | State of | Date | Signed (Notary Public) | Comm. Expires<br>/ / |
| Address of Notary Public | | | | |

(Notary Seal)

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-1A Rev. 6/95

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

| **Data Required for Real Wage Adjustment** | | | Page 1A | of 37 |
|---|---|---|---|---|
| Name of Facility<br>Bloomfield Health Care Center of CT, LLC | Period Covered: | | From 10/1/2018 | To 9/30/2019 |
| Address of Facility<br>335 Park Ave Bloomfield, CT 06002 | | | | |
| Report Prepared By<br>Marcum LLP | Phone Number<br>203-781-9600 | | Date<br>1/13/2020 | |

| 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.**

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-2 Rev. 10/2005

# General Information and Questionnaire

## Type of Facility - Organization Structure

| Phone No. of Facility | Report for Year Ended | Page | of |
|---|---|---|---|
| 860-242-8595 | 9/30/2019 | 2 | 37 |

| Name of Facility (as shown on license) | Address (*No. & Street, City, State, Zip*) |
|---|---|
| Bloomfield Health Care Center of CT, LLC | 335 Park Ave Bloomfield, CT 06002 |

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

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

N/A

**Administrator**

| Name of Administrator | Nursing Home Administrator's License No.: |
|---|---|
| Kimberly Phulgence | 1856 |

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

| Name | License No.: |
|---|---|
| N/A | |
| | |
| | |
| | |

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

# General Information and Questionnaire
## Partners/Members

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 3 | 37 |

| Legal Name of Partnership/LLC | Business Address | State(s) and/or Town(s) in Which Registered |
|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 335 Park Ave Bloomfield, CT 06002 | CT |

| Name of Partners/Members | Business Address | Title | % Owned |
|---|---|---|---|
| Marvin J. Ostreicher | 335 Park Ave Bloomfield, CT 06002 | President | 50 |
| Agnes Zitter | 335 Park Ave Bloomfield, CT 06002 | | 50 |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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

# General Information and Questionnaire
## Corporate Owners

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 3A | 37 |

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

| Legal Name of Corporation | Business Address | State(s) in Which Incorporated |
|---|---|---|
| N/A | | |

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

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

# General Information and Questionnaire
## Individual Proprietorship

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 3B | 37 |

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

Owner(s) of Facility

N/A

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

# General Information and Questionnaire
## Related Parties*

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 4 | 37 |

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

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

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

If "Yes," provide the following information:

| Name of Related Individual or Company | Business Address | Also Provides Goods/Services to Non-Related Parties | | | Description of Goods/Services Provided | Indicate Where Costs are Included in Annual Report Page # / Line # | Cost Reported | Actual Cost to the Related Party |
|---|---|---|---|---|---|---|---|---|
| | | Yes | No | %** | | | | |
| National HealthCare Associates-Aetna | 850 Silas Deane Hwy Wethersfield, CT 06109 | ○ | ⊙ | | Health Insurance | Page 15 / Line 1a5 | 541,614 | 541,614 |
| Preferred Therapy Solutions | 850 Silas Deane Hwy Wethersfield, CT 06109 | ○ | ⊙ | | PT,OT,ST SERVICES/CONSULTING | Various | 571,712 | 556,745 |
| NOA DIAGNOSTICS | 6851 Jericho Tpke, Suite 150 Syosset, NY 11791 | ○ | ⊙ | | Radiology | Page 20 / Line 5f | 6,171 | 5,313 |
| Bloomfield Healthcare Realty | 20 E Sunrise Hwy, Valley Stream NY 11581 | ○ | ⊙ | | Lease of Facility | Page 22 / Line 9 | 840,000 | ***840,000 |
| National HealthCare Associates | 20 E Sunrise Hwy, Valley Stream NY, 11581 | ○ | ⊙ | | Consulting | Page 16 / Line M11 | 14,358 | 14,358 |
| National HealthCare Associates | 20 E Sunrise Hwy, Valley Stream NY, 11581 | ○ | ⊙ | | Shared Services | Page 16 / Line M12 | 465,838 | 452,616 |
| National HealthCare Associates | 20 E Sunrise Hwy, Valley Stream NY, 11581 | ○ | ⊙ | | Interest on Computer Loan / Misc | Various | 7,833 | 7,833 |
| 850 SILAS DEANE | 850 Silas Deane Hwy Wethersfield, CT 06109 | ○ | ⊙ | | Rent / Other Expenses | Page 16 / Line M12 | 1,304 | 1,304 |
| See Attached for Continued List | Various | ○ | ⊙ | | Various | Various | 299,028 | 279,969 |

* Use additional sheets if necessary.

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

*** N/A Medicaid reimbursement is based upon fair rental value system. Replaced during rate setting.

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

# General Information and Questionnaire
## Related Parties*

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Center for Nursing & Rehab | 913-C | 9/30/2019 | 4a | 37 |

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

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

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

If "Yes," provide the following information:

| Name of Related Individual or Company | Business Address | Also Provides Goods/Services to Non-Related Parties | | | Description of Goods/Services Provided | Indicate Where Costs are Included in Annual Report Page # / Line # | Cost Reported | Actual Cost to the Related Party |
|---|---|---|---|---|---|---|---|---|
| | | Yes | No | %** | | | | |
| 20Sunrise | 20 E Sunrise Hwy, Valley Stream NY, 11581 | ○ | ⊙ | 0% | Rent/Other Expense | Page 16 / Line M12 | 11,918 | 11,918 |
| PROCARE LTC PHARMACY OF CT | 1492 Highland Ave Cheshire CT 06410 | ○ | ⊙ | 0% | Drugs/OTC/RX Consult | Various | 234,166 | 215,552 |
| Maple View Manor | 856 Maple St Rocky Hill CT 06067 | ○ | ⊙ | 0% | Consulting / Work Comp Fees | Various | 32,464 | 32,464 |
| CAMBRIDGE MANOR | 2428 Easton Tpke Fairfield CT 06825 | ○ | ⊙ | 0% | Work Comp Payments | Page 15 / Line 1a1 | 4,481 | 4,481 |
| REGENCY HOUSE OF WALL | 181 East Main Street, Wallingford, CT 06492 | ○ | ⊙ | 0% | Dietary Consulting | Page 13 / Line 1 | 488 | 488 |
| National HealthCare Associates | 20 E Sunrise Hwy, Valley Stream NY, 11581 | ○ | ⊙ | 0% | Banking Transactions | Page 16 / Line M13 | 7,533 | 7,533 |
| PREFERRED PROFESSIONAL SERVICES | 850 Silas Deane Hwy Wethersfield, CT 0610 | ○ | ⊙ | 0% | RN Agency | Page 13 / Line 11a1 | 7,978 | 7,533 |
| | | ○ | ⊙ | 0% | | | | |
| | | ○ | ⊙ | 0% | | | | |

* Use additional sheets if necessary.

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

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-5 Rev. 9/2002

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

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 5 | 37 |

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

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

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

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

N/A

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

N/A

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

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

N/A

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

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

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

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 6 | 37 |

| Name and Address of Lessor | Related * to Owners, Operators, Officers: Yes | Related * to Owners, Operators, Officers: No | Description of Items Leased | Date of Lease** | Term of Lease | Annual Amount of Lease | Amount Claimed |
|---|---|---|---|---|---|---|---|
| Reliable Health Systems, Nostrand Ave, Brooklyn, NY 11230 | ○ | ⊙ | Computer Equipment | 10/01/08 | Ongoing | 3,708 | 3,708 |
| Wescom Solutions, PO Box 674802, Detroit, MI 48267 | ○ | ⊙ | Software | 03/07/12 | Ongoing | 21,077 | 21,077 |
| Leaf, P.O. Box 644006, Cincinnati, OH 45264 | ○ | ⊙ | Copier | 01/01/16 | 39 Months | 2,677 | 2,677 |
| Leaf, P.O. Box 644006, Cincinnati, OH 45264 | ○ | ⊙ | Copier | 04/01/19 | 39 Months | 2,292 | 2,292 |
| Pitney Bowes, 2225 American Drive, Neenah, WI 54956-1005 | ○ | ⊙ | Postage Meter | 04/30/13 | Ongoing | 1,034 | 1,034 |
| | ○ | ⊙ | | | | | |
| | ○ | ⊙ | | | | | |
| | ○ | ⊙ | | | | | |
| | ○ | ⊙ | | | | | |
| | ○ | ⊙ | | | | | |

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total** *** 30,788

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

** Attach copies of newly acquired leases.

*** Amount should agree to Page 22, Line 6e.

THE OFFICE WORKS

**SALES ORDER**

**The Office Works, Inc.**
**45 Corporate Avenue**
**Plainville, CT 06062**
**1-800-634-4810 1-860-793-9994**

**Date:** March 13, 2019

| **BILL TO:** | **SHIP TO:** |
|---|---|
| Bloomfield Health Care<br>355 Park Avenue<br>Bloomfield, CT 06002 | Same |

| ITEM | DESCRIPTION | QTY | | SALE / LEASE PRICE |
|---|---|---|---|---|
| | | | | |
| **e-Studio 7616ACT** | **Toshiba 75 ppm color multifunctional copier** | 1 | | |
| MJ1111 | Console document finisher | 1 | | 39-month lease |
| | | | | $419.16 per month |
| **e-Studio 3518A** | **Toshiba 35 ppm multifunctional copier** | 1 | | |
| MR3031 | Document handler | 1 | | |
| MJ1042B | Inner finisher | 1 | | |
| KD1059B | Large capacity paper feed pedestal | 1 | | |
| | | | | |
| GD1370N | Fax board | 2 | | |
| | | | | |
| **M2040dn** | Kyocera desktop multifunctional copier | 3 | | |
| | | | | N/A |
| | | **DELIVERY** | | N/C |
| | | **SALES TAX** | | 6.35% of monthly payment |
| | | **TOTAL DUE** | | N/A |

**Notes / Provisions**

- Delivery, installation and training is included at N/C. The office works will remove the current leased copiers and return them to the leasing company at no charge.

**CUSTOMER:** Bloomfield Health Care

**Authorized Signature** [signature] FOR BLOOMFIELD

**Print Name** Michael Bokow

**Title** Purchasing

**Date** 4/8/19

**Phone** 516 705 4800

**The Office Works, Inc.**

**Accepted By**_____

**Print Name**_____

**Title**_____

**Sales Associate**_____

# LEASE AGREEMENT

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

| LESSEE LEGAL NAME: | Telephone No: |
|---|---|
| Bloomfield Health Care Center Inc | 8602428595 |

| Billing Address: | Equipment Location (if other than Billing Address): |
|---|---|
| 355 Park Avenue, Bloomfield, CT 06002 | 355 Park Avenue, Bloomfield, CT 06002 |

**EQUIPMENT DESCRIPTION:** (indicate quantity, new or used and include make, model, serial # and all attachments – see below and/or attached Schedule A)

| Unit Quantity | Description of Equipment Leased | Make and Type | Model Number | Serial Number |
|---|---|---|---|---|
| | * PLEASE REFER TO SCHEDULE A | | | |

| BASE TERM IN MONTHS | TOTAL NUMBER OF LEASE PAYMENTS | END OF LEASE PURCHASE OPTION | | |
|---|---|---|---|---|
| 39 | 39 @ $419.16 (plus taxes) | X Fair market value, plus taxes<br>___ 10% of Equipment cost, plus taxes<br>___ $1.00, plus taxes<br>(FMV unless another option is selected. You may not exercise a purchase option if you are in default. If you exercise a purchase option we will convey all of our right, title and interest in such Equipment to you on an AS-IS WHERE IS without warranty.) | (a) Advance Payment: | $0.00 |
| | | | (b) Security Deposit: | $0.00 |
| | | | (c) Documentation Fee: | $95.00 |
| | | | Total due a + b + c =: | $95.00 |

**If more than one lease payment is required as an Advance Payment, the balance will be applied to lease payments in inverse order, starting with the last lease payment.
**Your obligation to pay all amounts and perform all other obligations is non-cancellable, absolute, unconditional and not subject to abatement, set-off or defense.**

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

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

**2. DELIVERY, ACCEPTANCE, USE AND REPAIR:** You are responsible for Equipment delivery and installation. You unconditionally accept the Equipment upon the earlier of (a) your oral or written acceptance of the Equipment, or (b) 10 days after delivery of the Equipment. You authorize us to fill in the Lease Commencement Date, serial numbers and other information. **You will not move the Equipment from the above location without our written consent and are responsible for maintaining the Equipment in good repair.** We are not responsible for Equipment or vendor failures.

**3. INDEMNIFICATION:** You agree to indemnify, defend and hold us harmless from and against any losses, damages, penalties, claims and suits, including attorneys' fees and expenses related to the ordering, manufacture, installation, ownership, condition, use, lease, possession, delivery or return of Equipment.

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

**5. LATE FEES AND CHARGES:** If any amount is not paid within three (3) days of when due, you agree to pay us a late charge equal to the lesser of 10% of the amount past due or the maximum legal amount. Amounts which are not paid within 30 days of when due shall accrue interest at 1.5% per month (or if less, the maximum legal rate) until paid. You agree to pay $25 for each pay by phone and $35 for each returned payment.

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

**7. INSURANCE, RISK OF LOSS:** You bear all risk of loss or damage to the Equipment from its order until it is returned in the required condition or purchased by you ("Risk Period"). During the Risk Period you will maintain property and liability insurance on the Equipment acceptable to us, naming us loss payee and additional insured. If you do not provide us with proof of such insurance, we may secure insurance on the Equipment to cover our interests (and only our interests). If we obtain such insurance, you will pay us an additional amount for the cost of it and an administrative fee, the cost of which may be more than the cost to obtain your own insurance and on which we may make a profit.

**8. OWNERSHIP AND TAXES:** We own the Equipment (excluding licensed software). If you are deemed to own it, you grant us a security interest in the Equipment. You authorize us to file UCC financing statements to confirm our interest. You will pay, when due, all taxes, fines and penalties relating to the purchase, use, leasing and/or ownership of the Equipment. If we pay any taxes, (including property tax), fees or penalties on your behalf, you will pay us the amount we paid plus an administrative fee. You agree to pay us the documentation fee specified above or if not so specified, the greater of either $125 or 0.5% of the Equipment cost. If we require an Equipment site inspection, or you request administrative services, you agree to reimburse our costs.

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

**10. ASSIGNMENT: You have no right to sell or assign the Equipment or Lease.** We may sell or assign our rights in the Lease and/or Equipment and the new owner will have all our rights but will not be subject to any claim or defense you have against us.

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

**12. CREDIT INFORMATION:** You authorize us or any of our affiliates to obtain credit bureau reports, and make other credit inquiries that we deem necessary.

**13. CHOICE OF LAW: THIS LEASE WILL BE GOVERNED BY PENNSYLVANIA LAW. YOU CONSENT TO JURISDICTION IN THE STATE OR FEDERAL COURTS IN PENNSYLVANIA AND WAIVE ANY RIGHT TO A TRIAL BY JURY.**

**14. MISCELLANEOUS:** This Lease is the parties' entire agreement and can be amended only in writing signed by both parties. This Lease may be executed in counterparts (manually or by electronic means) and, when transmitted to us shall be binding upon you for all purposes. This Lease is not binding on us until we sign it. You agree not to raise as a defense to the enforcement of this Lease that it was executed or transmitted to us by electronic means. You will use the Equipment only for business purposes and not for personal, family or household use. The USA PATRIOT Act requires us to obtain, verify, and record information that identifies you thus we ask for your name, address and other information or documents that substantiate your identity.

**ACCEPTED BY LESSEE:** Bloomfield Health Care Center Inc
Print Name: MICHAEL BOKOW Title: PURCHASING
X [signature] FOR BLOOMFIELD E-Mail Address:
Lessee Authorized Signature Date: 4/18/19
Tax ID Number:

**PERSONAL GUARANTY:** Undersigned guarantees that Lessee will make all payments and perform all other obligations under the Lease when due. Undersigned agrees that this is a guaranty of payment and not of collection, and that we can proceed directly against undersigned without first proceeding against Lessee or the Equipment. Undersigned also waives all suretyship defenses and notification if the Lessee is in default and consents to any extensions or modifications granted to Lessee. Undersigned will pay us all expenses (including attorneys' fees) we incur in enforcing our rights against undersigned or Lessee. If more than one person signs this guaranty, each agrees that his/her liability is joint and several. Undersigned authorizes us and our affiliates to obtain credit bureau reports and make inquiries regarding undersigned's personal credit. You consent to jurisdiction in the State or Federal courts in Pennsylvania and expressly waive any right to a trial by jury.

SIGNED X _____ Print Name: _____ E-Mail Address: _____

Accepted by:
**LEAF Capital Funding, LLC By:** **Title:** **Date:**

LEAF

## SCHEDULE A TO LEASE AGREEMENT
## (EQUIPMENT DESCRIPTION)

Lease Application No.: **505634**

| QNT | Equipment Description | New/Used | Make | Model | Serial Number |
|---|---|---|---|---|---|
| **Location:** | 355 Park Avenue, Bloomfield, CT 06002 | | | | |
| 1 | Toshiba E-Studio 7516ACT | New | | E-Studio 7516ACT | |
| 1 | Toshiba E-Studio 3518A | New | | E-Studio 3518A | |
| 1 | Kyocera M2040DN | New | | M2040DN | |

LESSEE: Bloomfield Health Care Center Inc

BY: [signature] FOR BLOOMFIELD

PRINT NAME: Michael Bokow

TITLE: Purchasing

DATE: 4/8/19

**LEAF CAPITAL FUNDING, LLC**

BY: _____

PRINT NAME: _____

TITLE: _____

DATE: _____

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

# General Information and Questionnaire

## Accounting Basis

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of C | 913-C | 9/30/2019 | 7 | 37 |

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

◉ Accrual ○ Cash ○ Modified Cash

| | | |
|---|---|---|
| Is the accounting basis for this period the same as for the previous period? | ◉ Yes<br>○ No | If "No," explain. |

N/A

**Independent Accounting Firm**

| Name of Accounting Firm | Address (No. & Street, City, State, Zip Code) |
|---|---|
| 1 Blum, Shapiro & Company, P.C. | 2 Enterprise Dr., Shelton, CT 06484 |
| 2 | |
| 3 | |
| 4 | |

Services Provided by This Firm (*describe fully*)

| | | |
|---|---|---|
| 1 | Accounting Services | $ 20,400 |
| 2 | | $ |
| 3 | | $ |
| 4 | | $ |
| | | Charge for Services Provided $ 20,400 |

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

◉ Yes ○ No Page 15, Line 1d

**Legal Services Information**

| Name of Legal Firm or Independent Attorney | Telephone Number |
|---|---|
| 1 American Arbitration | 972-702-8222 |
| 2 Genser Dubow Genser & Cona LLP | 631-390-5000 |
| 3 Berchem Moses | 203-783-1200 |
| 4 Jackson Lewis | 914-872-8060 |
| 5 See Attached | Various |

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

1 13727 Noel Road Suite 700, Dallas, TX 75240
2 225 BROADHOLLOW RD MELVILLE NY 11747
3 75 BROAD STREET MILFORD, CT 06460
4 44 SOUTH Broadway 14th Floor, White Plains, NY 10601
5 Various

Services Provided by This Firm (*describe fully*)

| | | |
|---|---|---|
| 1 | Administration Fee | $ 325 |
| 2 | Resident Estate Issue (Disallowed on Pg 28) | $ 3,683 |
| 3 | EEOC Complaint (Case was dismissed) | $ 4,054 |
| 4 | Union Negotiations | $ 51,810 |
| 5 | Various (Disallowed on Pg 28) | $ 29,230 |
| | | Charge for Services Provided $ 89,102 |

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

◉ Yes ○ No Page 15, Line 1e

State of Connecticut

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

CSP-7 Rev. 6/95

# General Information and Questionnaire

## Accounting Basis

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 7a | 37 |

**Legal Services Information**

| Name of Legal Firm or Independent Attorney | Telephone Number |
|---|---|
| 1 GOLDMAN GRUDER & WOOD | 203-899-8900 |
| 2 STATE MARSHALL | 203-853-4054 |
| 3 TREASURER STATE OF CT | 860-702-3000 |

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

1 200 Connecticut Ave, Norwalk, CT 06854

2 60 Rampart Rd, Norwalk, CT 06854

3 55 Elm St #2, Hartford, CT 06106

Services Provided by This Firm (*describe fully*)

| | | |
|---|---|---|
| 1 | Collections (Disallowed on Pg 28) | $ 26,527 |
| 2 | Conservatorship (Disallowed on Pg 28) | $ 250 |
| 3 | Conservatorship (Disallowed on Pg 28) | $ 2,453 |
| | | Charge for Services Provided |
| | | $ 29,230 |

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

Page 15, Line 1e

◉ Yes ○ No

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

# Schedule of Resident Statistics

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 8 | 37 |

| | Total All Levels | Total CCNH Level | Total RHNS Level | Total (Specify) | Period 10/1 Thru 6/30 | | | | Period 7/1 Thru 9/30 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Total | CCNH | RHNS | (Specify) | Total | CCNH | RHNS | (Specify) |
| 1. Certified Bed Capacity | | | | | | | | | | | | |
| A. On last day of PREVIOUS report period | 120 | 120 | | | 120 | 120 | | | 120 | 120 | | |
| B. On last day of THIS report period | 120 | 120 | | | 120 | 120 | | | 120 | 120 | | |
| 2. Number of Residents | | | | | | | | | | | | |
| A. As of midnight of PREVIOUS report period | 81 | 81 | | | 81 | 81 | | | 88 | 88 | | |
| B. As of midnight of THIS report period | 107 | 107 | | | 88 | 88 | | | 107 | 107 | | |
| 3. Total Number of Days Care Provided During Period | | | | | | | | | | | | |
| A. Medicare | 1,623 | 1,623 | | | 1,332 | 1,332 | | | 291 | 291 | | |
| B. Medicaid (Conn.) | 28,852 | 28,852 | | | 21,026 | 21,026 | | | 7,826 | 7,826 | | |
| C. Medicaid (other states) | | | | | | | | | | | | |
| D. Private Pay | 981 | 981 | | | 701 | 701 | | | 280 | 280 | | |
| E. State SSI for RCH | | | | | | | | | | | | |
| F. Other (Specify) Managed Care | 1,875 | 1,875 | | | 1,299 | 1,299 | | | 576 | 576 | | |
| G. Total Care Days During Period (3A thru F) | 33,331 | 33,331 | | | 24,358 | 24,358 | | | 8,973 | 8,973 | | |
| 4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds | | | | | | | | | | | | |
| A. Medicaid Bed Reserve Days | 3 | 3 | | | 3 | 3 | | | | | | |
| B. Other Bed Reserve Days | | | | | | | | | | | | |
| 5. ***Total Resident Days*** **(3G + 4A + 4B)** | 33,334 | 33,334 | | | 24,361 | 24,361 | | | 8,973 | 8,973 | | |

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

# Schedule of Resident Statistics (Cont'd)

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 9 | 37 |

4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

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

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

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

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

| Item | Medicare | Medicaid | | Self-Pay | | | Other State Assisted | |
|---|---|---|---|---|---|---|---|---|
| | CCNH | CCNH | RHNS | CCNH | RHNS | (Specify) | R.C.H. | ICF-MR |
| No. of Residents | 4 | 88 | | 15 | | | | |
| Per Diem Rate | | | | | | | | |
| a. One bed rm. | Various | 252.35 | | 420.00 | | | | |
| b. Two bed rms. | Various | 252.35 | | 390.00 | | | | |
| c. Three or more bed rms. | | | | | | | | |

| 7. Total Number of Physical Therapy Treatments | TOTAL | CCNH | RHNS | (Specify) |
|---|---|---|---|---|
| A. Medicare - Part B | 5,124 | 5,124 | | |
| B. Medicaid (Exclusive of Part B) | | | | |
| 1. Maintenance Treatments | | | | |
| 2. Restorative Treatments | 80 | 80 | | |
| C. Other | 6,391 | 6,391 | | |
| D. ***Total Physical Therapy Treatments*** | 11,595 | 11,595 | | |
| 8. Total Number of Speech Therapy Treatments | | | | |
| A. Medicare - Part B | 460 | 460 | | |
| B. Medicaid (Exclusive of Part B) | | | | |
| 1. Maintenance Treatments | | | | |
| 2. Restorative Treatments | 19 | 19 | | |
| C. Other | 938 | 938 | | |
| D. ***Total Speech Therapy Treatments*** | 1,417 | 1,417 | | |
| 9. Total Number of Occupational Therapy Treatments | | | | |
| A. Medicare - Part B | 2,887 | 2,887 | | |
| B. Medicaid (Exclusive of Part B) | | | | |
| 1. Maintenance Treatments | | | | |
| 2. Restorative Treatments | 101 | 101 | | |
| C. Other | 6,530 | 6,530 | | |
| D. ***Total Occupational Therapy Treatments*** | 9,518 | 9,518 | | |

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

# Report of Expenditures - Salaries & Wages

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 10 | 37 |

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

| Item | Total Cost and Hours | | | | | |
|---|---|---|---|---|---|---|
| | CCNH | Hours | RHNS | Hours | (Specify) | Hours |
| A. Salaries and Wages* | | | | | | |
| 1. Operators/Owners (Complete also Sec. I of Schedule A1) | | | | | | |
| 2. Administrator(s) (Complete also Sec. III of Schedule A1) | 140,371 | 2,080 | | | | |
| 3. Assistant Administrator (Complete also Sec. IV of Schedule A1) | | | | | | |
| 4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.) | 159,871 | 7,533 | | | | |
| 5. Dietary Service | | | | | | |
| a. Head Dietitian | 39,582 | 742 | | | | |
| b. Food Service Supervisor | 54,192 | 2,120 | | | | |
| c. Dietary Workers | 357,552 | 19,974 | | | | |
| 6. Housekeeping Service | | | | | | |
| a. Head Housekeeper | 57,448 | 2,080 | | | | |
| b. Other Housekeeping Workers | 209,467 | 13,166 | | | | |
| 7. Repairs & Maintenance Services | | | | | | |
| a. Engineer or Chief of Maintenance | 52,342 | 1,736 | | | | |
| b. Other Maintenance Workers | 18,893 | 1,289 | | | | |
| 8. Laundry Service | | | | | | |
| a. Supervisor | | | | | | |
| b. Other Laundry Workers | 151,771 | 8,154 | | | | |
| 9. Barber and Beautician Services | | | | | | |
| 10. Protective Services | | | | | | |
| 11. Accounting Services | | | | | | |
| a. Head Accountant | | | | | | |
| b. Other Accountants | | | | | | |
| 12. Professional Care of Residents | | | | | | |
| a. Directors and Assistant Director of Nurses | 203,126 | 3,742 | | | | |
| b. RN | | | | | | |
| 1. Direct Care | 538,498 | 12,717 | | | | |
| 2. Administrative** | 126,164 | 4,232 | | | | |
| c. LPN | | | | | | |
| 1. Direct Care | 782,632 | 26,799 | | | | |
| 2. Administrative** | | | | | | |
| d. Aides and Attendants | 1,356,137 | 77,809 | | | | |
| e. Physical Therapists | | | | | | |
| f. Speech Therapists | | | | | | |
| g. Occupational Therapists | | | | | | |
| h. Recreation Workers | 105,539 | 4,666 | | | | |
| i. Physicians | | | | | | |
| 1. Medical Director | | | | | | |
| 2. Utilization Review | | | | | | |
| 3. Resident Care*** | | | | | | |
| 4. Other (Specify) | | | | | | |
| j. Dentists | | | | | | |
| k. Pharmacists | | | | | | |
| l. Podiatrists | | | | | | |
| m. Social Workers/Case Management | 125,374 | 3,731 | | | | |
| n. Marketing | | | | | | |
| o. Other (Specify) | | | | | | |
| See Attached Schedule | 65,280 | 2,528 | | | | |
| *A-13. Total Salary Expenditures* | 4,544,239 | 195,098 | | | | |

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

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

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

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

| Position | CCNH $ | CCNH Hours | RHNS $ | RHNS Hours | (Specify) $ | (Specify) Hours |
|---|---|---|---|---|---|---|
| | - | | | | | |
| Medical Records | $ 4,345 | 276 | | | | |
| Admissions | 60,900 | 2,251 | | | | |
| Respiratory Therapist (Disallowed on Pg 28a) | 35 | 1 | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Total | $ 65,280 | 2,528 | $ - | - | $ - | - |

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

| Service | CCNH $ | CCNH Hours | RHNS $ | RHNS Hours | (Specify) $ | (Specify) Hours |
|---|---|---|---|---|---|---|
| | - | | | | | |
| IV Nursing Consultant (Disallowed on Pg 28a) | $ 8,071 | 108 | | | | |
| Rehab Consultant (Disallowed on Pg 28a) | 14,599 | 292 | | | | |
| Medical Records | 1,915 | 94 | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Total | $ 24,585 | 494 | $ - | - | $ - | - |

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-11 Rev. 10/2005

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

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 11 | 37 |

| Name | Salary Paid | | | Fringe Benefits and/or Other Payments (describe fully) | Full Description of Services Rendered | Total Hours Worked | Line Where Claimed on Page 10 | Name and Address of All Other Employment** | Total Hours Worked | Compensation Received |
|---|---|---|---|---|---|---|---|---|---|---|
| | CCNH | RHNS | (Specify) | | | | | | | |
| **Section I - Operators/Owners** | | | | | | | | | | |
| Marvin J. Ostreicher | 20,800 | | | Non Discriminatory | Supervises operations, deals with DNS & Financial | 67 | 16, m11 | See Attached | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| **Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).** | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

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

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

**Bloomfield Health Center for Nursing & Rehab**
**Marvin J Ostreicher Time Study**
**9/30/2019**

| | BEDS | Total w/ Bnft |
|---|---|---|
| Bethel | 161 | 66.00 |
| Bloomfield | 120 | 67.00 |
| Bristol | 132 | 60.00 |
| Cambridge | 160 | 73.00 |
| Hebrew Home | 257 | 111.00 |
| Ludlowe | 144 | 60.00 |
| Maple View | 120 | 58.00 |
| Marlborough | 120 | 56.00 |
| Milford | 120 | 60.00 |
| Regency | 130 | 62.00 |
| Riverside | 345 | 93.00 |
| Village Crest | 95 | 58.00 |
| Water's Edge | 150 | 64.00 |
| Augusta | 72 | 57.00 |
| Belair | 102 | 53.00 |
| Brattleboro | 80 | 65.00 |
| Brentwood | 78 | 50.00 |
| Brewer | 111 | 64.00 |
| Catskill | 136 | 58.00 |
| Colony | 92 | 55.00 |
| Country | 111 | 58.00 |
| Dover | 112 | 58.00 |
| Eastside | 69 | 51.00 |
| Eliot | 114 | 62.00 |
| Glen Falls | 120 | 56.00 |
| Huntington | 320 | 94.00 |
| Kennebunk | 78 | 51.00 |
| Maywood | 120 | 65.00 |
| Newton Wellseley | 110 | 58.00 |
| Norway | 70 | 48.00 |
| Poughkeepsie | 200 | 74.00 |
| Reservoir | 144 | 71.00 |
| Rutland | 125 | 64.00 |
| Sachem | 111 | 54.00 |
| Sands Point | 180 | 70.00 |
| Utica | 117 | 53.00 |
| Westgate | 104 | 59.00 |
| Winship | 72 | 50.00 |
| | | |
| Vacation/PTO | | |
| Sick | | |
| Personal | | |
| Holiday | | |
| | | |
| Total | 2,948 | 1,498.00 |

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-12 Rev. 10/2005

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

| Name of Facility (as licensed) | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 12 | 37 |

| Name | Salary Paid | | | Fringe Benefits and/or Other Payments (describe fully) | Full Description of Services Rendered | Total Hours Worked | Line Where Claimed on Page 10 | Name and Address of All Other Employment** | Total Hours Worked | Compensation Received |
|---|---|---|---|---|---|---|---|---|---|---|
| | CCNH | RHNS | (Specify) | | | | | | | |
| **Section III - Administrators*** ** | | | | | | | | | | |
| Kimberly Phulgence | 140,371 | | | Non Discriminatory | Administrator | 2,080 | A2 | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| **Section IV - Assistant Administrators** | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

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

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

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

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

# B. Report of Expenditures - Professional Fees

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 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 | 488 | 10 | | | | |
| 2. Dentist | 8,834 | 131 | | | | |
| 3. Pharmacist | 11,499 | 153 | | | | |
| 4. Podiatrist | | | | | | |
| 5. Physical Therapy | | | | | | |
| a. Resident Care | 279,729 | 5,376 | | | | |
| b. Other | | | | | | |
| 6. Social Worker | | | | | | |
| 7. Recreation Worker | | | | | | |
| 8. Physicians | | | | | | |
| a. Medical Director (entire facility) | 36,300 | 300 | | | | |
| b. Utilization Review (Title 18 and 19 only) monthly meeting | | | | | | |
| c. Resident Care** | | | | | | |
| d. Administrative Services facility | | | | | | |
| 1. Infection Control Committee (Quarterly meetings) | | | | | | |
| 2. Pharmaceutical Committee (Quarterly meetings) | | | | | | |
| 3. Staff Development Committee (Once annually) | | | | | | |
| e. Other (Specify) | | | | | | |
| 9. Speech Therapist | | | | | | |
| a. Resident Care | 64,995 | 924 | | | | |
| b. Other | | | | | | |
| 10. Occupational Therapist | | | | | | |
| a. Resident Care | 214,525 | 3,377 | | | | |
| b. Other | | | | | | |
| 11. Nurses and aides and attendants | | | | | | |
| a. RN | | | | | | |
| 1. Direct Care | 18,173 | 286 | | | | |
| 2. Administrative*** | | | | | | |
| b. LPN | | | | | | |
| 1. Direct Care | 19,970 | 437 | | | | |
| 2. Administrative*** | | | | | | |
| c. Aides | 42,232 | 1,687 | | | | |
| d. Other | | | | | | |
| 12. Other (Specify) | | | | | | |
| See Attached Schedule | 24,585 | 494 | | | | |
| ***B-13 Total Fees Paid in Lieu of Salaries*** | 721,330 | 13,175 | | | | |

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

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

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

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-14 Rev. 6/95

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

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 14 | 37 |

| Name & Address of Individual | Full Explanation of Service | Related** to Owners, Operators, Officers | | Explanation of Relationship |
|---|---|---|---|---|
| | | Yes | No | |
| Gerident Solutions, P.O. Box 290539, Wethersfield, CT 06129 | Dentist | ○ | ⊙ | N/A |
| Procare LTC of CT, 111 Executive Blvd, Farmingdale, NY 11735 | Pharmacist / IV Nursing Consultant | ⊙ | ○ | Common Ownership |
| Preferred Thearpy-809 Main St., E.Hartford,CT, 06108 | PT, OT, ST / Rehab Consultant | ⊙ | ○ | Common Ownership |
| Dr Santo Buccheri - 357 Franklin Ave, Hartford, CT 06114 | Medical Director | ○ | ⊙ | N/A |
| Maxim Staffing Solutions. 12558 Collections Center Drive. Chicago, Il 60693 | RNs / LPNs/ CNAs | ○ | ⊙ | N/A |
| PREFERRED PROFESSIONAL SERVICES 850 Silas Deane Hwy Wethersfield, CT 06109 | RNs / LPNs/ CNAs | ⊙ | ○ | Common Ownership |
| The Nurse Network, 653 Main St, Plantsville, CT 06479 | RNs / LPNs/ CNAs | ○ | ⊙ | N/A |
| WORLDWIDE STAFFING, 175 Dwight Rd #202, Longmeadow, MA 01106 | LPN / CNAs | ○ | ⊙ | N/A |
| Regency House of Wallingford, 181 East Main Street, Wallingford, CT 06492 | Dietary Consultant | ⊙ | ○ | Common Ownership |
| Maple View Manor of CT, LLC, 856 Maple Street, Rocky Hill, CT 06067 | Medical Records Consultant | ⊙ | ○ | Common Ownership |
| | | ○ | ⊙ | |
| | | ○ | ⊙ | |
| | | ○ | ⊙ | |
| | | ○ | ⊙ | |
| | | ○ | ⊙ | |
| | | ○ | ⊙ | |
| | | ○ | ⊙ | |
| | | ○ | ⊙ | |
| | | ○ | ⊙ | |
| | | ○ | ⊙ | |
| | | ○ | ⊙ | |
| | | ○ | ⊙ | |

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

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-15 Rev. 9/2018

# C. Expenditures Other Than Salaries - Administrative and General

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 15 | 37 |

| Item | | Total | CCNH | RHNS | (Specify) |
|---|---|---|---|---|---|
| 1. Administrative and General | | | | | |
| a. Employee Health & Welfare Benefits | | | | | |
| 1. Workmen's Compensation | $ | 270,297 | 270,297 | | |
| 2. Disability Insurance | $ | | | | |
| 3. Unemployment Insurance | $ | 78,719 | 78,719 | | |
| 4. Social Security (F.I.C.A.) | $ | 333,812 | 333,812 | | |
| 5. Health Insurance | $ | 541,614 | 541,614 | | |
| 6. Life Insurance (employees only) (not-owners and not-operators) | $ | | | | |
| 7. Pensions (Non-Discriminatory) (not-owners and not-operators) | $ | | | | |
| 8. Uniform Allowance | $ | 29,877 | 29,877 | | |
| 9. Other (*Specify*) See Attached Schedule | $ | 7,375 | 7,375 | | |
| b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)* | $ | | | | |
| c. Bad Debts* | $ | 104,158 | 104,158 | | |
| d. Accounting and Auditing | $ | 20,400 | 20,400 | | |
| e. Legal (*Services should be fully described on Page 7)* | $ | 89,102 | 89,102 | | |
| f. Insurance on Lives of Owners and Operators (*Specify*)* | $ | | | | |
| g. Office Supplies | $ | 12,051 | 12,051 | | |
| h. Telephone and Cellular Phones | | | | | |
| 1. Telephone & Pagers | $ | 33,318 | 33,318 | | |
| 2. Cellular Phones | $ | 2,444 | 2,444 | | |
| i. Appraisal (*Specify purpose and attach copy*)* | $ | | | | |
| j. Corporation Business Taxes (*franchise tax*) | $ | 250 | 250 | | |
| k. Other Taxes (*Not related to property - See Page 22)* | | | | | |
| 1. Income* | $ | | | | |
| 2. Other (*Specify*) See Attached Schedule | $ | | | | |
| 3. Resident Day User Fee | $ | 628,078 | 628,078 | | |
| ***Subtotal*** | $ | 2,151,495 | 2,151,495 | | |

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

(Carry Subtotals forward to next page)

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



**Schedule of Other Employee Benefits**

| Description | CCNH | RHNS | (Specify) |
|---|---|---|---|
| | - | | |
| Background Checks | $ 7,375 | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| **Total** | $ 7,375 | $ - | $ - |

---

**Schedule of Other Taxes**

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

---

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-16 Rev. 9/2002

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

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 16 | 37 |

| Item | | Total | CCNH | RHNS | (Specify) |
|---|---|---|---|---|---|
| ***Subtotals Brought Forward:*** | | 2,151,495 | 2,151,495 | | |
| l. Travel and Entertainment | | | | | |
| 1. Resident Travel and Entertainment | $ | | | | |
| 2. Holiday Parties for Staff | $ | | | | |
| 3. Gifts to Staff and Residents | $ | 3,703 | 3,703 | | |
| 4. Employee Travel | $ | 2,438 | 2,438 | | |
| 5. Education Expenses Related to Seminars and Conventions | $ | 2,925 | 2,925 | | |
| 6. Automobile Expense (*not purchase or depreciation*) | $ | | | | |
| 7. Other (*Specify*) See Attached Schedule | $ | | | | |
| m. Other Administrative and General Expenses | | | | | |
| 1. Advertising Help Wanted (*all such expenses*) | $ | | | | |
| 2. Advertising Telephone Directory (*all such expenses*)*** | $ | | | | |
| 3. Advertising Other (*Specify*)*** See Attached Schedule | $ | 18,866 | 18,866 | | |
| 4. Fund-Raising*** | $ | | | | |
| 5. Medical Records | $ | | | | |
| 6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)*** | $ | | | | |
| 7. Postage | $ | 2,154 | 2,154 | | |
| * 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule | $ | 8,889 | 8,889 | | |
| 8a. Dues to Chamber of Commerce & Other Non-Allowable Org.*** | $ | 750 | 750 | | |
| 9. Subscriptions | $ | 2,435 | 2,435 | | |
| 10. Contributions*** See Attached Schedule | $ | | | | |
| 11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual*) | $ | 99,010 | 99,010 | | |
| 12. Administrative Management Services** | $ | 493,418 | 493,418 | | |
| 13. Other (*Specify*) See Attached Schedule | $ | 50,312 | 50,312 | | |
| ***C-14 Total Administrative & General Expenditures*** | $ | 2,836,395 | 2,836,395 | | |

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

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

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

**Schedule of Other Travel and Entertainment**

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

**Schedule of Other Advertising**

| Description | CCNH | RHNS | (Specify) |
|---|---|---|---|
| | - | | |
| Promotional Advertising (Disallowed on Pg 28) | $ 18,866 | | |
| | | | |
| **Total Other Advertising** | $ 18,866 | $ - | $ - |

**Schedule of Dues**

| Description | CCNH | RHNS | (Specify) |
|---|---|---|---|
| | - | | |
| CAHCF Dues | $ 8,889 | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| **Total Dues** | $ 8,889 | $ - | $ - |

**Schedule of Contributions**

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

**Schedule of Other Administrative and General**

| Description | CCNH | RHNS | (Specify) |
|---|---|---|---|
| | - | | |
| Computer License Fee | $ 121 | | |
| Licenses and Permits | 560 | | |
| Bank Charges ($2,743 Disallowed on Pg 28a) | 22,180 | | |
| Miscellaneous Expense (Disallowed on Pg 28a) | 27,451 | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| **Total Other Administrative and General** | $ 50,312 | $ - | $ - |

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-17 Rev. 10/97

# Schedule C-1 - Management Services*

| Name of Facility | License No. | Report for Year Ended | Page of |
|---|---|---|---|
| Bloomfield Health Care Center of CT, LL( | 913-C | 9/30/2019 | 17 \| 37 |

| Name & Address of Individual or Company Supplying Service | Cost of Management Service | Full Description of Mgmt. Service Provided | Indicate Where Costs are Included in Annual Report Page #/Line # |
|---|---|---|---|
| National Healthcare Associates, Inc. | 493,418 | Management Fees | Page 16, Line M12 |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-18 Rev. 9/2018

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

| Name of Facility | License No. | Report for Year Ended | Page of |
|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 18 \| 37 |

| Item | | Total | CCNH | RHNS | (Specify) |
|---|---|---|---|---|---|
| 2. Dietary | | | | | |
| a. In-House Preparation & Service | | | | | |
| 1. Raw Food | $ | 261,719 | 261,719 | | |
| 2. Non-Food Supplies | $ | | | | |
| 3. Other (*Specify*)_____ | $ | | | | |
| b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)* | $ | 10,070 | 10,070 | | |
| c. Other (*Specify*)_____ Other Dietary Supplies | $ | 28,222 | 28,222 | | |
| 2D. ***Total Dietary Expenditures*** (2a + b + c + d) | $ | 300,011 | 300,011 | | |

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

| | | | |
|---|---|---|---|
| G. Is cost of employee meals included in 2D? | O Yes | ⊙ No | |
| H. Did you receive revenue from employees? | O Yes | ⊙ No | If yes, specify amt. |
| I. Where is the revenue received reported in the Cost Report? (Page/Line Item) | | | |
| J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D? | O Yes | ⊙ No | If yes, specify cost. |
| K. Is any revenue collected from these people? | O Yes | ⊙ No | If yes, specify amt. |
| L. Where is the revenue received reported in the Cost Report? (Page/Line Item) | | | |
| M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? | O Yes | ⊙ No | If yes, specify cost. |
| N. Is any revenue collected from employees? | O Yes | ⊙ No | If yes, specify amt. |
| O. Where is the revenue received reported in the Cost Report? (Page/Line Item) | | | |

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

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-19 Rev. 9/2018

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

| Name of Facility | License No. | Report for Year Ended | Page of |
|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 19 \| 37 |

| Item | | Total | CCNH | RHNS | (Specify) |
|---|---|---|---|---|---|
| 3. Laundry<br>a. In-House Processing*<br>1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.*** | Lbs. | | | | |
| | Amt. $ | 8,426 | 8,426 | | |
| 2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.*** | Lbs. | | | | |
| | Amt. $ | | | | |
| 3. Personal clothing of residents washed, ironed, and/or processed.*** | Lbs. | | | | |
| | Amt. $ | | | | |
| 4. Repair and/or purchase of linens.*** | Lbs. | | | | |
| | Amt. $ | | | | |
| b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)* | $ | | | | |
| c. Other (*Specify*)<br>Laundry Supplies and Diapers | $ | 43,384 | 43,384 | | |
| 3D. ***Total Laundry Expenditures*** (3a + b + c) | $ | 51,810 | 51,810 | | |

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

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

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

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-20 Rev. 9/2018

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

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 20 | 37 |

| Item | | | Total | CCNH | RHNS | (Specify) |
|---|---|---|---|---|---|---|
| 4. Housekeeping | Sq. Ft. Serviced by Personnel | | | | | |
| a. In-House Care | | | | | | |
| 1. Supplies - Cleaning (*Mops, pails, brooms, etc.*) | Amt. | $ | 23,332 | 23,332 | | |
| b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*) | Sq. Ft. Serviced by Personnel | | | | | |
| | Amt. | $ | | | | |
| C. Other (*Specify*) | | $ | | | | |
| 4D. ***Total Housekeeping Expenditures*** (4a + b + c) | | $ | 23,332 | 23,332 | | |
| 5. Resident Care (Supplies)** | | | | | | |
| a. Prescription Drugs*** | | | | | | |
| 1. Own Pharmacy | | $ | 207,355 | 207,355 | | |
| 2. Purchased from | | $ | | | | |
| b. Medicine Cabinet Drugs | | $ | 7,789 | 7,789 | | |
| c. Medical and Therapeutic Supplies | | $ | 88,094 | 88,094 | | |
| d. Ambulance/Limousine*** | | $ | 6,675 | 6,675 | | |
| e. Oxygen | | | | | | |
| 1. For Emergency Use | | $ | | | | |
| 2. Other*** | | $ | 4,943 | 4,943 | | |
| f. X-rays and Related Radiological Procedures*** | | $ | 6,828 | 6,828 | | |
| g. Dental (*Not dentists who should be included under salaries or fees*) | | $ | | | | |
| h. Laboratory*** | | $ | 12,080 | 12,080 | | |
| i. Recreation | | $ | 35,237 | 35,237 | | |
| j. Direct Management Services* | | $ | | | | |
| k. Indirect Management Services* | | $ | | | | |
| l. Other (Specify)**** See Attached Schedule | | $ | 65,444 | 65,444 | | |
| 5M. ***Total Resident Care Expenditures*** (5a - 5j) | | $ | 434,445 | 434,445 | | |

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

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

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

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

**Schedule of Other Resident Care**

| Description | CCNH | RHNS | (Specify) |
|---|---|---|---|
| | - | | |
| Flu Vaccine - Medical Services | 4,541 | | |
| IV Thy Supplies - Rehab Tpy and Ancllry (Disallowed on Pg 29a) | 6,312 | | |
| Medical Staff Meetings - Medical Services | (200) | | |
| Purch Services - Nursing | 1,435 | | |
| Equip Rental - Nursing ($27,972 Disallowed on Pg 29a) | 28,923 | | |
| Equip Rental - Rehab Tpy and Ancllry (Disallowed on Pg 29a) | 10,150 | | |
| Equip Rental - Respiratory (Disallowed on Pg 29a) | 14,283 | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| **Total Other Resident Care** | $ 65,444 | $ - | $ - |

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-21 Rev. 10/2001

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

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 21 | 37 |

| Name of Individual or Company | Address | Related ** to Owners, Operators, Officers | | Explanation of Relationship | Full Explanation of Service Provided* | Total Cost/Page Ref.*** | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Yes | No | | | CCNH | RHNS | (Specify) | Pg | Line |
| ADM Environmental Group | Avenue, Brooklyn, Ny 11230 | ○ | ⊙ | N/A | Waster Service/ Monthly Recycling Service | 27,994 | | | 22 | 6f |
| ADP | P.O. Box 842875, Boston, MA 02284 | ○ | ⊙ | N/A | Payroll Processing | 10,578 | | | 16 | m11 |
| M.J Daly & Sons | 110 Mattatuck HTS, Waterbury CT 06705 | ○ | ⊙ | N/A | HVAC | 22,689 | | | 22 | 6f |
| XTREME LANDSCAPING | 40 Stark Drive East Granby, CT 06026 | ○ | ⊙ | N/A | Landscaping / Snow Removal | 15,055 | | | 22 | 6f |
| | | ○ | ⊙ | | | | | | | |
| | | ○ | ⊙ | | | | | | | |
| | | ○ | ⊙ | | | | | | | |
| | | ○ | ⊙ | | | | | | | |
| | | ○ | ⊙ | | | | | | | |
| | | ○ | ⊙ | | | | | | | |
| | | ○ | ⊙ | | | | | | | |
| | | ○ | ⊙ | | | | | | | |
| | | ○ | ⊙ | | | | | | | |
| | | ○ | ⊙ | | | | | | | |

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

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-22 Rev. 6/95

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

| Name of Facility | License No. | Report for Year Ended | Page of |
|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 22 \| 37 |

| Item | | Total | CCNH | RHNS | (Specify) |
|---|---|---|---|---|---|
| 6. Maintenance & Operation of Plant | | | | | |
| a. Repairs & Maintenance | $ | | | | |
| b. Heat | $ | 61,145 | 61,145 | | |
| c. Light & Power | $ | 124,055 | 124,055 | | |
| d. Water | $ | 29,245 | 29,245 | | |
| e. Equipment Lease (*Provide detail on page 6*) | $ | 30,788 | 30,788 | | |
| f. Other (*itemize*) | $ | 136,554 | 136,554 | | |
| See Attached Schedule | | | | | |
| 6g. ***Total Maint. & Operating Expense*** (6a - 6f) | $ | 381,787 | 381,787 | | |
| 7. Depreciation (*complete schedule page 23**) | | | | | |
| a. Land Improvements | $ | | | | |
| b. Building & Building Improvements | $ | | | | |
| c. Non-Movable Equipment | $ | 1,155 | 1,155 | | |
| d. Movable Equipment | $ | 67,415 | 67,415 | | |
| *7e. ***Total Depreciation Costs*** (7a + b + c + d) | $ | 68,570 | 68,570 | | |
| 8. Amortization (*Complete att. Schedule Page 24**) | | | | | |
| a. Organization Expense | $ | | | | |
| b. Mortgage Expense | $ | | | | |
| c. Leasehold Improvements | $ | 67,143 | 67,143 | | |
| d. Other (*Specify*) | $ | | | | |
| *8e. ***Total Amortization Costs*** (8a + b + c + d) | $ | 67,143 | 67,143 | | |
| 9. Rental payments on leased real property less real estate taxes included in item 10b | $ | 840,000 | 840,000 | | |
| 10. Property Taxes | | | | | |
| a. Real estate taxes paid by owner | $ | | | | |
| b. Real estate taxes paid by lessor | $ | 104,369 | 104,369 | | |
| c. Personal property taxes | $ | 16,437 | 16,437 | | |
| 11. ***Total Property Expenses*** (7e + 8e + 9 + 10) | $ | 1,096,519 | 1,096,519 | | |

* 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) |
|---|---|---|---|
| | - | | |
| Supplies | $ 11,545 | | |
| Consulting Fees | 13,687 | | |
| Purch Services - Maintenance | 51,685 | | |
| Purch Services - Security | 14,735 | | |
| Ground Services | 12,575 | | |
| Pest Control | 3,463 | | |
| Carting | 28,864 | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| **Total Other Repairs and Maintenance** | $ 136,554 | $ - | $ - |

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

# Depreciation Schedule

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 23 | 37 |

| Property Item | Historical Cost Exclusive of Land | Less Salvage Value | Cost to Be Depreciated | Accumulated Depreciation to Beginning of Year's Operations | Method of Computing Depreciation | Useful Life | Depreciation for This Year | Totals |
|---|---|---|---|---|---|---|---|---|
| A. **Land Improvements** | | | | | | | | |
| 1. Acquired prior to this report period | | | | | | | | |
| 2. Disposals (attach schedule) | | | | | | | | |
| 3. Acquired during this report period (attach schedule) | | | | | | | | |
| A-4. Subtotal | | | | | | | | |
| B. **Building and Building Improvements** | | | | | | | | |
| 1. Acquired prior to this report period | 5,657,365 | | 5,657,365 | 4,961,152 | S/L | Various | | |
| 2. Disposals (attach schedule) | | | | | | | | |
| 3. Acquired during this report period (attach schedule) | | | | | | | | |
| B-4. Subtotal | | | | | | | | |
| C. **Non-Movable Equipment** | | | | | | | | |
| 1. Acquired prior to this report period | 36,366 | | 36,366 | 33,580 | S/L | Various | 1,155 | |
| 2. Disposals (attach schedule) | | | | | | | | |
| 3. Acquired during this report period (attach schedule) | | | | | | | | |
| C-4. Subtotal | | | | | | | | 1,155 |

| | Is a mileage logbook maintained? | | Date of Acquisition | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Yes | No | Month | Year | Historical Cost Exclusive of Land | Less Salvage Value | Cost to Be Depreciated | Accumulated Depreciation to Beginning of Year's Operations | Method of Computing Depreciation | Useful Life | Depreciation for This Year | Totals |
| D. **Movable Equipment** | | | | | | | | | | | | |
| 1. Motor Vehicles (Specify name, model and year of each vehicle) | | | | | | | | | | | | |
| a. | | | | | | | | | | | | |
| b. | | | | | | | | | | | | |
| c. | | | | | | | | | | | | |
| d. | | | | | | | | | | | | |
| 2. Movable Equipment | | | | | | | | | | | | |
| a. Acquired prior to this report period | | | Var | Var | 558,520 | | 558,520 | 178,100 | S/L | Various | 61,594 | |
| b. Disposals (attach schedule) | | | | | | | | | | | | |
| c. Acquired during this report period (attach schedule) | | | Var | Var | 37,702 | | 37,702 | | S/L | Various | 5,821 | |
| D-3. Subtotal | | | | | | | | | | | | 67,415 |
| E. ***Total Depreciation*** | | | | | | | | | | | | 68,570 |

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

**Schedule of Movable Equipment Acquired during this report period**

| Acquisition Date | Description of Item | Cost | Useful Life | Depreciation | |
|---|---|---|---|---|---|
| **Additions:** | | | | | |
| 11/30/2018 | Table Base & Top | $ 1,097 | 10 | $ 110 | |
| 11/30/2018 | Dining Armchair | 5,005 | 10 | 501 | |
| 11/30/2018 | Video Entry System | 2,270 | 5 | 454 | |
| 1/31/2019 | HP260 G3 Desktop Mini PC | 776 | 3 | 259 | |
| 2/28/2019 | Install Aiphone Intercom Syste | 5,929 | 10 | 593 | |
| 2/28/2019 | HP 260 G3 Desktop Mini PC | 561 | 3 | 187 | |
| 2/28/2019 | HP 260 G3 Desktop Mini PC | 776 | 3 | 259 | |
| 2/28/2019 | LATI 7490 Laptop | 1,422 | 3 | 474 | |
| 5/21/2019 | Chair, Table & Couch | 9,893 | 10 | 989 | |
| 8/31/2019 | 2 x MCQUAY PTAC installation | 9,974 | 5 | 1,995 | |
| **Total additions for Movable Equipment** | | $ 37,702 | | $ 5,821 | * |
| **Deletions:** | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| **Total deletions for Movable Equipment** | | $ - | | $ - | ** |

*Ties to Page 23, Line D2c
**Ties to Page 23, Line D2b

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

| Acquisition Date | Description of Item | Cost | Useful Life | Depreciation | |
|---|---|---|---|---|---|
| **Additions:** | | | | | |
| 10/15/2018 | Roofing Replacements | $ 4,632 | 10 | $ 463 | |
| 1/31/2019 | HVAC - Installed new assemblie | 5,028 | 15 | 335 | |
| 1/31/2019 | HVAC-Changed actuator | 4,349 | 15 | 290 | |
| 2/28/2019 | HVAC-Ceiling Fan Heater Repair | 8,073 | 15 | 538 | |
| 2/28/2019 | HVAC-Ceiling Fan Heater Repair | 8,073 | 15 | 538 | |
| 3/31/2019 | Roofing Replacements | 2,251 | 10 | 225 | |
| 6/1/2019 | Roofing Replacements | 2,375 | 10 | 238 | |
| 9/29/2019 | Power Supply on Fire Alarm | 3,880 | 10 | 388 | |
| 9/30/2019 | New Flex Control Panel & Float | 6,522 | 15 | 435 | |
| | | | | | |
| | | | | | |
| **Total additions for Leasehold Improvement** | | $ 45,182 | | $ 3,450 | * |
| **Deletions:** | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| **Total deletions for Leasehold Improvement** | | $ - | | $ - | ** |

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

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-24 Rev. 10/2006

# Amortization Schedule*

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 24 | 37 |

| Item | Date of Acquisition Month | Date of Acquisition Year | Length of Amortization | Cost to Be Amortized | Accumulated Amort. to Beginning of Year's Operations | Basis for Computing Amortization** | Rate % | Amortization for This Year | Totals |
|---|---|---|---|---|---|---|---|---|---|
| A. **Organization Expense** | | | | | | | | | |
| 1. | | | | | | | | | |
| 2. | | | | | | | | | |
| 3. | | | | | | | | | |
| A-4. Subtotal | | | | | | | | | |
| B. **Mortgage Expense** | | | | | | | | | |
| 1. | | | | | | | | | |
| 2. | | | | | | | | | |
| 3. | | | | | | | | | |
| B-4. Subtotal | | | | | | | | | |
| C. **Leasehold Improvements and Other** | | | | | | | | | |
| 1. Acquired prior to this report period | Var | Var | Various | 865,552 | 459,052 | S/L | Variou | 63,693 | |
| 2. Disposals (attach schedule) | | | | | | | | | |
| 3. Acquired during this report period (attach schedule) | Var | Var | Various | 45,182 | | S/L | Variou | 3,450 | |
| C-4. Subtotal | | | | | | | | | 67,143 |
| D. ***Total Amortization*** | | | | | | | | | 67,143 |

* Straight-line method must be used.

** Specify which of the following bases were used:

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

**Bloomfield Health Center for Nursing & Rehab**
**FIXED ASSET / DEPRECIATION SCHEDULE**

| Asset Type | Description | Date In Service | Method | Life | Historical Cost | 2018 A/D | 2019 Deprec. | 2019 A/D | NBV |
|---|---|---|---|---|---|---|---|---|---|
| **LEASHOLD IMPROVEMENTS** | | | | | | | | | |
| LI | Prior Period Acquisitions (Per 9/30/18 CR) | Various | S/L | Various | 865,552 | 459,052 | 63,693 | 522,745 | 342,807 |
| **2019 Additions** | | | | | | | | | |
| LI | Roofing Replacements | 10/15/2018 | S/L | 10 | 4,632 | - | 463 | 463 | 4,169 |
| LI | HVAC - Installed new assemblie | 1/31/2019 | S/L | 15 | 5,028 | - | 335 | 335 | 4,693 |
| LI | HVAC-Changed actuator | 1/31/2019 | S/L | 15 | 4,349 | - | 290 | 290 | 4,059 |
| LI | HVAC-Ceiling Fan Heater Repair | 2/28/2019 | S/L | 15 | 8,073 | - | 538 | 538 | 7,535 |
| LI | HVAC-Ceiling Fan Heater Repair | 2/28/2019 | S/L | 15 | 8,073 | - | 538 | 538 | 7,535 |
| LI | Roofing Replacements | 3/31/2019 | S/L | 10 | 2,251 | - | 225 | 225 | 2,026 |
| LI | Roofing Replacements | 6/1/2019 | S/L | 10 | 2,375 | - | 238 | 238 | 2,137 |
| LI | Power Supply on Fire Alarm | 9/29/2019 | S/L | 10 | 3,880 | - | 388 | 388 | 3,492 |
| LI | New Flex Control Panel & Float | 9/30/2019 | S/L | 15 | 6,522 | - | 435 | 435 | 6,087 |
| **TOTAL LEASEHOLD IMPROVEMENTS** | | | | | **910,734** | **459,052** | **67,143** | **526,195** | **384,539** |
| **Building Improvements** | | | | | | | | | |
| Bldng Imp | Prior Period Acquisitions (Per 9/30/18 CR) | Various | S/L | Various | 5,657,365 | 4,961,152 | 247,095 | 5,208,247 | 449,118 |
| **TOTAL Building Improvements** | | | | | **5,657,365** | **4,961,152** | **247,095** | **5,208,247** | **449,118** |
| **NON-MOVABLE EQUIPMENT** | | | | | | | | | |
| NME | Prior Period Acquisitions (Per 9/30/18 CR) | Various | S/L | Various | 36,366 | 33,580 | 1,155 | 34,735 | 1,631 |
| **TOTAL NON-MOVABLE EQUIPMENT** | | | | | **36,366** | **33,580** | **1,155** | **34,735** | **1,631** |
| **MOVABLE EQUIPMENT** | | | | | | | | | |
| MME | Prior Period Acquisitions (Per 9/30/18 CR) | Various | S/L | Various | 558,520 | 178,100 | 61,594 | 239,694 | 318,826 |
| **2019 Additions** | | | | | | | | | |
| MME | Table Base & Top | 11/30/2018 | S/L | 10 | 1,097 | - | 110 | 110 | 987 |
| MME | Dining Armchair | 11/30/2018 | S/L | 10 | 5,005 | - | 501 | 501 | 4,504 |
| MME | Video Entry System | 11/30/2018 | S/L | 5 | 2,270 | - | 454 | 454 | 1,816 |
| MME | HP260 G3 Desktop Mini PC | 1/31/2019 | S/L | 3 | 776 | - | 259 | 259 | 517 |
| MME | Install Aiphone Intercom Syste | 2/28/2019 | S/L | 10 | 5,929 | - | 593 | 593 | 5,336 |
| MME | HP 260 G3 Desktop Mini PC | 2/28/2019 | S/L | 3 | 561 | - | 187 | 187 | 374 |
| MME | HP 260 G3 Desktop Mini PC | 2/28/2019 | S/L | 3 | 776 | - | 259 | 259 | 517 |
| MME | LATI 7490 Laptop | 2/28/2019 | S/L | 3 | 1,422 | - | 474 | 474 | 948 |
| MME | Chair, Table & Couch | 5/21/2019 | S/L | 10 | 9,893 | - | 989 | 989 | 8,904 |
| MME | 2 x MCQUAY PTAC installation | 8/31/2019 | S/L | 5 | 9,974 | - | 1995 | 1,995 | 7,979 |
| **TOTAL MOVABLE EQUIPMENT** | | | | | **596,222** | **178,100** | **67,415** | **245,515** | **350,707** |
| **TOTAL ASSETS PER CR SCHEDULE** | | | | | **7,200,687** | **5,631,884** | **382,808** | **6,014,692** | **1,185,995** |
| **TOTAL ASSETS PER TRIAL BALANCE** | | | | | **1,543,321** | **-** | **135,713** | **806,445** | **736,876** |
| **LESS REALTY ASSETS** | | | | | **(5,657,365)** | **(4,961,152)** | **(247,095)** | **(5,208,247)** | **(449,118)** |
| **ROUNDING** | | | | | **1** | | | | **1** |
| **VARIANCE** | | | | | **(0)** | **670,732** | **-** | **-** | **(0)** |
| TOTAL REALTY ASSETS PER SCHEDULE | | | | | 5,657,365 | | | | |
| TOTAL REALTY ASSETS PER REALTY TB | | | | | 7,189,076 | | | | |
| HISTORICAL VARIANCE ROLLED FORWARD** | | | | | 1,531,711 | | | | |

**F/S vs C/R NBV - Page 31, Line B9** 0
**F/S vs C/R Depreciation - Page 36, Line F1** -

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-25 Rev. 9/2002

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

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, | 913-C | 9/30/2019 | 25 | 37 |

11. Property Questionnaire

**Part A**

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

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

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

| Description | Total |
|---|---|
| 1. Date Land Purchased | |
| 2. Date Structure Completed | |
| 3. If **NOT** Original Owner, Date of Purchase | |
| 4. Date of Initial Licensure | |
| 5. Total Licensed Bed Capacity | 120 |
| 6. Square Footage | |
| 7. Acquisition Cost | |
| a. Land | |
| b. Building | |

| **Part B - Owner and Related Parties** | 1st Mortgage | 2nd Mortgage | 3rd Mortgage | 4th Mortgage |
|---|---|---|---|---|
| 1. Financing | | | | |
| a. Type of Financing (e.g., fixed, variable) | Fixed | | | |
| b. Date Mortgage Obtained | 07/01/02 | | | |
| c. Interest Rate for the Cost Year | 733.00% | | | |
| d. Term of Mortgage (number of years) | 15 | | | |
| e. Amount of Principal Borrowed | 8,226,480 | | | |
| f. Principal balance outstanding as of 9/30/19 | 2,412,910 | | | |
| **Complete if Mortgage was Refinanced During Current Cost Year** | | | | |
| g. Type of Financing (e.g., fixed, variable) | | | | |
| h. Date of Refinancing | | | | |
| i. New Interest Rate | | | | |
| j. Term of Mortgage (number of years) | | | | |
| k. Amount of Principal Borrowed | | | | |
| l. Principal Outstanding on Note Paid-Off | | | | |

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

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

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

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-26 Rev. 6/95

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

| Name of Facility | License No. | Report for Year Ended | Page of |
|---|---|---|---|
| Bloomfield Health Care Center of CT, | 913-C | 9/30/2019 | 26 \| 37 |

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

*(Carry Subtotals forward to next page )*

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-27 Rev. 6/95

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

| Name of Facility | License No. | Report for Year Ended | Page of |
|---|---|---|---|
| Bloomfield Health Care Center of C | 913-C | 9/30/2019 | 27 \| 37 |

| Item | | | | Total | CCNH | RHNS | (Specify) |
|---|---|---|---|---|---|---|---|
| Subtotals Brought Forward: | | | | | | | |
| 12. C. Movable Equipment | | | | | | | |
| 1. Automotive Equipment | | | $ | | | | |
| A. Item | Rate | Amount | | | | | |
| Lender | | | | | | | |
| Address of Lender | | | | | | | |
| 2. Other (*Specify*) | | | $ | | | | |
| A. Item | Rate | Amount | | | | | |
| Lender | | | | | | | |
| Address of Lender | | | | | | | |
| B. Item | Rate | Amount | | | | | |
| Lender | | | | | | | |
| Address of Lender | | | | | | | |
| 12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) | | | $ | | | | |
| 12. D. Other Interest Expense (*Specify*) Admin / Computer Loan / Equipment Interest | | | $ | 14,701 | 14,701 | | |
| 13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) | | | $ | 14,701 | 14,701 | | |
| 14. Insurance | | | | | | | |
| a. Insurance on Property (buildings only) | | | $ | 10,641 | 10,641 | | |
| b. Insurance on Automobiles | | | $ | | | | |
| c. Insurance other than Property (as specified above) | | | | | | | |
| 1. Umbrella (*Blanket Coverage*) | | | $ | 8,654 | 8,654 | | |
| 2. Fire and Extended Coverage | | | $ | | | | |
| 3. Other (*Specify*) Liability / Crime Insurance | | | $ | 49,046 | 49,046 | | |
| 14d. ***Total Insurance Expenditures (14a + b + c)*** | | | $ | 68,341 | 68,341 | | |
| 15. ***Total All Expenditures (A-13 thru C-14)*** | | | $ | 10,472,910 | 10,472,910 | | |

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-28 Rev. 9/2018

# D. Adjustments to Statement of Expenditures

| Name of Facility | License No. | Report for Year Ended | Page of |
|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 28 \| 37 |

| Item No. | Page No. | Line No. | Item Description | Total Amount of Decrease | CCNH | RHNS | (Specify) |
|---|---|---|---|---|---|---|---|
| ***Page 10 - Salaries and Wages*** | | | | | | | |
| 1. | | | Outpatient Service Costs $ | | | | |
| 2. | | | Salaries not related to Resident Care $ | | | | |
| 3. | | | Occupational Therapy $ | | | | |
| 4. | | | Other - See attached Schedule $ | 12,215 | 12,215 | | |
| ***Page 13 - Professional Fees*** | | | | | | | |
| 5. | | | Resident Care Physicians ** $ | | | | |
| 6. | 13 | B10a | Occupational Therapy $ | 214,525 | 214,525 | | |
| 7. | | | Other - See attached Schedule $ | 22,670 | 22,670 | | |
| ***Pages 15 & 16 - Administrative and General*** | | | | | | | |
| 8. | | | Discriminatory Benefits $ | | | | |
| 9. | 15 | 1c | Bad Debts $ | 104,158 | 104,158 | | |
| 10. | | | Accounting $ | | | | |
| 10a. | 15 | 1e | Legal $ | 32,913 | 32,913 | | |
| 11. | | | Telephone $ | | | | |
| 12. | 15 | 1h2 | Cellular Telephone $ | 1,004 | 1,004 | | |
| 13. | | | Life insurance premiums on the life of Owners, Partners, Operators $ | | | | |
| 14. | 16 | L3 | Gifts, flowers and coffee shops $ | 3,703 | 3,703 | | |
| 15. | | | Education expenditures to colleges or universities for tuition and related costs for owners and employees $ | | | | |
| 16. | 16 | L4 | Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $ | 2,387 | 2,387 | | |
| 17. | | | Automobile Expense (e.g. personal use) $ | | | | |
| 18. | 16 | m2/3 | Unallowable Advertising * $ | 18,866 | 18,866 | | |
| 19. | | | Income Tax / Corporate Business Tax $ | | | | |
| 20. | | | Fund Raising / Contributions $ | | | | |
| 21. | 16 | m12 | Unallowable Management Fees $ | 205,546 | 205,546 | | |
| 22. | | | Barber and Beauty $ | | | | |
| 23. | | | Other - See attached Schedule $ | 34,205 | 34,205 | | |
| ***Page 18 - Dietary Expenditures*** | | | | | | | |
| 24. | | | Meals to employees, guests and others who are not residents $ | | | | |
| ***Page 19 - Laundry Expenditures*** | | | | | | | |
| 25. | | | Laundry services to employees, guests and others who are not residents $ | | | | |
| ***Page 20 - Housekeeping Expenditures*** | | | | | | | |
| 26. | | | Housekeeping services to employees, guests and others who are not residents $ | | | | |
| | | | Subtotal (Items 1 - 26) $ | 652,192 | 652,192 | | |

* All except "Help Wanted".

*(Carry Subtotal forward to next page)*

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

**Schedule of Other Salaries Adjustment**

| Page Ref | Line Ref | Description | CCNH | RHNS | (Specify) |
|---|---|---|---|---|---|
| 10 | B12o | Respiratory Therapist | $ 35 | | |
| 10 | B12o | Admissions Salary Related to Marketing | 12,180 | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| **Total Other Salaries Adjustment** | | | $ 12,215 | $ - | $ - |

**Schedule of Fees Adjustments**

| Page Ref | Line Ref | Description | CCNH | RHNS | (Specify) |
|---|---|---|---|---|---|
| 13 | B12o | IV Nursing Consultant | $ 8,071 | | |
| 13 | B12o | Rehab Consultant | 14,599 | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| **Total Other Fees Adjustments** | | | $ 22,670 | $ - | $ - |

**Schedule of Other A&G Adjustments**

| Page Ref | Line Ref | Description | CCNH | RHNS | (Specify) |
|---|---|---|---|---|---|
| 16 | m13 | Non Routine Bank Charges | $ 2,743 | | |
| 16 | m8a | Chamber of Commerce Dues | 750 | | |
| 16 | m13 | Miscellaneous Expense | 27,451 | | |
| 15 | Var | Benefits Associated with Marketing Salaries | 3,261 | | |
| | | | | | |
| | | | | | |
| **Total Other A&G Adjustments** | | | $ 34,205 | $ - | $ - |

**National Health Care Associates, Inc. (CT)** **Pg. 28b**
**Disallowance Schedule for Cell Phones**
**September 30, 2019**

| | | Amount | |
|---|---|---|---|
| Total Cell Phone Expense | | 2,444 | **TB Linked** |
| Cell Phone Allowed Based on Bed Capacity | | 4 | |
| Monthly Allowable amount per Cell Phone | $ | 30 | |
| Months in Cost Report Year | | 12 | |
| Total Allowable Cost | $ | 1,440 | |
| Days in Cost Report (365out of 365 Days) | | 365 | |
| Days in Cost Report Year | | 365 | |
| Partial Year Allowable % | | 100% | |
| Revised Allowable Cost | $ | 1,440 | |
| **Disallowed Cell Phone (Page 28, Line 12)** | **$** | **1,004** | |

**Bloomfield Health Center for Nursing & Rehab** 
**Calculation of Allowable Management Fee**
**September 30, 2019**

| Descrption | Amount | | | |
|---|---|---|---|---|
| Management fees Charged | 493,418 | Page 16, Line m12 | | |
| Accounting Charges | 20,400 | Page 15, Line 1d | | |
| Total Management Fees Per Agreement | 513,818 | | | |
| Patient Days | 33,334 | Page 8 of C/R | | |
| Imputed Days - 90% Occupancy (365/365 Days) | 39,420 | Calculation | | |
| **Amount Per Patient Day (Greater of 90% or Actaul Days)** | | | **$** | **13.03** |
| PPD Allowance Per Client 9/30/18 | | | 7.81 | J.01a |
| 2019 CPI Increase % | | | 1.01% | J.01b |
| PPD Allowance 9/30/2019 | | | 7.82 | |
| **Amount over (Under)** | | | **$** | **5.2143** |
| Total Days | | | 39,420 | Page 8 of C/R |
| **Disallowed Management Fee** | | | **$** | **205,546** |

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-29 Rev. 9/2018

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

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 29 | 37 |

| Item No. | Page No. | Line No. | Item Description | | Total Amount of Decrease | CCNH | RHNS | (Specify) |
|---|---|---|---|---|---|---|---|---|
| | | | Subtotals Brought Forward | $ | 652,192 | 652,192 | | |
| ***Page 20 - Resident Care Supplies****** | | | | | | | | |
| 27. | 20 | 5a2 | Prescription Drugs | $ | 207,355 | 207,355 | | |
| 28. | 20 | 5d | Ambulance/Limousine | $ | 6,675 | 6,675 | | |
| 29. | 20 | 5f | X-rays, etc | $ | 6,828 | 6,828 | | |
| 30. | 20 | 5h | Laboratory | $ | 12,080 | 12,080 | | |
| 31. | | | Medical Supplies | $ | | | | |
| 32. | 20 | 5e2 | Oxygen (non emergency) | $ | 4,943 | 4,943 | | |
| 33. | | | Occupational Therapy | $ | | | | |
| 34. | | | Other - See Attached Schedule | $ | 71,472 | 71,472 | | |
| ***Page 22 - Maintenance and Property*** | | | | | | | | |
| 35. | | | Excess Movable Equipment Depreciation See Attached Schedule | $ | 1,335 | 1,335 | | |
| 36. | | | Depreciation on Unallowable Motor Vehicles | $ | | | | |
| 37. | | | Unallowable Property and Real Estate Taxes | $ | | | | |
| 38. | | | Rental of Building Space or Rooms | $ | | | | |
| 39. | | | Other - See Attached Schedule | $ | | | | |
| ***Page 27 - Insurance*** | | | | | | | | |
| 40. | | | Mortgage Insurance | $ | | | | |
| 41. | | | Property Insurance | $ | | | | |
| ***Other - Miscellaneous*** | | | | | | | | |
| 42. | | | Other - Indirect | $ | 4,950 | 4,950 | | |
| 43. | | | Interest Income on Account Rec. | $ | | | | |
| 44. | | | Other - Miscellaneous Administrative | $ | | | | |
| 45. | | | Management Fees Direct | $ | | | | |
| 46. | | | Management Fees Indirect | $ | | | | |
| 47. | | | Other - Direct | $ | 6,501 | 6,501 | | |
| ***Not For Profit Providers Only*** | | | | | | | | |
| 48. | | | Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule | $ | | | | |
| 49. | ***Total Amount of Decrease (Items 1 - 48)*** | | | $ | 974,331 | 974,331 | | |

*** 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 | 5i | Cable Television Disallowance (See Attached) | $ 10,874 | | |
| 20 | 5l | Equipment Rental - Nursing | 27,972 | | |
| 20 | 5l | IV Thy Supplies - Rehab Tpy and Ancllry | 6,312 | | |
| 20 | 5l | Equip Rental - Rehab Tpy and Ancllry | 10,150 | | |
| 20 | 5l | Equip Rental - Respiratory | 14,283 | | |
| 20 | 5c | Part B Nursing Supplies | 1,881 | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| **Total Other Ancillary Costs** | | | $ 71,472 | $ - | $ - |

**Schedule of Excess Movable Equipment Depreciation**

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

**Schedule of Other Property Adjustments**

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

**Schedule of Other - Indirect Adjustments**

| Page Ref | Line Ref | Description | CCNH | RHNS | (Specify) |
|---|---|---|---|---|---|
| 30 | IV1 | Meals sold to guests, employees & others | $ 4,950 | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| **Total Other Adjustments** | | | $ 4,950 | $ - | $ - |

**Schedule of Other - Miscellaneous Administrative Adjustments**

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

**Schedule of Other - Direct Adjustments**

| Page Ref | Line Ref | Description | CCNH | RHNS | (Specify) |
|---|---|---|---|---|---|
| 27 | 12d | Interest Expense on Late Payments | $ 393 | | |
| 30 | IV 8 | ITT Rebate Program Revenue | 623 | | |
| 30 | IV 8 | Synergy Rebate | 5,468 | | |
| 30 | IV 8 | Transcription Income | 17 | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| **Total Other Adjustments** | | | $ 6,501 | $ - | $ - |

**Schedule of Unallowable Building Interest**

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

**National Health Care Associates, Inc. (CT)** **Pg. 29b**
**Cable TV Disallowance**
**September 30, 2019**

| | | | |
|---|---|---|---|
| Total Cable TV Expense | | 14,474 | TB Linked |
| Total Monthy Fee Allowed | $ | 300 | |
| Total Months | | 12 | |
| Total Allowable Expense | $ | 3,600 | |
| Partial Year Cost Report (365 out of 365 Days) | $ | 365 | |
| Days in Cost Report Year | | 365 | |
| Partial Year Allowable % | | 100.00% | |
| Revised Allowable Cost | $ | 3,600 | |
| **Disallowed Expense** | **$** | **10,874** | {a} |

**Tickmark**

{a} Ties to page 29a

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

# F. Statement of Revenue

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LI | 913-C | 9/30/2019 | 30 | 37 |

| Item | | Total | CCNH | RHNS | (Specify) |
|---|---|---|---|---|---|
| **I. Resident Room, Board & Routine Care Revenue** | | | | | |
| 1. a. Medicaid Residents (*CT only*) | $ | 10,882,280 | 10,882,280 | | |
| b. Medicaid Room and Board Contractual Allowance ** | $ | (3,989,374) | (3,989,374) | | |
| 2. a. Medicaid (*All other states*) | $ | | | | |
| b. Other States Room and Board Contractual Allowance ** | $ | | | | |
| 3. a. Medicare Residents *(all inclusive)* | $ | 681,695 | 681,695 | | |
| b. Medicare Room and Board Contractual Allowance ** | $ | 244,712 | 244,712 | | |
| 4. a. Private-Pay Residents and Other | $ | 1,483,295 | 1,483,295 | | |
| b. Private-Pay Room and Board Contractual Allowance ** | $ | (102,269) | (102,269) | | |
| **II. Other Resident Revenue** | | | | | |
| 1. a. Prescription Drugs - Medicare | $ | 84,190 | 84,190 | | |
| b. Prescription Drugs - Medicare Contractual Allowance ** | $ | (84,190) | (84,190) | | |
| c. Prescription Drugs - Non-Medicare | $ | 94,901 | 94,901 | | |
| d. Prescription Drugs - Non-Medicare Contractual Allowance ** | $ | (89,298) | (89,298) | | |
| 2. a. Medical Supplies - Medicare | $ | 2,765 | 2,765 | | |
| b. Medical Supplies - Medicare Contractual Allowance ** | $ | (2,765) | (2,765) | | |
| c. Medical Supplies - Non-Medicare | $ | | | | |
| d. Medical Supplies - Non-Medicare Contractual Allowance ** | $ | | | | |
| 3. a. Physical Therapy - Medicare | $ | 262,787 | 262,787 | | |
| b. Physical Therapy - Medicare Contractual Allowance ** | $ | (163,913) | (163,913) | | |
| c. Physical Therapy - Non-Medicare | $ | 225,298 | 225,298 | | |
| d. Physical Therapy - Non-Medicare Contractual Allowance ** | $ | (162,806) | (162,806) | | |
| 4. a. Speech Therapy - Medicare | $ | 69,858 | 69,858 | | |
| b. Speech Therapy - Medicare Contractual Allowance ** | $ | (50,067) | (50,067) | | |
| c. Speech Therapy - Non-Medicare | $ | 103,521 | 103,521 | | |
| d. Speech Therapy - Non-Medicare Contractual Allowance ** | $ | (89,320) | (89,320) | | |
| 5. a. Occupational Therapy - Medicare | $ | 231,358 | 231,358 | | |
| b. Occupational Therapy - Medicare Contractual Allowance ** | $ | (170,572) | (170,572) | | |
| c. Occupational Therapy - Non-Medicare | $ | 209,057 | 209,057 | | |
| d. Occupational Therapy - Non-Medicare Contractual Allowance ** | $ | (180,086) | (180,086) | | |
| 6. a. Other *(Specify)* - Medicare | $ | 44,031 | 44,031 | | |
| b. Other *(Specify)* - Non-Medicare | $ | 64,638 | 64,638 | | |
| **III. *Total Resident Revenue*** (Section I. thru Section II.) | $ | 9,599,726 | 9,599,726 | | |
| **IV. Other Revenue*** | | | | | |
| 1. Meals sold to guests, employees & others | $ | 4,950 | 4,950 | | |
| 2. Rental of rooms to non-residents | $ | | | | |
| 3. Telephone | $ | | | | |
| 4. Rental of Television and Cable Services | $ | | | | |
| 5. Interest Income *(Specify)* | $ | 61 | 61 | | |
| 6. Private Duty Nurses' Fees | $ | | | | |
| 7. Barber, Coffee, Beauty and Gift shops | $ | | | | |
| 8. Other (*Specify*) | $ | 45,165 | 45,165 | | |
| ***V. Total Other Revenue*** (1 thru 8) | $ | 50,176 | 50,176 | | |
| ***VI. Total All Revenue*** (III +V) | $ | 9,649,902 | 9,649,902 | | |

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

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

**Schedule of Other Resident Revenue - Medicare**

**Related Exp**

| Page Ref | Description | CCNH | RHNS | (Specify) |
|---|---|---|---|---|
| | | - | | |
| 30 II 6a | Medicare Pt A IV Therapy-Bloom- - - | $ 14,236 | | |
| 30 II 6a | Medicare Pt A Lab-Bloom- - - | 28,379 | | |
| 30 II 6a | Medicare Pt A X-Ray-Bloom- - - | 2,036 | | |
| 30 II 6a | Medicare Pt A Settlement-Bloom- - - | 2,246 | | |
| 30 II 6a | Medicare Pt B Prior Period-Bloom- - - | (2,866) | | |
| **Total Other Resident Revenue - Medicare** | | $ 44,031 | $ - | $ - |

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

**Related Exp**

| Page Ref | Description | CCNH | RHNS | (Specify) |
|---|---|---|---|---|
| | | - | | |
| 30 II 6b | Medicaid IV Therapy-Bloom- - - | $ 1 | | |
| 30 II 6b | Medicaid Lab-Bloom- - - | 9,772 | | |
| 30 II 6b | Medicaid X-Ray-Bloom- - - | 325 | | |
| 30 II 6b | Private Lab-Bloom- - - | 236 | | |
| 30 II 6b | Comm Ins IV Therapy-Bloom- - - | 11,957 | | |
| 30 II 6b | Comm Ins Lab-Bloom- - - | 3,945 | | |
| 30 II 6b | Comm Ins X-Ray-Bloom- - - | 494 | | |
| 30 II 6b | Mgd Medicare IV Therapy | 5,575 | | |
| 30 II 6b | Mgd Medicare Lab | 26,030 | | |
| 30 II 6b | Mgd Medicare Specialty Beds | 4,226 | | |
| 30 II 6b | Mgd Medicare X-Ray | 4,038 | | |
| 30 II 6b | Mgd Medicare Prior Period | (1,961) | | |
| **Total Other Resident Revenue** | | $ 64,638 | $ - | $ - |

## Interest Income

**Account**

| Page Ref | Account | Balance | CCNH | RHNS | (Specify) |
|---|---|---|---|---|---|
| | | | - | | |
| 30 IV 5 | Interest on Money Market Account | 84,147 | $ 61 | | |
| | | | | | |
| | | | | | |
| **Total Interest Income** | | | $ 61 | $ - | $ - |

**Schedule of Other Revenue**

| Page Ref | Description | CCNH | RHNS | (Specify) |
|---|---|---|---|---|
| | | - | | |
| 30 IV 8 | United Health Care Dividends | $ 15,138 | | |
| 30 IV 8 | ITT Rebate Program Revenue (Disallowed on Pg 29a) | 623 | | |
| 30 IV 8 | Stericycle Class Action Settlement (No CY Expense) | 101 | | |
| 30 IV 8 | Synergy Rebate (Disallowed on Pg 29a) | 5,468 | | |
| 30 IV 8 | Prior Period Revenue | 12,882 | | |
| 30 IV 8 | Transcription Income (Disallowed on Pg 29a) | 17 | | |
| 30 IV 8 | Credit from PY | 10,936 | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Total Other Revenue** | | $ 45,165 | $ - | $ - |

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

# G. Balance Sheet

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, I | 913-C | 9/30/2019 | 31 | 37 |

| Account | | | | Amount |
|---|---|---|---|---|
| **Assets** | | | | |
| A. Current Assets | | | | |
| 1. Cash (*on hand and in banks*) | | | | $ 263,890 |
| 2. Resident Accounts Receivable (Less Allowance for Bad Debts) | | | | $ 1,125,743 |
| 3. Other Accounts Receivable (Excluding Owners or Related Parties) | | | | $ |
| 4 Inventories | | | | $ 16,651 |
| 5. Prepaid Expenses | | | | $ 102,161 |
| a. | | | | |
| b. | | | | |
| c. | | | | |
| d. See Schedule | | 102,161 | | |
| 6. Interest Receivable | | | | $ |
| 7. Medicare Final Settlement Receivable | | | | $ |
| 8. Other Current Assets (*itemize*) | | | | $ |
| See Schedule | | | | |
| A-9. ***Total Current Assets*** (Lines A1 thru 8) | | | | $ 1,508,445 |
| B. Fixed Assets | | | | |
| 1. Land | | | | $ |
| 2. Land Improvements | *Historical Cost | | | $ |
| | Accum. Depreciation | | Net | |
| 3. Buildings | *Historical Cost | | | $ |
| | Accum. Depreciation | | Net | |
| 4. Leasehold Improvements | *Historical Cost | 910,734 | | $ 384,539 |
| | Accum. Depreciation | 526,195 | Net | |
| 5. Non-Movable Equipment | *Historical Cost | 36,366 | | $ 1,631 |
| | Accum. Depreciation | 34,735 | Net | |
| 6. Movable Equipment | *Historical Cost | 596,222 | | $ 350,707 |
| | Accum. Depreciation | 245,515 | Net | |
| 7. Motor Vehicles | *Historical Cost | | | $ |
| | Accum. Depreciation | | Net | |
| 8. Minor Equipment-Not Depreciable | | | | $ |
| 9. Other Fixed Assets (*itemize*) | | | | $ (1) |
| Rounding | | (1) | | |
| See Schedule | | | | |
| B-10. ***Total Fixed Assets*** (Lines B1 thru 9) | | | | $ 736,876 |

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

(*Carry Total forward to next page*)

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

# G. Balance Sheet (cont'd)

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, L | 913-C | 9/30/2019 | 32 | 37 |

| Account | | | | Amount |
|---|---|---|---|---|
| | | | Total Brought Forward: | $ 2,245,321 |
| C. Leasehold or like property recorded for Equity Purposes. | | | | |
| 1. Land | | | | $ |
| 2. Land Improvements | *Historical Cost | | | |
| | Accum. Depreciation | | Net | $ |
| 3. Buildings | *Historical Cost | | | |
| | Accum. Depreciation | | Net | $ |
| 4. Non-Movable Equipment | *Historical Cost | | | |
| | Accum. Depreciation | | Net | $ |
| 5. Movable Equipment | *Historical Cost | | | |
| | Accum. Depreciation | | Net | $ |
| 6. Motor Vehicles | *Historical Cost | | | |
| | Accum. Depreciation | | Net | $ |
| 7. Minor Equipment-Not Depreciable | | | | $ |
| C-8 ***Total Leasehold or Like Properties*** (C1 thru 7) | | | | $ |
| D. Investment and Other Assets | | | | |
| 1. Deferred Deposits | | | | $ |
| 2. Escrow Deposits | | | | $ |
| 3. Organization Expense | *Historical Cost | | | |
| | Accum. Depreciation | | Net | $ |
| 4. Goodwill (Purchased Only) | | | | $ |
| 5. Investments Related to Resident Care (*itemize*) | | | | $ |
| 6. Loans to Owners or Related Parties (*itemize*) | | | | $ 140 |
| Name and Address | Amount | Loan Date | | |
| Due from Related | 140 | | | |
| 7. Other Assets (*itemize*) | | | | $ 11,500 |
| Security Deposits | | 11,500 | | |
| See Schedule | | | | |
| D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7) | | | | $ 11,640 |
| D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8) | | | | $ 2,256,961 |

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

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-33 Rev. 6/95

# G. Balance Sheet (cont'd)

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 33 | 37 |

| Account | | | | Amount |
|---|---|---|---|---|
| **Liabilities** | | | | |
| A. Current Liabilities | | | | |
| 1. Trade Accounts Payable | | | | $ 700,468 |
| 2. Notes Payable (*itemize*) | | | | $ 63,142 |
| Notes Payable ST2-Bloom- - - | | 25,413 | | |
| Notes Payable ST4-Bloom- - - | | 2,549 | | |
| Notes Payable ST5-Bloom- - - | | 35,180 | | |
| See Schedule | | | | |
| 3. Loans Payable for Equipment (*Current portion*) (*itemize*) | | | | $ 20,714 |
| Name of Lender | Purpose | Amount | Date Due | |
| M&T Bank | Equipment | 20,714 | Various | |
| 4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*) | | | | $ 272,406 |
| 5. Accrued Payroll (*Owners and/or Stockholders only*) | | | | $ |
| 6. Accrued Payroll Taxes Payable | | | | $ |
| 7. Medicare Final Settlement Payable | | | | $ |
| 8. Medicare Current Financing Payable | | | | $ |
| 9. Mortgage Payable (*Current Portion*) | | | | $ |
| 10. Interest Payable (*Exclusive of Owner and/or Related Parties*) | | | | $ |
| 11. Accrued Income Taxes* | | | | $ |
| 12. Other Current Liabilities (*itemize*) | | | | $ 313,505 |
| See Schedule | | 313,505 | | |
| A-13. ***Total Current Liabilities*** (Lines A1 thru 12) | | | | $ 1,370,235 |

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

*(Carry Total forward to next page)*

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

# G. Balance Sheet (cont'd)

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 34 | 37 |

| Account | Amount |
|---|---|
| Total Brought Forward: | 1,370,235 |
| **Liabilities (cont'd)** | |
| B. Long-Term Liabilities | |
| 1. Loans Payable-Equipment (*itemize*) | $ 106,919 |

| Name of Lender | Purpose | Amount | Date Due |
|---|---|---|---|
| M&T Bank | Equipment | 106,919 | Various |

| | |
|---|---|
| 2. Mortgages Payable | $ |
| 3. Loans from Owners or Related Parties (*itemize*) | $ 7,673,505 |

| Name and Address of Lender | Amount | Loan Date |
|---|---|---|
| Due to Realty / Related | 7,673,505 | |

| | | |
|---|---|---|
| 4. Other Long-Term Liabilities (*itemize*) | | $ 113,595 |
| Notes Payable | 34,654 | |
| Due to Medicaid | 78,941 | |
| | | |
| See Schedule | | |
| B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4) | | $ 7,894,019 |
| C. ***Total All Liabilities*** (Lines A-13 + B-5) | | $ 9,264,254 |

Schedule of Prepaid Expenses Page 31 Line A5

| Page Ref | Line Ref | Description | |
|---|---|---|---|
| 31 | A5 | Prepaid Workers Comp | $ 13,979 |
| 31 | A5 | Prepaid Gen Insurance | 5,146 |
| 31 | A5 | Prepaid Expenses Other | 5,874 |
| 31 | A5 | Prepaid Real Estate Taxes | 27,693 |
| 31 | A5 | Prepaid Personal Property Taxes | 11,190 |
| 31 | A5 | Prepaid Mgmt Assets | 38,279 |
| | | | |
| Total Prepaid Expenses | | | $ 102,161 |

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

| Page Ref | Line Ref | Description | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Total Other Current Assets (Itemize) | | | $ - |

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

| Page Ref | Line Ref | Description | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Total Other Other Fixed Assets (Itemize) | | | $ - |

Schedule of Other Assets Page 32 Line D7

| Page Ref | Line Ref | Description | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Total Other Assets | | | $ - |

Schedule of Notes Payable (Itemize) Page 33 Line A2

| Page Ref | Line Ref | Description | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Total Notes Payable | | | $ - |

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

| Page Ref | Line Ref | Description | |
|---|---|---|---|
| 33 | A12 | Loans and Exchange | $ 60 |
| 33 | A12 | Unclaimed ADP Checks | 4,179 |
| 33 | A12 | Patient Funds | 44,081 |
| 33 | A12 | Patient Recreation Fund | 340 |
| 33 | A12 | Union Dues Payable | 48 |
| 33 | A12 | Accrued Expenses | 195,802 |
| 33 | A12 | Accrued Workers Comp | 54,359 |
| 33 | A12 | Accrued Purchase | 14,636 |
| Total Other Current Liabilities (Itemize) | | | $ 313,505 |

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

| Page Ref | Line Ref | Description | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Total Other Current Liabilities (Itemize) | | | $ - |

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-35 Rev. 6/95

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

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, | 913-C | 9/30/2019 | 35 | 37 |

| Account | | Amount |
|---|---|---|
| A. | **Reserves** | |
| | 1. Reserve for value of leased land | $ |
| | 2. Reserve for depreciation value of leased buildings and appurtenances to be amortized | $ |
| | 3. Reserve for depreciation value of leased personal property (*Equity)* | $ |
| | 4. Reserve for leasehold real properties on which fair rental value is based | $ |
| | 5. Reserve for funds set aside as donor restricted | $ |
| | 6. Total Reserves | $ |
| B. | **Net Worth** | |
| | 1. Owner's Capital | $ |
| | 2. Capital Stock | $ |
| | 3. Paid-in Surplus | $ |
| | 4. Treasury Stock | $ |
| | 5. Cumulated Earnings | $ (6,184,285) |
| | 6. Gain or Loss for Period 10/1/2018 thru 9/30/2019 | $ (823,008) |
| | 7. Total Net Worth | $ (7,007,293) |
| C. | ***Total Reserves and Net Worth*** | $ (7,007,293) |
| D. | ***Total Liabilities, Reserves, and Net Worth*** | $ 2,256,961 |

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

# H. Changes in Total Net Worth

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LL | 913-C | 9/30/2019 | 36 | 37 |

| Account | | | | Amount |
|---|---|---|---|---|
| A. | Balance at End of Prior Period as shown on Report of 09/30/2018 | | | $ (6,184,285) |
| B. | Total Revenue (*From Statement of Revenue Page 30*) | | | $ 9,649,902 |
| C. | Total Expenditures (*From Statement of Expenditures Page 27*) | | | $ 10,472,910 |
| D. | Net Income or Deficit | | | $ (823,008) |
| E. | Balance | | | $ (7,007,293) |
| F. | Additions | | | |
| | 1. Additional Capital Contributed (*itemize*) | | | |
| | 2. Other (*itemize*) | | | |
| F-3. | Total Additions | | | $ |
| G. | Deductions | | | |
| | 1. Drawings of Owners/Operators/Partners (*Specify*) | | | $ |
| | Name and Address (*No., City, State, Zip*) | Title | Amount | |
| | | | | |
| | 2. Other Withdrawings *(Specify)* | | | $ |
| | Purpose | | Amount | |
| | | | | |
| | 3. Total Deductions | | | $ |
| H. | ***Balance at End of Period*** | 09/30/19 | | $ (7,007,293) |

State of Connecticut
**Annual Report of Long-Term Care Facility**
CSP-37 Rev. 9/2002

# I. Preparer's/Reviewer's Certification

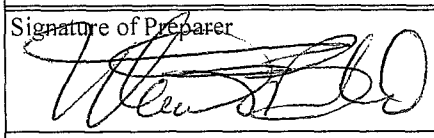
| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|---|---|---|---|
| Bloomfield Health Care Center of CT, LLC | 913-C | 9/30/2019 | 37 | 37 |

*Check appropriate category*

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

## Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

| Signature of Preparer | Title | Date Signed |
|---|---|---|
|  | PRINCIPAL | 2/13/20 |

| Printed Name of Preparer | |
|---|---|
| Matthew S. Bavolack | |
| Addres Address | Phone Number |
| 555 Long Wharf Drive, New Haven, CT 06511 | 203-781-9600 |
| Contacted Person Regarding Additional Information Needed Regarding This Report | Phone Number |
| John Phelps | 516-705-4813 |
| Contact Email Address | |
| jphelps@nathealthcare.com | |

MARCUM
ADVISORY ▲ CONSULTING

## ACCOUNTANTS' CONSULTING REPORT

Management is responsible for the accompanying Annual Report of Long-Term Care Facility (the "Cost Report") for Bloomfield Health Care Center for Nursing and Rehabilitation for the year ended September 30, 2019, included in the accompanying prescribed form. We have prepared the Cost Report in accordance with the American Institute of Certified Public Accountants' Statements on Standards for Consulting Services. The Cost Report was prepared in conformity with regulations prescribed by The State of CT Department of Social Services (DSS) from data provided to us by the management of Bloomfield Health Care Center for Nursing and Rehabilitation. We did not audit or review the Cost Report included in the accompanying prescribed form, nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any form of assurance on the Cost Report included in the accompanying prescribed form.

Management is responsible for maintaining its records in accordance with accounting principles generally accepted in the United States of America and in accordance with reimbursement regulations set forth by DSS. Management is also responsible for designing, implementing, and maintaining internal control relevant to the preparation and fair presentation of the financial data and supplemental information included in the Cost Report.

This report is intended solely for the information and use of the management Bloomfield Health Care Center for Nursing and Rehabilitation and DSS and is not intended to be, and should not be, used by anyone other than these specified parties.

*MARCUM LLP*

New Haven, CT
February 6, 2020

# Annual Report of Long-Term Care Facility Cost Year 2019 Checklist

This checklist is not required to be submitted with the Annual Report

**Facility Name** Bloomfield Health Care Center of CT, LLC

Complete the following check list. **Provide an explanation for any *"No" answers.*** Attach additional sheets to explain further, if necessary.

| Yes | No | |
|---|---|---|
| ✓ | | 1. Have all related parties been properly disclosed on Pages 4, 11, 12, 14, 17 and 21? |

**Explanation:** _____

| Yes | No | |
|---|---|---|
| ✓ | | 2. Are the methods of allocating costs consistent with prior year? If not, explain the reporting change. |

**Explanation:** _____

| Yes | No | |
|---|---|---|
| ✓ | | 3. Are costs allocated based on the methods prescribed on Page 5 of the Annual Report? If not, provide the basis of your allocation. |

**Explanation:** _____

| Yes | No | |
|---|---|---|
| ✓ | | 4. Do equipment leases listed on Page 6 agree with equipment leases reported on Page 22, Line 6e? If not, state where these costs are included in the Annual Report. |

**Explanation:** _____

Yes [✓] No [ ]

5. Do accounting and legal fees reported on Page 7 agree with Page 15, Lines 1d and 1e, respectively?

**Explanation:** _____

Yes [✓] No [ ]

6. During cost year, did you report all certified bed changes on Page 9? Do the bed change dates agree to the license issued by the Department of Health?

**Explanation:** _____

Yes [✓] No [ ]

7. If there has been a change in Administrators, have the dates of employment and applicable hours for each Administrator been reported on Page 12?

**Explanation:** _____

Yes [✓] No [ ]

8. Have hours been reported for all expenses claimed on Page 13? Hours must be actual rather than estimated.

**Explanation:** _____

Yes [✓] No [ ]

9. Has resident day user fee expense been properly reported on Page 15, Line 1k3?

**Explanation:** _____

Yes [✓] No [ ]

10. Have purchased services greater than $10,000 reported on Pages 16, 18, 19, 20 and 22 been detailed on Page 21?

**Explanation:** _____

Yes [✓] No [ ]

11. Have the dietary and laundry questionnaires on Pages 18 and 19 been completed?

**Explanation:** _____

Yes [✓] No [ ]

12. Has the personal use portion of automobile expense been disallowed, including, depreciation, lease payments, insurance and taxes?

**Explanation:** _____

Yes [✓] No [ ]

13. Does historical cost and accumulated depreciation of all assets reported on Pages 23 and 24 roll forward from the prior cost year?

**Explanation:** _____

Yes [✓] No [ ]

14. Does the net book value of all assets reported on Pages 23 and 24 agree with the net book value reported on Pages 31 and 32?

**Explanation:** _____

Yes [✓] No [ ]

15. Has asset useful life been reported in accordance with the 2013 edition of the American Hospital Association guidelines?

**Explanation:** _____

Yes [✓] No [ ]

16. Have all assets been categorized between movable and fixed in accordance with the 2013 edition of the American Hospital Association guidelines?

**Explanation:** _____

Yes [✓] No [ ]

17. Have all contractual allowances been properly reported on Page 30?

**Explanation:** _____

_____

Yes [✓] No [ ]

18. Were all discrepancies on the Error Page addressed?

**Explanation:** _____

_____

Yes [✓] No [ ]

19. Have Pages 1 and 37 been signed? ***Cost reports without a signed Page 1 and 37 will not be accepted.***

**Explanation:** _____

_____

Yes [✓] No [ ]

20. Have detailed schedules been provided for all "other" line items, fixed asset and movable equipment additions? ***If detail is not provided, appropriate disallowances will be made.***

**Explanation:** _____

_____

Yes [✓] No [ ]

21. Have all costs associated with non-nursing home businesses (i.e., Adult Daycare, Meals on Wheels, Outpatient Therapy Services, etc.) been disallowed on Pages 28 and/or 29 of the Annual Report?

**Explanation:** _____

_____

Yes [✓] No [ ]

22. Has all required documentation been submitted to the Annual Report review and audit contractor?

**Explanation:** _____

_____