



### General Information

Name of Facility (as licensed) Bidwell Care Center,LLC	License No. 2290	Report for Year Ended 9/30/2021	Page 1	of 37
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#### Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Bidwell Care Center,LLC [facility name], for the cost report period beginning October 1, 2020 and ending September 30, 2021, 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) Patrick Neagle			Printed Name (Owner) Chris Wright		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Bidwell Care Center,LLC		Period Covered:	From 10/1/2020	To 9/30/2021
Address of Facility 333 Bidwell Street Manchester, CT 06040				
Report Prepared By iCare Management, LLC		Phone Number 860-570-2140	Date 1/20/2022	
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. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

## General Information and Questionnaire

### Type of Facility - Organization Structure

	Phone No. of Facility 860-533-3086	Report for Year Ended 9/30/2021	Page 2	of 37
Name of Facility (as shown on license) Bidwell Care Center,LLC		Address (No. & Street, City, State, Zip) 333 Bidwell Street Manchester, CT 06040		
License Numbers:	CCNH 2290	RHNS	(Specify)	Medicare Provider No. 07-5314
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?				
<input type="radio"/> Yes <input checked="" type="radio"/> No                   If "Yes," explain fully.				
<b>Administrator</b>				
Name of Administrator Patrick Neagle		Nursing Home Administrator's License No.:	1927	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		



## General Information and Questionnaire Corporate Owners

Name of Facility Bidwell Care Center, LLC	License No. 2290	Report for Year Ended 9/30/2021	Page 3A	of 37
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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	Business Address	Title	No. Shares Held by Each





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

Name of Facility Bidwell Care Center,LLC	License No. 2290	Report for Year Ended 9/30/2021	Page 4	of 37
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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 Attached		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

\* Use additional sheets if necessary.

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

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility Bidwell Care Center, LLC	License No. 2290	Report for Year Ended 9/30/2021	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

### 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	
Bidwell Care Center, LLC		2290	9/30/2021			6	37	
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
ADP, Inc., One ADP Drive MS-100, Augusta, GA 30909	<input type="radio"/>	<input checked="" type="radio"/>	Time Clocks and Payroll Punch Equip	06/01/10	automatic renewals	8,222	8,222	
GE Capital C/O Wells Fargo, P.O.Box 41564, Philadelphai, PA 19101	<input type="radio"/>	<input checked="" type="radio"/>	Copier	03/05/14	automatic renewals	10,561	10,561	
Pitney Bowes-Global Financial PO Box 371887, Pittsburgh, PA 15250-7874	<input type="radio"/>	<input checked="" type="radio"/>	Postage Rental	12/26/18	Month to month	638	638	
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?						<input type="radio"/> Yes <input checked="" type="radio"/> No	<b>Total ***</b>	19,422

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

**General Information and Questionnaire**  
**Accounting Basis**

Name of Facility Bidwell Care Center,LLC	License No. 2290	Report for Year Ended 9/30/2021	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:  
 Accrual     Cash     Modified Cash

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

**Independent Accounting Firm**

Name of Accounting Firm 1 O'Connor, Davies LLP 2 3 4	Address (No. & Street, City, State, Zip Code) 100 Great Meadow Road, Ste 401, Wethersfield, CT 06109
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Services Provided by This Firm (*describe fully*)

1 Taxes, financial statements, accounting support	\$ 9,206
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 9,206

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    15D

**Legal Services Information**

Name of Legal Firm or Independent Attorney 1 iCare Health Management, LLC 2 3 4 Various others (American Arbitration , Various Arbitration, Murtha Cullina,Jackson Lewis) 5	Telephone Number 860-570-2140
--	----------------------------------

Address (*No. & Street, City, State, Zip Code*)  
 1 341 Bidwell Street, Manchester CT  
 2  
 3  
 4  
 5

Services Provided by This Firm (*describe fully*)

1 Lease and contract issues, general legal advice, Labor Law	\$ 910
2 Lease and contract issues, general legal advice, union funds advice	\$
3 Employment law, arbitrations, contract negotiations	\$
4 Employment Arbitrations, healthcare law & Conservatorships	\$ 972
5 Collections	\$
	Charge for Services Provided
	\$ 1,881

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    15E

**Schedule of Resident Statistics**

Name of Facility Bidwell Care Center,LLC			License No. 2290		Report for Year Ended 9/30/2021				Page 8	of 37			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	131	131			131	131							
B. On last day of THIS report period	131	131							131	131			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	109	109			109	109							
B. As of midnight of THIS report period	119	119							119	119			
3. Total Number of Days Care Provided During Period													
A. Medicare	2,053	2,053			1,504	1,504			549	549			
B. Medicaid (Conn.)	37,357	37,357			27,693	27,693			9,664	9,664			
C. Medicaid (other states)													
D. Private Pay	513	513			341	341			172	172			
E. State SSI for RCH													
F. Other (Specify) Insurance	243	243			216	216			27	27			
G. Total Care Days During Period (3A thru F)	40,166	40,166			29,754	29,754			10,412	10,412			
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. <b>Total Resident Days (3G + 4A + 4B)</b>	40,166	40,166			29,754	29,754			10,412	10,412			

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

Name of Facility Bidwell Care Center, LLC			License No. 2290			Report for Year Ended 9/30/2021			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> 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			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
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	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	10		106				3						
Per Diem Rate													
a. One bed rm.	528.00		307.00				396.00						
b. Two bed rms.													
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								2,911	2,911				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								732	732				
2. Restorative Treatments								1,833	1,833				
C. Other								4,354	4,354				
D. <b>Total Physical Therapy Treatments</b>								9,830	9,830				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								408	408				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								253	253				
2. Restorative Treatments								139	139				
C. Other								444	444				
D. <b>Total Speech Therapy Treatments</b>								1,244	1,244				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								1,931	1,931				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								660	660				
2. Restorative Treatments								1,727	1,727				
C. Other								3,900	3,900				
D. <b>Total Occupational Therapy Treatments</b>								8,218	8,218				

### Report of Expenditures - Salaries & Wages

Name of Facility Bidwell Care Center, LLC	License No. 2290	Report for Year Ended 9/30/2021	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	130,251	2,048				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	236,967	9,733				
5. Dietary Service						
a. Head Dietitian	79,870	2,044				
b. Food Service Supervisor	70,894	2,085				
c. Dietary Workers	476,618	23,104				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	58,336	1,934				
b. Other Maintenance Workers	35,644	1,820				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
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	188,901	3,343				
b. RN						
1. Direct Care	656,926	14,541				
2. Administrative**	210,897	5,194				
c. LPN						
1. Direct Care	1,046,441	30,169				
2. Administrative**						
d. Aides and Attendants	1,896,297	90,029				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	128,794	5,540				
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	140,739	4,169				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	40,520	2,010				
<i>A-13. Total Salary Expenditures</i>	5,398,096	197,762				

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

Name of Facility				License No.	Report for Year Ended			Page	of	
Bidwell Care Center,LLC				2290	9/30/2021			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)							
<b>Section I - Operators/Owners</b>										
<b>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).</b>										

\* 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.

**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	
Bidwell Care Center,LLC				2290	9/30/2021			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)							
<b>Section III - Administrators***</b>										
Patrick Neagle	80,181			same as employees less union funds	Administrator	1,144	A2			
Cori Knutsen	50,070			same as employees less union funds	Administrator	904	A2			
				same as employees less union funds	Administrator		A2			
<b>Section IV - Assistant Administrators</b>										

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of		
Bidwell Care Center,LLC	2290	9/30/2021	13	37		
<b>Total Cost and Hours</b>						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian						
2. Dentist						
3. Pharmacist	6,700	216				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	181,988	3,486				
b. Other						
6. Social Worker	10,355	137				
7. Recreation Worker	14,835	7+Cable				7+Cable
8. Physicians						
a. Medical Director (entire facility)	70,800	606				
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) Physician Care Contract Services	20,217	82				
9. Speech Therapist						
a. Resident Care	46,666	894				
b. Other						
10. Occupational Therapist						
a. Resident Care	133,676	2,561				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	150,765	1,915				
2. Administrative***	92,262	1,806				
b. LPN						
1. Direct Care	43,147	485				
2. Administrative***						
c. Aides	798	15				
d. Other						
12. Other (Specify) See Attached Schedule	212,008	5,243				
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>984,216</b>	<b>17,446</b>				

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

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

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

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

Name of Facility Bidwell Care Center,LLC		License No. 2290		Report for Year Ended 9/30/2021	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Tocuhpoints Therapy	Therapy	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Shared Employees	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Pharm Scripts	Pharmacy Contract	<input type="radio"/>	<input checked="" type="radio"/>			
Guardian Consulting Srv	Pharmacy Consulting	<input type="radio"/>	<input checked="" type="radio"/>			
Healthdrive Physician Services	Audiology, Dental and Podiatry	<input type="radio"/>	<input checked="" type="radio"/>			
Claris Health	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
Dr Kapur	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
Dr. Bogacki Robert	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
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		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			

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

**C. Expenditures Other Than Salaries - Administrative and General**

Name of Facility	License No.	Report for Year Ended		Page	of
Bidwell Care Center,LLC	2290	9/30/2021		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 164,617	164,617			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$				
4. Social Security (F.I.C.A.)	\$ 450,893	450,893			
5. Health Insurance	\$ 954,772	954,772			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 296,163	296,163			
8. Uniform Allowance	\$				
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 37,061	37,061			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 71,992	71,992			
d. Accounting and Auditing	\$ 9,206	9,206			
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 1,881	1,881			
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$				
g. Office Supplies	\$ 17,237	17,237			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 25,435	25,435			
2. Cellular Phones	\$ 402	402			
i. Appraisal ( <i>Specify purpose and         attach copy</i> )*	\$				
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$				
k. Other Taxes ( <i>Not related to property - See Page 22</i> )					
1. Income*	\$				
2. Other ( <i>Specify</i> ) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 805,585	805,585			
<b>Subtotal</b>	\$ 2,835,245	2,835,245			

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

(Carry Subtotals forward to next page)



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

Name of Facility	License No.	Report for Year Ended		Page	of
Bidwell Care Center, LLC	2290	9/30/2021		16	37
Item	Total	CCNH	RHNS	(Specify)	
<b>Subtotals Brought Forward:</b>	2,835,245	2,835,245			
<b>l. Travel and Entertainment</b>					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 283	283			
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 1,335	1,335			
5. Education Expenses Related to Seminars and Conventions	\$ 1,212	1,212			
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$ 867	867			
7. Other ( <i>Specify</i> ) See Attached Schedule	\$ 910	910			
<b>m. Other Administrative and General Expenses</b>					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$ 8,992	8,992			
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 5,209	5,209			
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	\$ 3,190	3,190			
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 8,917	8,917			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 1,756	1,756			
10. Contributions*** See Attached Schedule	\$ 2,549	2,549			
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$ 125,235	125,235			
12. Administrative Management Services**	\$ 401,001	401,001			
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 18,495	18,495			
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 3,415,195	3,415,195			

\* 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)
MEALS	\$ 910		\$ -
<b>Total Other Travel and Entertainment</b>	\$ 910	\$ -	\$ -

## Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
COMMUNICATIONS SPECIAL EVENTS	\$ 5,209		\$ -
<b>Total Other Advertising</b>	\$ 5,209	\$ -	\$ -

## Schedule of Dues

Description	CCNH	RHNS	(Specify)
ALTCFM			
CAHCF Dues	\$ 8,917		\$ -
OTHER DUES			
<b>Total Dues</b>	\$ 8,917	\$ -	\$ -

## Schedule of Contributions

Description	CCNH	RHNS	(Specify)
CONTRIBUTIONS	\$ 2,549		\$ -
<b>Total Contributions</b>	\$ 2,549	\$ -	\$ -

## Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
SOCIAL SERVICE SUPPLIES	\$ 30		\$ -
SOC SVC MINOR EQUIPMENT	\$ -		\$ -
ADMINISTRATIVE MINOR EQUIPMENT	\$ 2,755		\$ -
EMPLOYEE RELATIONS	\$ 383		\$ -
EMPLOYEE RELATIONS-OTHER	\$ 88		\$ -
PERMITS & LICENSES	\$ 681		\$ -
VOLUNTEER EXPENSE	\$ -		\$ -
BANK FEES	\$ 2,975		\$ -
CMS REVISIT USER FEES	\$ -		\$ -
PENALTIES	\$ -		\$ -
LATE FEES	\$ 345		\$ -
INTERNET EXPENSES	\$ 11,238		\$ -
Rounding	\$ -		
<b>Total Other Administrative and General</b>	\$ 18,495	\$ -	\$ -



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

Name of Facility	License No.	Report for Year Ended	Page	of
Bidwell Care Center,LLC	2290	9/30/2021	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 #	
iCare Management, LLC/iCare Health Management, LLC	401,001	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12	
iCare Management, LLC/iCare Health Management, LLC	166,224	MANAGEMENT FEES- DIRECT CARE	Pg 20 j	
iCare Management, LLC/iCare Health Management, LLC	41,231	MANAGEMENT FEES- INDIRECT CARE	Pg 20 j	

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

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

Name of Facility Bidwell Care Center,LLC		License No. 2290	Report for Year Ended 9/30/2021	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 259,994	259,994		
2.	Non-Food Supplies	\$ 34,032	34,032		
3.	Other (Specify) _____ DIETARY SUPPLEMENTS	\$ 20,918	20,918		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$ (53,645)	(53,645)		
c. Other (Specify) _____ DIETARY MINOR EQUIPMENT		\$ 4,530	4,530		
2D. <b>Total Dietary Expenditures</b> (2a + b + c + d)		\$ 265,830	265,830		
2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F.	Resident Meals: Total no. of meals served per day:*	330	330		
G.	Is cost of employee meals included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		
H.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K.	Is any revenue collected from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
N.	Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility		License No.	Report for Year Ended	Page	of
Bidwell Care Center,LLC		2290	9/30/2021	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. \$	127	127		
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)	\$	366,487	366,487		
c. Other (Specify) LAUNDRY MINOR EQUIPMENT	\$	21	21		
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	\$	<b>366,635</b>	<b>366,635</b>		
<b>3E. Laundry Questionnaire</b>					
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
K. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

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

All allocations should add to total recorded in 3D.

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
Bidwell Care Center,LLC	2290	9/30/2021		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care					
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	24,340	24,340		
b. Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )	Sq. Ft. Serviced by Personnel				
	Amt. \$	387,736	387,736		
C. Other ( <i>Specify</i> )		\$			
HOUSEKEEPING MINOR EQUIPMENT					
<b>4D. Total Housekeeping Expenditures (4a + b + c)</b>		\$ 412,076	412,076		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from PHARMACY	\$	112,346	112,346		
b. Medicine Cabinet Drugs	\$	(7,181)	(7,181)		
c. Medical and Therapeutic Supplies	\$	138,809	138,809		
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$	6,342	6,342		
2. Other***	\$				
f. X-rays and Related Radiological Procedures***	\$	4,423	4,423		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$	6,017	6,017		
i. Recreation	\$				
j. Direct Management Services*	\$	166,224	166,224		
k. Indirect Management Services*	\$	41,231	41,231		
l. Other (Specify)**** See Attached Schedule	\$	88,357	88,357		
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>		\$ 556,565	556,565		

\* 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)
NURSING ADMIN SUPPLIES	\$ 6,568		\$ -
NURSING MINOR EQUIP	\$ 1,554		\$ -
MEDICAL RECORDS SUPPLIES	\$ -		\$ -
MEDICAL RECORDS MINOR EQUIPMENT	\$ -		\$ -
NON-COVERED PPS DR. VISITS	\$ -		\$ -
RESIDENT CARE SUPPLIES	\$ 462		\$ -
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 6,641		\$ -
PERSONAL CARE SUPPLIES	\$ 520		\$ -
INCONTINENCY SUPPLIES	\$ (884)		\$ -
VACCINE RESIDENTS	\$ 532		\$ -
PATIENT SPECIAL NEEDS	\$ 363		\$ -
PHYSICAL THERAPY SUPPLIES	\$ -		\$ -
PHYSICAL THERAPY EQUIPMENT RENT	\$ -		\$ -
PHYSICAL THERAPY MINOR EQUIPMENT	\$ -		\$ -
OCCUPATIONAL THERAPY SUPPLIES	\$ -		\$ -
OCCUPATIONAL THERAPY EQUIP RENTAL	\$ -		\$ -
OCCUPATIONAL THERAPY MINOR EQUIP	\$ -		\$ -
SPEECH THERAPY SUPPLIES	\$ -		\$ -
SPEECH THERAPY EQUIPMENT RENT	\$ -		\$ -
SPEECH THERAPY MINOR EQUIPMENT	\$ -		\$ -
RENTALS FOR NURSING EQUIPMENT NON BILLABLE	\$ 20,943		\$ -
EQUIPMENT RENTAL: AIDS UNIT	\$ -		\$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ 2,201		\$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ -		\$ -
HI LOW BED RENTAL & MATTRESSES	\$ -		\$ -
IV THERAPY SUPPLIES	\$ 13,664		\$ -
IV THERAPY CONTRACT SERVICE	\$ -		\$ -
MEDICAL WASTE CONTRACT SERVICE	\$ 1,563		\$ -
ACTIVITIES SUPPLIES	\$ 3,459		\$ -
ACTIVITIES MINOR EQUIPMENT	\$ 308		\$ -
ADMISSIONS SUPPLIES	\$ -		\$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$ 4,845		\$ -
STRIKE COSTS NON REIMBURSABLE	\$ 25,618		\$ -
COVID NON REIMBURSABLE	\$ -		\$ -
<b>Total Other Resident Care</b>	<b>\$ 88,357</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility Bidwell Care Center,LLC			License No. 2290		Report for Year Ended 9/30/2021			Page of 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
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Housekeeping Services	380,448			20	4b
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Laundry Services	366,487			19	3b
Eagle Elevator		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Elevator Contract	6,126			22	6F
Brightview Landscapes LLC/Stevan Infante		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Snow Removal/Landscaping	17,826			22	6F
CWPM LLC		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Trash removal	22,509			22	6F
American HealthTech		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Software Maintenance Contract	20,604			16	M11
Automatic Data Processing		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Payroll Services	39,482			16	M11
National Datacare Corp	P.O. Box 9001006, Louisville, KY 40290	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Resident Trust Software	4,006			16	M11
Prime Care Technology services		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Computer Consulting Services	35,230			16	M11
Priotiry Express		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Courier Services	2,713			16	M11
Point Right Inc		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Nursing Software	4,692			16	M11
		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR						
		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR						
		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR						

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

\*\* Refer to Page 4 for definition of related.

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

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

Name of Facility Bidwell Care Center, LLC	License No. 2290	Report for Year Ended 9/30/2021	Page 22	of 37
Item	Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant				
a. Repairs & Maintenance	\$ 30,562	30,562		
b. Heat	\$ 9,796	9,796		
c. Light & Power	\$ 86,475	86,475		
d. Water	\$ 53,264	53,264		
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 19,422	19,422		
f. Other ( <i>itemize</i> )	\$ 81,101	81,101		
See Attached Schedule				
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$ 280,619	280,619		
7. Depreciation ( <i>complete schedule page 23*</i> )				
a. Land Improvements	\$			
b. Building & Building Improvements	\$ 29,421	29,421		
c. Non-Movable Equipment	\$			
d. Movable Equipment	\$ 34,977	34,977		
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$ 64,398	64,398		
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )				
a. Organization Expense	\$			
b. Mortgage Expense	\$			
c. Leasehold Improvements	\$ 59,433	59,433		
d. Other ( <i>Specify</i> )	\$			
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$ 59,433	59,433		
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 463,476	463,476		
10. Property Taxes				
a. Real estate taxes paid by owner	\$			
b. Real estate taxes paid by lessor	\$ 108,731	108,731		
c. Personal property taxes	\$ 15,465	15,465		
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$ 711,502	711,502		

\* 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**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
PLANT SUPPLIES	\$ 8,404		\$ -
PLANT CONTRACT SERVICE LABOR	\$ 278		\$ -
ELEVATOR CONTRACT SERVICE	\$ 6,126		\$ -
FIRE/SPRINKLER CONTRACT SERVICE	\$ 5,629		\$ -
LANDSCAPING CONTRACT SERVICE	\$ 8,420		\$ -
SNOW REMOVAL CONTRACT SERVICE	\$ 9,406		\$ -
TRASH REMOVAL CONTRACT SERVICE	\$ 22,509		\$ -
HVAC CONTRACT SERVICE	\$ -		\$ -
SECURITY CONTRACT SERVICE	\$ -		\$ -
PLANT CONTRACT SERVICE OTHER	\$ 10,190		\$ -
PLANT MINOR EQUIPMENT	\$ 6,539		\$ -
RENT AUTO	\$ -		\$ -
RENT EQUIPMENT	\$ 3,600		\$ -
RENT OTHER	\$ -		\$ -
<b>Total Other Repairs and Maintenance</b>	\$ 81,101	\$ -	\$ -





Schedule of Land Improvements Acquired during this report period

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

\*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
<b>Additions:</b>				
<b>Total additions for Building Improvements</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
<b>Total additions for Non-Movable Equipment</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ - **

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2





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

CSP-24 Rev. 10/2006

**Amortization Schedule\***

Name of Facility Bidwell Care Center,LLC			License No. 2290		Report for Year Ended 9/30/2021			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period				1,107,049	646,323			52,262	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				147,753				7,170	
C-4. Subtotal									59,433
<b>D. Total Amortization</b>									59,433

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

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

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

Name of Facility Bidwell Care Center, LLC	License No. 2290	Report for Year Ended 9/30/2021	Page 25	of 37	
<b>11. Property Questionnaire</b>					
<b>Part A</b>					
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> 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	12/01/03				
2. Date Structure Completed	12/01/03				
3. If <b>NOT</b> Original Owner, Date of Purchase	12/01/03				
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	131				
6. Square Footage	47,916				
7. Acquisition Cost					
a. Land					
b. Building					
<b>Part B - Owner and Related Parties</b>		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)					
b. Date Mortgage Obtained					
c. Interest Rate for the Cost Year					
d. Term of Mortgage (number of years)					
e. Amount of Principal Borrowed					
f. Principal balance outstanding as of _____					
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>					
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					
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	
Summit Manchester, LLC	333 Bidwell Street, Manchester, CT	08/09/17	15 year with year extensio	\$482,171 yr 1	

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Bidwell Care Center,LLC		2290	9/30/2021		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. <b>Total Building Interest Expense</b> (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Bidwell Care Center,LLC		2290		9/30/2021		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) INTEREST				\$	4,038	4,038	
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>				\$	4,038	4,038	
14. Insurance							
a. Insurance on Property (buildings only)				\$	13,327	13,327	
b. Insurance on Automobiles				\$	2,857	2,857	
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$	86,236	86,236	
2. Fire and Extended Coverage				\$			
3. Other (Specify) Other insurance, crime				\$	12,850	12,850	
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$	115,270	115,270	
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$	12,510,041	12,510,041	



### D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Bidwell Care Center, LLC				2290	9/30/2021	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	C	Bad Debts	\$ 71,992	71,992		
10.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m3	Unallowable Advertising *	\$ 5,209	5,209		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 345	345		
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 77,547	77,547		

\* 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)
<b>Total Other Salaries Adjustment</b>			\$ -	\$ -	\$ -

## Schedule of Fees Adjustments

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

## Schedule of Other A&amp;G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16a		PENALTIES	\$ -		\$ -
16a		LATE FEES	\$ 345		\$ -
16a		PRIOR PERIOD EXPENSES			
		rounding			
		Provider User Fee for Medicare days	\$ -		\$ -
<b>Total Other A&amp;G Adjustments</b>			\$ 345	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Bidwell Care Center,LLC			2290	9/30/2021	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 77,547	77,547		
<b>Page 20 - Resident Care Supplies***</b>							
27.			Prescription Drugs	\$			
28.	20	5d	Ambulance/Limousine	\$			
29.	20	5f	X-rays, etc	\$ 4,423	4,423		
30.	20	5h	Laboratory	\$ 6,017	6,017		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ (14)	(14)		
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
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	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$ (0)	(0)		
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 87,972	87,972		

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

## Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5J	Non Covered PPS Visits	-		-
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	(5)		
13	B9A	ST- Resident Care (for outpatient therapy - see schedule)	(5)		
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)	(5)		
<b>Total Other Ancillary Costs</b>			\$ (14)	\$ -	\$ -

## Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Excess Movable Equipment Depreciation</b>			\$ -	\$ -	\$ -

## Schedule of Other Property Adjustments

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

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	4A1	Houskeeping Supplies (for Outpatient Therapy - see schedule)	\$ (0)		
20	4B	Housekeeping purchased services (for Outpatient Therapy see schedule)	\$ (0)		
22	6B	Heat (for outpatient Therapy see schedule)	\$ (0)		
22	6C	Light and Power (for outpatient therapy see schedule)	\$ (0)		
22	6D	water (for outpatient therapy see schedule)	\$ (0)		
22	6A	Repair&Maint (for outpatient therapy see schedule)	\$ (0)		
<b>Total Other Adjustments</b>			\$ (0)	\$ -	\$ -

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Unallowable Building Interest</b>			\$ -	\$ -	\$ -

### F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Bidwell Care Center,LLC	2290	9/30/2021		30	37
Item	Total	CCNH	RHNS	(Specify)	
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 10,368,640	10,368,640			
b. Medicaid Room and Board Contractual Allowance **	\$				
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 1,213,344	1,213,344			
b. Medicare Room and Board Contractual Allowance **	\$				
4. a. Private-Pay Residents and Other	\$ 309,840	309,840			
b. Private-Pay Room and Board Contractual Allowance **	\$				
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 89,916	89,916			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (89,916)	(89,916)			
c. Prescription Drugs - Non-Medicare	\$ 14,075	14,075			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (14,075)	(14,075)			
2. a. Medical Supplies - Medicare	\$ 4,445	4,445			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (4,445)	(4,445)			
c. Medical Supplies - Non-Medicare	\$ 3,015	3,015			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (3,015)	(3,015)			
3. a. Physical Therapy - Medicare	\$ 164,442	164,442			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (122,134)	(122,134)			
c. Physical Therapy - Non-Medicare	\$ 122,528	122,528			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (122,528)	(122,528)			
4. a. Speech Therapy - Medicare	\$ 22,564	22,564			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (15,829)	(15,829)			
c. Speech Therapy - Non-Medicare	\$ 41,504	41,504			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (41,504)	(41,504)			
5. a. Occupational Therapy - Medicare	\$ 139,326	139,326			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (108,877)	(108,877)			
c. Occupational Therapy - Non-Medicare	\$ 114,042	114,042			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (107,261)	(107,261)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 462,055	462,055			
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 106,740	106,740			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 12,546,892	12,546,892			
<b>IV. Other Revenue*</b>					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income ( <i>Specify</i> )	\$ 24	24			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 2,484,746	2,484,746			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 2,484,769	2,484,769			
<b>VI. Total All Revenue</b> (III +V)	\$ 15,031,661	15,031,661			

\* 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)
	Lab Medicare	\$ 17,810		
	Lab Medicare CA	\$ (17,810)		
	Oxygen Medicare	\$ 44		
	Oxygen Medicare CA	\$ (44)		
	Equipment rental	\$ 2,742		
	Equipment rental CA	\$ (2,742)		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds Medicare	\$ -		
	Therapy Beds Medicare CA	\$ -		
	Radiology Medicare	\$ 4,214		
	Radiology Medicare CA	\$ (4,214)		
	IV Therapy	\$ 22,351		
	IV Therapy CA	\$ (22,351)		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose testing	\$ -		
	Glucose testing CA	\$ -		
	Outpatient therapy Medicare	\$ (214)		
	MEDICAID COVID REVENUE	\$ 124,703		
	CRF MEDICAID REVENUE	\$ 337,566		
<b>Total Other Resident Revenue - Medicare</b>		\$ 462,055	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Lab	4,145		
	Lab CA	(4,145)		
	Oxygen	\$ 753	\$ -	
	Oxygen CA	\$ (753)	\$ -	
	Equipment rental	\$ 11,364		
	Equipment rental CA	\$ (11,364)		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds	\$ -		
	Therapy Beds CA	\$ -		
	Radiology	\$ 209		
	Radiology CA	\$ (209)		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose Testing	\$ -		
	Glucose Testing CA	\$ -		
	IV therapy	\$ 11,823	\$ -	
	IV therapy CA	\$ (11,823)	\$ -	
	Flu shot revenue	\$ 915		
	Outpatient therapy	\$ -		
	prior period revenue	\$ 100		
	Optum B	\$ 255,107		
	Optum B CA	\$ (137,307)		
	C/A VBP	\$ (12,075)		
	rounding	\$ 1		
<b>Total Other Resident Revenue</b>		\$ 106,740	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	INTEREST INCOME	\$ 24			
<b>Total Interest Income</b>		\$ 24	\$ -	\$ -	

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	MEALS	\$ -		
	TELEVISION INCOME	\$ -		
	OTHER INCOME: DMHAS OPERATING REVENUE	\$ -		
	OTHER INCOME: DMHAS ORGANIZATIONAL REV	\$ -		
	OTHER INCOME: DEFERRED REVENUE	\$ 10,389		
	MEDICARE COVID STIMULUS REVENUE	\$ -		
	CONCESSIONS / VENDING INCOME	\$ -		
	RESIDENT LATE FEE REVENUE	\$ -		
	RESIDENT ATTORNEY FEE REVENUE	\$ -		
	TELEPHONE INCOME	\$ -		
	OTHER INCOME	\$ 200		
	OPTUM DIVIDENDS REVENUE	\$ 23,655		
	OPTUM OUTLIERS	\$ -		
	HHS GENERAL FUND REVENUE	\$ -		
	HHS INFECTION CONTROL REVENUE	\$ 1,198,702		
	CARES ACT REVENUE	\$ 1,245,800		
	EMPLOYEE TESTING REVENUE	\$ -		
	COVID ECHO TRAINING REVENUE	\$ 6,000		
<b>Total Other Revenue</b>		\$ 2,484,746	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Bidwell Care Center, LLC	2290	9/30/2021	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	932,612
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,967,486
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	126,855
a. Prepaid Insurance	87,296			
b. Prepaid Property Taxes	36,210			
c. Prepaid Expenses Other	3,349			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	(1,093,178)
Due From (to) Related Parties	(169,795)			
Other Owners reserves	(923,383)			
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	1,933,775
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost 287,612		\$	101,190
	Accum. Depreciation 186,421	Net		
4. Leasehold Improvements	*Historical Cost 1,254,802		\$	549,046
	Accum. Depreciation 705,756	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost 1,139,845		\$	102,333
	Accum. Depreciation 1,037,512	Net		
7. Motor Vehicles	*Historical Cost 7,009		\$	
	Accum. Depreciation 7,009	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
Construction in Progress				
See Schedule				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	752,570

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

(Carry Total forward to next page)



Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
<b>Total Prepaid Expenses</b>			\$ -

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

Page Ref	Line Ref	Description	
<b>Total Other Current Assets (Itemize)</b>			\$ -

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

Page Ref	Line Ref	Description	
<b>Total Other Fixed Assets (Itemize)</b>			\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
<b>Total Other Assets</b>			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
<b>Total Notes Payable</b>			\$ -

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

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			\$ -

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

Page Ref	Line Ref	Description	
<b>Total Other Long-Term Liabilities (Itemize)</b>			\$ -

### G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bidwell Care Center, LLC	2290	9/30/2021	32	37
<b>Account</b>			<b>Amount</b>	
Total Brought Forward:			\$	2,686,345
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 <b>Total Leasehold or Like Properties</b> (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	429,818
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	115,837
	Patient Trust Funds	113,282		
	Long Term Deposit - primecare	2,555		
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	
Name and Address	Amount	Loan Date		
7. Other Assets ( <i>itemize</i> )			\$	
_____				
_____				
See Schedule				
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	545,655
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$	3,232,000

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

**G. Balance Sheet (cont'd)**

Name of Facility		License No.	Report for Year Ended	Page	of
Bidwell Care Center,LLC		2290	9/30/2021	33	37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	516,869
2. Notes Payable ( <i>itemize</i> )				\$	
Working Capital Line of Credit					
_____ _____ _____ See Schedule					
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$	595,169
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable ( <i>Current Portion</i> )				\$	
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities ( <i>itemize</i> )				\$	1,327,418
Related Party Payables		1,116,390			
Accrued Expenses		18,468			
Accrued Resident User Fees		207,320			
Accrued Workers Comp Expense		(14,761)	See Schedule		
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>				<b>\$</b>	<b>2,439,456</b>

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

(Carry Total forward to next page)

### G. Balance Sheet (cont'd)

Name of Facility Bidwell Care Center, LLC	License No. 2290	Report for Year Ended 9/30/2021	Page 34	of 37
Account			Amount	
Total Brought Forward:			2,439,456	
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )				
Name of Lender	Purpose	Amount	Date Due	\$
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$
Patient Trust Funds		113,282		
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 113,282
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 2,552,738

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bidwell Care Center, LLC	2290	9/30/2021	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
<b>B. Net Worth</b>				
1. Owner's Capital			\$	25,000
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(1,867,358)
6. Gain or Loss for Period			\$	2,521,620
	10/1/2020	thru	9/30/2021	
7. Total Net Worth			\$	679,262
<b>C. Total Reserves and Net Worth</b>			\$	679,262
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	3,232,000

### H. Changes in Total Net Worth

Name of Facility Bidwell Care Center, LLC	License No. 2290	Report for Year Ended 9/30/2021	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2020			\$	
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$ 15,031,661	
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$ 12,510,041	
D. Net Income or Deficit			\$ 2,521,620	
E. Balance			\$ 2,521,620	
F. Additions				
1. Additional Capital Contributed ( <i>itemize</i> )				
2. Other ( <i>itemize</i> )				
F-3. Total Additions				
G. Deductions			\$	
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )			\$	
Name and Address ( <i>No., City, State, Zip</i> )	Title	Amount		
2. Other Withdrawings ( <i>Specify</i> )			\$	
Purpose	Amount			
3. Total Deductions			\$	
H. <b>Balance at End of Period</b>			\$ 2,521,620	
09/30/21				

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

Name of Facility Bidwell Care Center, LLC	License No. 2290	Report for Year Ended 9/30/2021	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
<b>Preparer/Reviewer Certification</b>				
<p>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.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
iCare Management, LLC				
Address Address			Phone Number	
341 Bidwell Street, Manchester, CT 06040			860-570-2140	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Kartik Patel			860-570-2140	
Contact Email Address				
Kpatel@icarehn.com				