State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2018

Name of Facility (as licensed) Bloomfield Health Care Center of CT, LLC	
Address (No. & Street, City, State, Zip Code) 355 Park Ave Bloomfield, CT 06002	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)	
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	9134		

For Department Use Only

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

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General Information

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Bloomfield Health Care Center of CT, LLC	913-C	9/30/2018	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, 2017 and ending September 30, 2018, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

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

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Bloomfield Health Care Center of CT, LLC	Period Covered:		From 10/1/2017	To 9/30/2018
Address of Facility 355 Park Ave Bloomfield, CT 06002				
Report Prepared By Blum, Shapiro & Company, P.C.	Phone Number (203) 944-2100		Date 2/11/2019	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-242-8595	9/30/2018	2	37

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

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

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

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

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
Bloomfield Health Care Center of CT, LLC	355 Park Ave Bloomfield, CT 06002	CT

Name of Partners/Members	Business Address	Title	% Owned
Marvin J. Ostreicher	355 Park Ave Bloomfield, CT 06002	President	50%
Agnes Zitter	355 Park Ave Bloomfield, CT 06002		50%

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2018	3A	37

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

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

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

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General Information and Questionnaire
Individual Proprietorship

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⊙ No

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

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

If "Yes," provide the following information:

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

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

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

N/A

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Reliable Health Systems, Nostrand Ave, Brooklyn, NY 11230	○	⊙	Computer Equipment	10/01/08	60 / ongoing	3,708	3,708
Wescom Solutions, PO Box 674802, Detroit, MI 48267	○	⊙	Software	03/07/12	Ongoing	24,177	24,177
Leaf, P.O. Box 644006, Cincinnati, OH 45264	○	⊙	Copier	01/01/16	39 months	4,588	4,545
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total ***** 32,430

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1	Compilation, preparation of Medicare and Medicaid cost reports, and year end tax services	$ 24,630
2		$
3		$
4		$
		Charge for Services Provided: $ 24,630

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

⊙ Yes ○ No — Page 15, line 1D

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 See attachment	
2	
3	
4	
5	

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	See attachment	$ 48,913
2		$
3		$
4		$
5		$
		Charge for Services Provided: $ 48,913

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

⊙ Yes ○ No — Page 15, line 1e

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Schedule of Resident Statistics

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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30 Total	Period 10/1 Thru 6/30 CCNH	Period 10/1 Thru 6/30 RHNS	Period 10/1 Thru 6/30 (Specify)	Period 7/1 Thru 9/30 Total	Period 7/1 Thru 9/30 CCNH	Period 7/1 Thru 9/30 RHNS	Period 7/1 Thru 9/30 (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	97	97			97	97			84	84		
B. As of midnight of THIS report period	81	81			84	84			81	81		
3. Total Number of Days Care Provided During Period												
A. Medicare	3,364	3,364			2,763	2,763			601	601		
B. Medicaid (Conn.)	26,713	26,713			20,303	20,303			6,410	6,410		
C. Medicaid (other states)												
D. Private Pay	880	880			484	484			396	396		
E. State SSI for RCH												
F. Other (Specify) Managed Care	312	312			267	267			45	45		
G. Total Care Days During Period (3A thru F)	31,269	31,269			23,817	23,817			7,452	7,452		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	31,269	31,269			23,817	23,817			7,452	7,452		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	6	64		11				
Per Diem Rate								
a. One bed rm.	PPS	242.61		415.00				
b. Two bed rms.	PPS	242.61		385.00				
c. Three or more bed rms.	PPS							

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	6,525	6,525		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	1,531	1,531		
C. Other	7,020	7,020		
D. ***Total Physical Therapy Treatments***	15,076	15,076		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	606	606		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	211	211		
C. Other	1,215	1,215		
D. ***Total Speech Therapy Treatments***	2,032	2,032		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	3,670	3,670		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	1,423	1,423		
C. Other	7,232	7,232		
D. ***Total Occupational Therapy Treatments***	12,325	12,325		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)		53				
2. Administrator(s) (Complete also Sec. III of Schedule A1)	143,871	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	117,696	4,866				
5. Dietary Service						
a. Head Dietitian	26,772	783				
b. Food Service Supervisor	48,905	1,760				
c. Dietary Workers	350,999	19,836				
6. Housekeeping Service						
a. Head Housekeeper	57,505	2,080				
b. Other Housekeeping Workers	200,324	12,588				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	51,426	1,640				
b. Other Maintenance Workers	28,570	1,745				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	146,795	8,037				
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	154,821	2,896				
b. RN						
1. Direct Care	475,689	11,328				
2. Administrative**	77,096	1,631				
c. LPN						
1. Direct Care	807,190	28,218				
2. Administrative**						
d. Aides and Attendants	1,408,065	80,936				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	92,988	4,624				
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	99,007	3,458				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	4,287,719	188,559				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Therapy Consulting - Nursing	$ 27,991	Disallowed				
Therapy Consulting - Rehab Therapy and Ancillary	$ 24,667	Disallowed				
Total	$ 52,658	Disallowed	$ -	-	$ -	-

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

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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Marvin J. Ostreicher, 184 Wildacre Ave, Lawrence, NY 11559				Same as employees	Supervises operations, deals with DNS & financial management	53	p.16/ m13	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.

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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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	143,871			Same as employees	Management and supervision of a healthcare facility	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.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2018	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	863	16				
2. Dentist	8,552	Disallowed				
3. Pharmacist	10,097	Disallowed				
4. Podiatrist	81	Disallowed				
5. Physical Therapy						
a. Resident Care	314,360	5,938				
b. Other						
6. Social Worker	3,612	197				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	36,300	253				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	156	4				
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	85,324	1,362				
b. Other						
10. Occupational Therapist						
a. Resident Care	239,067	3,879				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	94,052	1,291				
2. Administrative***						
b. LPN						
1. Direct Care	12,549	271				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	52,658	Disallowed				
B-13 Total Fees Paid in Lieu of Salaries	857,671	13,211				

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

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

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

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

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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 06109	Dentist	○	⊙	
Procare LTC of CT - 111 Executive Blvd. Farmingdale, NY 11735	Pharmacist / Consult nursing	⊙	○	Common Ownership
Preferred Thearpy - 809 Main St. E.Hartford, CT 06108	PT, OT, ST / Consult Rehab	⊙	○	Common Ownership
Dr Santo Buccheri - 357 Franklin Ave Hartford, CT 06114	Medical Director	○	⊙	
HealthDrive Audiology Group - 888 Worcester Street Wellesly, MA 02482-3744	Resident Care	○	⊙	
Prime Healthcare - 30 Jordan Lane Wethersfield, CT 06109-1244	Resident Care	○	⊙	
The Nurse Network - 653 Main Street Plantsville, CT 06479	RN & LPN	○	⊙	
Mass Tex Imaging - 3 Electronics Ave #201 Danvers, MA 01923-1099	RN	○	⊙	
Maxim Staffing Solutions - 12558 Collections Center Drive Chicago, IL 60693	RN	○	⊙	
Maple View Manor of CT, LLC - 856 Maple Street Rocky Hill, CT 06067	Social Worker	⊙	○	Common Ownership
Regency House of Wallingford, Inc. - 181 East Main Street Wallingford, CT 06492	Dieticians	⊙	○	Common Ownership
Cambridge Manor of Fairfield, LLC - 2428 Easton Turnpike Fairfield, CT 06825	Dieticians	⊙	○	Common Ownership
Steven Blume DPM - 129 Peach Tree Road Glastonbury, CT 06033	Podiatrtist	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2018	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	311,730	311,730		
2. Disability Insurance	$				
3. Unemployment Insurance	$	71,153	71,153		
4. Social Security (F.I.C.A.)	$	317,243	317,243		
5. Health Insurance	$	522,063	522,063		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$				
(not-owners and not-operators)					
8. Uniform Allowance	$	30,450	30,450		
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	24,630	24,630		
e. Legal (*Services should be fully described on Page 7)*	$	48,913	48,913		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	16,323	16,323		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	30,557	30,557		
2. Cellular Phones	$	2,253	2,253		
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	$	586,563	586,563		
Subtotal	$	1,962,128	1,962,128		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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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	9/30/2018	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,962,128	1,962,128		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	1,322	1,322		
4. Employee Travel	$	2,807	2,807		
5. Education Expenses Related to Seminars and Conventions	$	30	30		
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*)	$	8,505	8,505		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	20,119	20,119		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	2,213	2,213		
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	8,539	8,539		
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	1,907	1,907		
10. Contributions***	$	675	675		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$	437,200	437,200		
13. Other (*Specify*)	$	178,872	178,872		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,624,317	2,624,317		

* 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	$ 20,119		
Total Other Advertising	$ 20,119	$ -	$ -

Schedule of Dues

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

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Political Contributions - Disallowed	$ 675		
Total Contributions	$ 675	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Charges - Disallowed	$ 22,617		
Licenses & Permits	$ 2,222		
Miscellaneous Expenses - Disallowed	$ 3,624		
Purchased Services - Admin Staff	$ 20,800		
Purchased Services - Fiscal Operations	$ 19,804		
Penalties - Disallowed	$ 9,865		
Consulting Fees - Administration	$ 54,289		
Background Check - Admin	$ 3,939		
Crime Insurance - Disallowed	$ 618		
IT Services - Admin	$ 37,991		
Purchased Services - Administration	$ 365		
Prior Period Expense - Disallowed	$ 2,738		
Total Other Administrative and General	$ 178,872	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
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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.	437,200	See Attached	Page 16, line M12

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

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

Name of Facility	License No.	Report for Year Ended	Page
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2018	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	253,012	253,012		
2. Non-Food Supplies	$	27,664	27,664		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	280,676	280,676		

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2018	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	6,338	6,338		
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*) Diapers - $31,042, Supplies - $7,374	$	38,416	38,416		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	44,754	44,754		

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2018	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.	$	23,083	23,083		
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)		$	23,083	23,083		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from PCA		$	176,400	176,400		
b. Medicine Cabinet Drugs		$	11,669	11,669		
c. Medical and Therapeutic Supplies		$	90,048	90,048		
d. Ambulance/Limousine***		$	12,213	12,213		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	351	351		
f. X-rays and Related Radiological Procedures***		$	5,754	5,754		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	8,124	8,124		
i. Recreation		$	34,431	34,431		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	42,860	42,860		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	381,850	381,850		

* 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)
IV Therapy Supplies - Rehab Therapy and Ancillary	7,514		
Purchased Services - Nursing	791		
Rental Expense - Recreation Therapy	135		
Equipment Rental - Nursing	9,976		
Equipment Rental - Rehab Therapy and Ancillary	13,278		
Equipment Rental - Respiratory	11,166		
Total Other Resident Care	$ 42,860	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2018	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
ADM Environmental Group	Avenue, Brooklyn, Ny 11230	○	⊙		Waster Service/ Monthly Recycling Service	24,984			22	6f
ADP	P.O. Box 842875, Boston, MA 02284	○	⊙		Payroll Processing	11,081			16	m13
M.J Daly & Sons	110 Mattatuck HTS, Waterbury CT 06705	○	⊙		HVAC	15,244			22	6A
Xtreme Landscaping	40 Stark Drive East Granby, CT 06026	○	⊙		Landscaping/ Snow Removal	14,559			22	6F
Smart Care Equipment	P.O. Box 74008980 Chicago, IL 60674-8980	○	⊙		Dietary Equipment Repair	11,748			18	2b
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2018	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	96,615	96,615		
b. Heat	$	64,144	64,144		
c. Light & Power	$	126,919	126,919		
d. Water	$	24,240	24,240		
e. Equipment Lease (*Provide detail on page 6*)	$	32,430	32,430		
f. Other (*itemize*)	$	70,939	70,939		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	415,287	415,287		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	1,155	1,155		
d. Movable Equipment	$	65,949	65,949		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	67,104	67,104		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	70,472	70,472		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	70,472	70,472		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	845,000	845,000		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	112,162	112,162		
c. Personal property taxes	$	13,990	13,990		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,108,728	1,108,728		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Pest Control	$ 3,507		
Plowing/Landscaping	$ 14,559		
Security	$ 6,419		
Carting	$ 29,727		
Ground Supplies	$ 138		
Consulting Fees	$ 15,555		
Short Term Lease - Pitney Bowes Postage Meter	$ 1,034		
Total Other Repairs and Maintenance	$ 70,939	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2018	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				
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			32,425	SL	30	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		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					520,494			112,151	SL	Various	64,624	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					38,026				SL	Various	1,325	
D-3. Subtotal												65,949
E. ***Total Depreciation***												67,104

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Schedule of Land Improvements Acquired during this report period

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

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

Schedule of Building Improvements Acquired during this report period

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

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

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Non-Movable Equipment		$ -		$ -	*
Deletions:					
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:					
11/30/2017	Compressor	$ 2,287	12	$ 175	
1/31/2018	Food Blender	$ 1,330	5	$ 199	
4/30/2018	Dryer Motor	$ 1,638	10	$ 82	
4/30/2018	Washer	$ 13,355	15	$ 445	
7/31/2018	Security Camera Monitor	$ 991	5	$ 50	
8/21/2018	Disposer	$ 1,832	5	$ 61	
8/29/2018	Pump	$ 1,018	10	$ 17	
8/31/2018	Pump	$ 1,018	10	$ 17	
8/31/2018	Ice Machine	$ 4,733	10	$ 79	
8/31/2018	Circulator Pump	$ 5,943	8	$ 124	
8/31/2018	Door Conversion Kit Install	$ 2,842	10	$ 47	
9/30/2018	Chromebook	$ 1,039	3	$ 29	
Total additions for Movable Equipment		$ 38,026		$ 1,325	*
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:					
10/1/2017	ILED Lights	$ 1,966	15	$ 131	
11/30/2017	Door Materials	$ 3,669	10	$ 306	
12/7/2017	Door Locks	$ 739	5	$ 123	
6/30/2018	Fan Motor, Blade Instasll	$ 1,607	10	$ 54	
9/30/2018	Fan Replacement	$ 6,012	10	$ 50	
Total additions for Leasehold Improvement		$ 13,993		$ 664	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2018	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period			Various	851,559	388,580	SL		69,808	
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)			Various	13,993		SL		664	
C-4. Subtotal									70,472
D. ***Total Amortization***									70,472

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT,	913-C	9/30/2018	25	37

11. Property Questionnaire

Part A

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

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

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

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

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	07/01/02			
c. Interest Rate for the Cost Year	7.33%			
d. Term of Mortgage (number of years)	15			
e. Amount of Principal Borrowed	8,226,480			
f. Principal balance outstanding as of 9/30/18	2,636,346			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of CT	913-C	9/30/2018	26 | 37

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

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of (	913-C	9/30/2018	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*)		$	6,606	6,606		
A. Item	Rate	Amount				
Equipment Loan - Various	4-5%	6,606				
Lender M & T Bank						
Address of Lender PO Box 62176, Baltimore MD 21264						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		$	6,606	6,606		
12. D. Other Interest Expense (*Specify*) Admin. Interest - $7,767, Comp. Loan Int - $3,992		$	11,759	11,759		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)		$	18,365	18,365		
14. Insurance						
a. Insurance on Property (buildings only)		$	10,136	10,136		
b. Insurance on Automobiles		$				
c. Insurance other than Property (as specified above)						
1. Umbrella (*Blanket Coverage*)		$	10,400	10,400		
2. Fire and Extended Coverage		$				
3. Other (*Specify*) Liability Ins - $40,706, Boiler Ins - $116		$	40,822	40,822		
14d. ***Total Insurance Expenditures (14a + b + c)***		$	61,358	61,358		
15. ***Total All Expenditures (A-13 thru C-14)***		$	10,103,808	10,103,808		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2018	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.	10	12M	Salaries not related to Resident Care $	7,625	7,625		
3.			Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians ** $	156	156		
6.	13	B10a	Occupational Therapy $	239,067	239,067		
7.			Other - See attached Schedule $	72,110	72,110		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $				
10.			Accounting $				
10a.			Legal $	45,718	45,718		
11.			Telephone $				
12.	15	1h2	Cellular Telephone $	1,533	1,533		
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.	16	m3	Unallowable Advertising * $	20,119	20,119		
19.	15	1j	Income Tax / Corporate Business Tax $	250	250		
20.	16	m10	Fund Raising / Contributions $	675	675		
21.	16	m12	Unallowable Management Fees $	217,721	217,721		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	154,252	154,252		
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) $	759,226	759,226		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Salaries Adjustment			$ -	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B2	Dentist	$ 8,552		
13	B3	Pharmacist	$ 10,097		
13	B4	Podiatrist	$ 81		
13	B12	Therapy Consulting - Nursing	$ 27,991		
13	B12	Therapy Consulting - Rehab Therapy and Ancillary	$ 24,667		
13	B8a	Excess Disallowed of Medical Director Salary			
13	B6	Consulting Fees - Social Service	$ 722		
Total Other Fees Adjustments			$ 72,110	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
15	Misc.	Benefits on Salaries not Related to Resident Care	$ 2,030		
16	L3	Gifts to Staff and Residents	$ 1,322		
16	M13	Penalties	$ 9,865		
16	M13	Bank Charges	$ 22,617		
16	M13	Misc. Exp	$ 3,624		
16	M13	Crime Insurance	$ 618		
16	M13	Prior Period Expense	$ 2,738		
15	1a1	Workers Compensation Retro Expense	$ 111,438		
Total Other A&G Adjustments			$ 154,252	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2018	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	759,226	759,226		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $	176,400	176,400		
28.	20	5d	Ambulance/Limousine $	12,213	12,213		
29.	20	5f	X-rays, etc $	5,754	5,754		
30.	20	5h	Laboratory $	8,124	8,124		
31.	20	5c	Medical Supplies $	3,441	3,441		
32.	20	500	Oxygen (non emergency) $	351	351		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	55,846	55,846		
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 $				
43.			Interest Income on Account Rec. $				
44.			Other - Miscellaneous Administrative $				
45.			Management Fees Direct $				
46.			Management Fees Indirect $				
47.			Other - Direct $	13,859	13,859		
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)***		$	1,036,549	1,036,549		

*** 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.

Attachment Page 29

Bloomfield Health Care Center of CT, LLC
9/30/2018

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5l	Equipment Rental - Nursing	$ 9,976		
20	5l	Equipment Rental - Rehab/Therapy	$ 13,278		
20	5l	IV Thy Supplies - Rehab Therapy and Ancillary	$ 7,514		
20	5a2 / b	Procare Disallowance Price Markup	$ 353		
20	5I	Cable TV Expense - Resident Rooms	$ 13,293		
20	5l	Purchased Services Nursing	$ 266		
20	5l	Equipment Rental - Respiratory	$ 11,166		
Total Other Ancillary Costs			$ 55,846	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

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

---

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	12D	Interest Expense	$ 7,767		
30	IV5	Interest Income	$ 28		
30	8	Misc. Income - Other	$ 6,064		
Total Other Adjustments			$ 13,859	$ -	$ -

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LL	913-C	9/30/2018	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	9,942,168	9,942,168		
b. Medicaid Room and Board Contractual Allowance **	$	(3,692,639)	(3,692,639)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,292,716	1,292,716		
b. Medicare Room and Board Contractual Allowance **	$	314,612	314,612		
4. a. Private-Pay Residents and Other	$	799,947	799,947		
b. Private-Pay Room and Board Contractual Allowance **	$	(225,808)	(225,808)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	137,058	137,058		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(135,494)	(135,494)		
c. Prescription Drugs - Non-Medicare	$	30,471	30,471		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(25,441)	(25,441)		
2. a. Medical Supplies - Medicare	$	2,772	2,772		
b. Medical Supplies - Medicare Contractual Allowance **	$	(2,772)	(2,772)		
c. Medical Supplies - Non-Medicare	$	81	81		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(81)	(81)		
3. a. Physical Therapy - Medicare	$	471,062	471,062		
b. Physical Therapy - Medicare Contractual Allowance **	$	(270,012)	(270,012)		
c. Physical Therapy - Non-Medicare	$	73,486	73,486		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(70,424)	(70,424)		
4. a. Speech Therapy - Medicare	$	146,668	146,668		
b. Speech Therapy - Medicare Contractual Allowance **	$	(102,170)	(102,170)		
c. Speech Therapy - Non-Medicare	$	36,246	36,246		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(34,270)	(34,270)		
5. a. Occupational Therapy - Medicare	$	412,139	412,139		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(294,618)	(294,618)		
c. Occupational Therapy - Non-Medicare	$	70,973	70,973		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(67,779)	(67,779)		
6. a. Other *(Specify)* - Medicare	$	2,038	2,038		
b. Other *(Specify)* - Non-Medicare	$	1	1		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	8,810,930	8,810,930		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	28	28		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	10,340	10,340		
V. Total Other Revenue (1 thru 8)	$	10,368	10,368		
VI. Total All Revenue (III +V)	$	8,821,298	8,821,298		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30, Line II6a	Medicare A Contra	$ (18,877)		
30, Line II6a	Medicare A Ambulance	$ 1,696		
30, Line II6a	Medicare A IV Therapy	$ 2,589		
30, Line II6a	Medicare A Lab	$ 11,285		
30, Line II6a	Medicare A X-Ray	$ 3,307		
30, Line II6a	Medicare A Settlement	$ 5,613		
30, Line II6a	Medicare B Prior Period	$ (3,575)		
30, Line II6a	Managed Medicare Contra	$ (14,722)		
30, Line II6a	Managed Medicare Ambulance	$ 1,112		
30, Line II6a	Managed Medicare IV Therapy	$ 1,948		
30, Line II6a	Managed Medicare Lab	$ 10,965		
30, Line II6a	Managed Medicare X-Ray	$ 697		
Total Other Resident Revenue - Medicare		$ 2,038	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30, line II6b	Medicaid Contra	$ (1,530)		
30, line II6b	Medicaid IV Therapy	$ 95		
30, line II6b	Medicaid Lab	$ 1,405		
30, line II6b	Medicaid X-Ray	$ 30		
30, line II6b	Commercial Insurance Contra	$ (2,307)		
30, line II6b	Commercial Insurance IV Therapy	$ 1,141		
30, line II6b	Commercial Insurance Lab	$ 405		
30, line II6b	Commercial Insurance X-Ray	$ 762		
Total Other Resident Revenue		$ 1	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30, line IV5	Interest Income (Money Market)		$ 28		
Total Interest Income			$ 28	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30, line IV8	Miscellaneous Other Income	$ 8,449		
30, line IV8	Prior Period	$ 1,725		
30, line IV8	Transcription Income	$ 166		
Total Other Revenue		$ 10,340	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, I	913-C	9/30/2018	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 198,728
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,216,939
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 16,771
5. Prepaid Expenses				$ 107,902
a. Insurance		287		
b. Taxes (Personal Property & Real Estate)		40,207		
c. Management Fees		43,103		
d. See Schedule		24,305		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 24,857
Patient Funds		24,857		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,565,197
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	887,892		$ 428,840
	Accum. Depreciation	459,052	Net	
5. Non-Movable Equipment	*Historical Cost	36,366		$ 2,786
	Accum. Depreciation	33,580	Net	
6. Movable Equipment	*Historical Cost	536,180		$ 358,080
	Accum. Depreciation	178,100	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 789,706

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, I	913-C	9/30/2018	32	37

	Account				Amount
			Total Brought Forward:	$	2,354,903
C.	Leasehold or like property recorded for Equity Purposes.				
	1. Land			$	
	2. Land Improvements	*Historical Cost			
		Accum. Depreciation	Net	$	
	3. Buildings	*Historical Cost	5,657,365		
		Accum. Depreciation	4,961,152 Net	$	696,213
	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)			$	696,213
D.	Investment and Other Assets				
	1. Deferred Deposits			$	
	2. Escrow Deposits			$	
	3. Organization Expense	*Historical Cost			
		Accum. Depreciation	Net	$	
	4. Goodwill (Purchased Only)			$	
	5. Investments Related to Resident Care (*itemize*)			$	
	6. Loans to Owners or Related Parties (*itemize*)			$	
	Name and Address	Amount	Loan Date		
	7. Other Assets (*itemize*)			$	11,500
	Security Deposits		11,500		
	See Schedule				
D-8.	***Total Investments and Other Assets*** (Lines D1 thru 7)			$	11,500
D-9.	***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$	3,062,616

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

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	A5	Other	$ 9,282
31	A5	Worker's Compensation	$ 15,023
Total Prepaid Expenses			$ 24,305

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	Due to Realty	400,000
Total Other Current Liabilities (Itemize)			$ 400,000

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

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2018	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 2,838,697
	2. Notes Payable (*itemize*)				$
	See Schedule				
	3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$ 60,587
	Name of Lender	Purpose	Amount	Date Due	
	M&T Bank	Equipment	60,587	Various	
	4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 228,120
	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*)				$ 3,751,817
	Accrued Expenses	18,430	Accrued Worker's Compe	37,011	
	Patient Personal Funds	24,857	Revenue Assessment	144,008	
	Due to Related Party - Short Term	3,095,825	Accrued Accounting Fees	24,130	
	Due to Third Party	7,556	See Schedule	400,000	
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 6,879,221

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2018	34	37

Account	Amount
Total Brought Forward:	6,879,221
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$ 97,796

Name of Lender	Purpose	Amount	Date Due
M&T Bank	Equipment	97,796	Various

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

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ 1,573,671
Due to Related Party - Long Term	1,446,038	
Equipment Obligation	127,633	
See Schedule		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 1,671,467
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 8,550,688

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT,	913-C	9/30/2018	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$ 696,213
	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	$ 696,213
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (4,901,775)
	6. Gain or Loss for Period 10/1/2017 thru 9/30/2018	$ (1,282,510)
	7. Total Net Worth	$ (6,184,285)
C.	***Total Reserves and Net Worth***	$ (5,488,072)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 3,062,616

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, L	913-C	9/30/2018	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2017			$ (4,904,881)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 8,821,298
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 10,103,808
D.	Net Income or Deficit			$ (1,282,510)
E.	Balance			$ (6,187,391)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Maple View Manor of CT, LLC		30,000	
	2. Other (*itemize*)			
	Tax Refund		422	
F-3.	Total Additions			$ 30,422
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$ 27,316
	Purpose		Amount	
	Prior Period		27,316	
	3. Total Deductions			$ 27,316
H.	***Balance at End of Period*** 09/30/18			$ (6,184,285)

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,	913-C	9/30/2018	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer

Blum, Shapiro & Company, P.C.

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