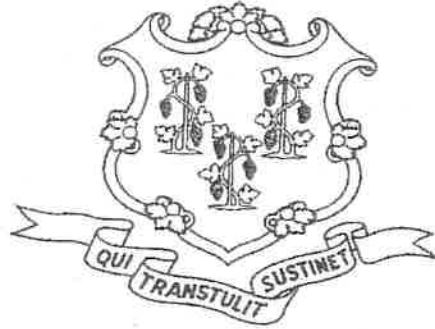


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2022

Name of Facility (as licensed) Bloomfield Health Care Center of CT, LLC	
Address (No. & Street, City, State, Zip Code) 335 Park Ave Bloomfield, CT 06002	
Type of Facility	
<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)	
Report for Year Beginning 10/1/2021	Report for Year Ending 9/30/2022

License Numbers:	CCNH 913-C	RHNS	(Specify)	Medicare Provider 07-5138
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Medicaid Provider Numbers:	CCNH 9134	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) Bloomfield Health Care Center of CT, LLC	License No. 913-C	Report for Year Ended 9/30/2022	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 Bloomfield Health Care Center of CT, LLC [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

(a) Subject to Desk Audit review

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) Portia Bachman			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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State of Connecticut
Department of Social Services
 55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment		Page 1A	of 37
Name of Facility Bloomfield Health Care Center of CT, LLC		Period Covered: From 10/1/2021	To 9/30/2022
Address of Facility 335 Park Ave Bloomfield, CT 06002			
Report Prepared By Marcum LLP		Phone Number 203-781-9600	Date 2/7/2023
Item	Total	CCNH	RHNS (Specify)
1. Dietary wages paid \$			
2. Laundry wages paid \$			
3. Housekeeping wages paid \$			
4. Nursing wages paid \$			
5. All other wages paid \$			
6. Total Wages Paid \$			
7. Total salaries paid \$			
8. Total Wages and Salaries Paid (As per page 10 of Report) \$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-242-8595		Report for Year Ended 9/30/2022		Page 2	of 37
Name of Facility (as shown on license) Bloomfield Health Care Center of CT, LLC			Address (No. & Street, City, State, Zip) 335 Park Ave Bloomfield, CT 06002		
License Numbers:	CCNH 913-C	RHNS	(Specify)	Medicare Provider No. 07-5138	
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.					
Administrator					
Name of Administrator Portia Bachman			Nursing Home Administrator's License No.:	2050	
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 Bloomfield Health Care Center of CT, LLC	License No. 913-C	Report for Year Ended 9/30/2022	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address		State(s) in Which Incorporated	
N/A				
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
N/A				
Names of Stockholders Owning at Least 10% of Shares				
N/A				

**General Information and Questionnaire
 Related Parties***

Name of Facility Bloomfield Health Care Center of CT, LLC	License No. 913-C	Report for Year Ended 9/30/2022	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	%**				
National HealthCare Associates-Aetna	850 Silas Deane Hwy Wethersfield, CT 06109	<input type="radio"/>	<input checked="" type="radio"/>		Health Insurance	Page 15 / Line 1a5	499,699	499,699
Preferred Therapy Solutions	850 Silas Deane Hwy Wethersfield, CT 06109	<input type="radio"/>	<input checked="" type="radio"/>		PT, OT, ST Services / Consulting	Various / Various	468,797	441,520
NOA DIAGNOSTICS	6851 Jericho Tpke, Suite 150 Syosset, NY 11791	<input type="radio"/>	<input checked="" type="radio"/>		Radiology	Page 20 / Line 5f	11,051	9,876
Bloomfield Healthcare Realty	20 E Sunrise Hwy, Valley Stream NY 11581	<input type="radio"/>	<input checked="" type="radio"/>		Lease of Facility***	Page 22 / Line 9	840,000	840,000
National HealthCare Associates	20 E Sunrise Hwy, Valley Stream NY 11581	<input type="radio"/>	<input checked="" type="radio"/>		Consulting	Page 16 / Line M12	14,834	14,834
National HealthCare Associates	20 E Sunrise Hwy, Valley Stream NY 11581	<input type="radio"/>	<input checked="" type="radio"/>		Shared Services	Page 16 / Line M12	588,724	588,724
National HealthCare Associates	20 E Sunrise Hwy, Valley Stream NY 11581	<input type="radio"/>	<input checked="" type="radio"/>		Interest on Computer Loan	Page 27 / Line 12d	4,096	4,096
PROCARE LTC PHARMACY OF CT	1492 Highland Ave Cheshire CT 06410	<input type="radio"/>	<input checked="" type="radio"/>		Drugs/OTC/RX Consult	Page 20 / Various	252,088	235,073
See additional Page 4a Attached	Various	<input type="radio"/>	<input checked="" type="radio"/>		Various	Various / Various	491,653	491,653

* Use additional sheets if necessary.
 ** Provide the percentage amount of revenue received from non-related parties.

**General Information and Questionnaire
Related Parties***

Name of Facility Bloomfield Health Center for Nursing & Rehab		License No. 913-C	Report for Year Ended 9/30/2022			Page 4a	of 37	
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	%**				
Maple View Manor	856 Maple St Rocky Hill CT 06067	<input type="radio"/>	<input checked="" type="radio"/>	0%	Workers Comp	Page 15 / Line 1A1	424	424
Regency House of Wallingford, Inc.	181 East Main Street, Wallingford CT, 06492	<input checked="" type="radio"/>	<input type="radio"/>	95%	Shared Employee	Various / Various	998	998
Riverside Health Care Center, Inc.	745 Main Street, East Hartford CT, 06108	<input type="radio"/>	<input checked="" type="radio"/>	0%	Shared Administrator	Page 16 / Line M11	9,027	9,027
National HealthCare Associates	20 E Sunrise Hwy, Valley Stream NY, 11581	<input type="radio"/>	<input checked="" type="radio"/>	0%	Banking Transactions	Page 16 / Line M13	12,407	12,407
PREFERRED PROFESSIONAL SERVICES	850 Silas Deane Hwy Wethersfield, CT 0610	<input type="radio"/>	<input checked="" type="radio"/>	0%	RN/LPN/Aides Agency	Page 13 / Various	468,797	468,797
		<input type="radio"/>	<input checked="" type="radio"/>	0%				

* Use additional sheets if necessary.

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

***N/A Fair rent replaces rent during rate setting

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility Bloomfield Health Care Center of CT, LLC	License No. 913-C	Report for Year Ended 9/30/2022	Page 5	of 37
If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:				
Item	Method of Allocation			
Dietary	Number of meals served to residents			
Laundry	Number of pounds processed			
Housekeeping	Number of square feet serviced			
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants			
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (See listing page 13)			
Maintenance and operation of plant	Square feet			
Property costs (depreciation)	Square feet			
Employee health and welfare	Gross salaries			
Management services	Appropriate cost center involved			
All other General Administrative expenses	Total of Direct and Allocated Costs			
The preparer of this report must answer the following questions applicable to the cost information provided.				
1. In the preparation of this Report, were all costs allocated as required? <input checked="" type="radio"/> Yes <input type="radio"/> 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.)				
<input checked="" type="radio"/> Yes <input type="radio"/> 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
Bloomfield Health Care Center of CT, LLC			913-C	9/30/2022			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						
Reliable Health Systems, Nostrand Ave, Brooklyn, NY 11230	<input type="radio"/>	<input checked="" type="radio"/>	Computer Equipment	10/01/08	Ongoing	3,802	3,802	
Wescom Solutions, PO Box 674802, Detroit, MI 48267	<input type="radio"/>	<input checked="" type="radio"/>	Software	03/07/12	Ongoing	41,032	41,032	
Leaf, P.O. Box 644006, Cincinnati, OH 45264	<input type="radio"/>	<input checked="" type="radio"/>	Copier	01/01/16	39 Months	4,012	4,012	
Pitney Bowes, 2225 American Drive, Neenah, WI 54956-1005	<input type="radio"/>	<input checked="" type="radio"/>	Postage Meter	04/30/13	Ongoing	2,050	2,050	
The Office Works Inc, P.O. Box 5066, Hartford, CT 06102-5066	<input type="radio"/>	<input checked="" type="radio"/>	Copier	07/01/22	39 Months	1,336	1,336	
	<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"/>						
							Total ***	52,232

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes No

Total *** 52,232

* 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.



SALES ORDER

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

DATE: 5-19-22

BILL TO:
Bloomfield Health Care Center
355 Park Avenue
Bloomfield, CT 06002

SHIP TO:
Same

ITEM	DESCRIPTION	QTY	Each	TOTAL
e-Studio 6516ACT	Toshiba 55 ppm color multifunction copier	1		
e-Studio 3518A	Toshiba 35 ppm multifunction copier	1		
MR3031B	Document handler	1		39-month lease
MJ1111B	Document finisher	1		409.35 per month
MJ1042B	Document inner finisher	1		
KD1059B	2,000 sheet paper-feed pedestal	1		
GD1370	Fax Board	1		
M2640idw	Kyocera 42 ppm desktop multifunction copier	1		
			DELIVERY	N/C
			SALES TAX	6.35% on each payment
			TOTAL DUE	N/A

Notes / Provisions

- Delivery, Installation, network connection and training is included.
- The cost per page service and maintenance agreement will be billed at \$.0068 for black pages and \$.0490 for color pages for the Toshiba MFP's and \$.0089 for the Kyocera desktop MFP.
- The Office Works will remove the old copiers (ID #'s 8640, 8668 & 8677) and return them to the leasing company at no charge.

CUSTOMER: Bloomfield Health Care Center

Authorized Signature: Michael Baker

Print Name: Michael Baker

Title: Purchasing

Date: 6/18/22

Phone: _____

The Office Works, Inc.

Accepted By: _____

Print Name: _____

Title: _____

Sales Associate

LEASE AGREEMENT

LESSEE LEGAL NAME: Bloomfield Haealth Care Center		Telephone No:
Billing Address: 355 Park Avenue, Bloomfield, CT 06002		Equipment Location (If other than Billing Address):
EQUIPMENT DESCRIPTION: (indicate quantity, new or used and Include make, model, serial # and all attachments – see below and/or attached Schedule A)		
(1) Toshiba e-Studio 6516ACT multifunction copy system (1) Toshiba e-Studio 3518A multifunction Copy system (1) Kyocera M2640idw multifunction copier		
BASE TERM IN MONTHS	TOTAL NUMBER OF LEASE PAYMENTS	END OF LEASE PURCHASE OPTION
39	@ \$409.35 (plus taxes) followed by N/A @ \$N/A (plus taxes)	<input checked="" type="checkbox"/> Fair market value, plus taxes <input type="checkbox"/> 10% of Equipment cost, plus taxes <input type="checkbox"/> \$1.00, plus taxes (FMV unless another option is selected. You may not exercise a purchase option if you are in default. If you exercise a purchase option we will convey all of our right, title and interest in such Equipment to you on an AS-IS WHERE IS without warranty.)
		(a) Advance Payment: \$ N/A (b) Security Deposit: \$ N/A (c) Documentation Fee: \$ 95.00 Total due a + b + c =: \$ 95.00
**If more than one lease payment is required as an Advance Payment, the balance will be applied to lease payments in inverse order, starting with the last lease payment. Your obligation to pay all amounts and perform all other obligations is non-cancellable, absolute, unconditional and not subject to abatement, set-off or defense.		

In this agreement ("Lease"), "we," "our," and "us" refers to The Office Works Inc as Lessor and "you" and "your" refer to the Lessee. You agree to lease the Equipment upon the following terms and conditions:

- LEASE PAYMENTS AND TERM:** The Lease is enforceable on you upon your execution. The term of the Lease shall commence on the date the Equipment is delivered to you ("Lease Commencement Date"). The first Lease Payment shall be due on the date we specify in the month following the Lease Commencement Date as set forth in our invoice, and the remaining Lease Payments will be due on the same day of each subsequent month (each, a "Payment Date") until paid in full. The Base Term shall commence on the date one month prior to the first Payment Date. We may charge you a portion of one Lease Payment for the period from the Lease Commencement Date until the first day of the Base Term ("Interim Rent"). The Interim Rent shall be due as invoiced. We may adjust the Lease Payments up to 15% if the actual costs are different than the estimate used to calculate the Lease Payments.
- DELIVERY, ACCEPTANCE, USE AND REPAIR:** You are responsible for Equipment delivery and installation. You unconditionally accept the Equipment upon the earlier of (a) your oral or written acceptance of the Equipment, or (b) 10 days after delivery of the Equipment. You authorize us to fill in the Lease Commencement Date, serial numbers and other information. You will not move the Equipment from the above location without our written consent and are responsible for maintaining the Equipment in good repair. We are not responsible for Equipment or vendor failures.
- INDEMNIFICATION:** You agree to indemnify, defend and hold us harmless from and against any losses, damages, penalties, claims and suits, including attorneys' fees and expenses related to the ordering, manufacture, installation, ownership, condition, use, lease, possession, delivery or return of Equipment.
- LEASE EXPIRATION, RENEWAL:** Unless you notify us at least 90 days prior to the expiration of the Lease of your election to return or purchase the Equipment, this lease will renew for successive 12 month periods at the same monthly Lease Payment until you either exercise the purchase option or provide us with at least 90 days notice and return the Equipment. If you return the Equipment, (i) it must be to the location we designate and you are responsible for all return costs and we may charge a Restocking Fee equal to one Lease Payment, and (ii) you must securely remove all data from any and all disk drives or magnetic media prior to returning the Equipment (and you are solely responsible for selecting an appropriate removal standard that meets your business needs and complies with applicable laws). You will pay us for any loss in value resulting from failure to maintain the Equipment in accordance with this Lease or for damages incurred in shipping and handling. If you exercise a purchase option we will convey all of our interest in such Equipment to you on an AS-IS WHERE IS basis without representation or warranty.
- LATE FEES AND CHARGES:** If any amount is not paid within three (3) days of when due, you agree to pay us a late charge equal to the lesser of 10% of the amount past due or the maximum legal amount. Amounts which are not paid within 30 days of when due shall accrue interest at 1.5% per month (or if less, the maximum legal rate) until paid. You agree to pay \$25 for each pay by phone and \$35 for each returned payment.
- NO WARRANTY:** We do not manufacture the Equipment and you have selected the Equipment and the supplier. WE MAKE NO EXPRESS OR IMPLIED WARRANTIES, INCLUDING THOSE OF MERCHANTABILITY OR FITNESS FOR A PURPOSE AND ARE NOT RESPONSIBLE FOR CONSEQUENTIAL OR INCIDENTAL DAMAGES.
- INSURANCE, RISK OF LOSS:** You bear all risk of loss or damage to the Equipment from its order until it is returned in the required condition or purchased by you ("Risk Period"). During the Risk Period you will maintain property and liability insurance on the Equipment acceptable to us, naming us loss payee and additional insured. If you do not provide us with proof of such insurance, we may secure insurance on the Equipment to

- cover our interests (and only our interests). If we obtain such insurance, you will pay us an additional amount for the cost of it and an administrative fee, the cost of which may be more than the cost to obtain your own insurance and on which we may make a profit.
- OWNERSHIP AND TAXES:** We own the Equipment (excluding licensed software). If you are deemed to own it, you grant us a security interest in the Equipment. You authorize us to file UCC financing statements to confirm our interest. You will pay, when due, all taxes, fines and penalties relating to the purchase, use, leasing and/or ownership of the Equipment. If we pay any taxes (including property tax), fees or penalties on your behalf, you will pay us the amount we paid plus an administrative fee. You agree to pay us the documentation fee specified above or if not so specified, the greater of either \$125 or 0.5% of the Equipment cost. If we require an Equipment site inspection, or you request administrative services, you agree to reimburse our costs.
- DEFAULT:** If you or any guarantor do not pay us any amount within ten (10) days of its due date, or breach any terms of this Lease, any guaranty or any license relating to the Equipment, you will be in default. If you default, we may require you to do any combination of the following: (a) immediately pay all amounts then due, plus the present value of the remaining Lease Payments, Interim Rent and residual value of the Equipment, as determined by us, discounted at an annual rate of 3%; (b) return all of the Equipment; (c) allow us to repossess the Equipment; or (d) use any and all remedies available to us under applicable law. If you default, you agree to pay the cost of repossession and our attorney's fees and costs. In addition to all other charges and as reimbursement for expenses incurred and not as a penalty, we may require you to reimburse us for the phone calls, letters, and any additional expense incurred in the collection or servicing of this Lease for you. If we take possession of the Equipment, we may sell or otherwise dispose of it with or without notice, at a public or private sale, and apply the net proceeds (after we have deducted all costs related to the sale or disposition of the Equipment) to the amounts that you owe us. You agree that if notice of sale is required by law, 10 days' notice shall constitute reasonable notice. You remain responsible for any amounts that are due after we have applied such net proceeds. We may apply any security deposits to your obligations and if you do not default, the balance will be refunded without interest.
- ASSIGNMENT:** You have no right to sell or assign the Equipment or Lease. We may sell or assign our rights in the Lease and/or Equipment and the new owner will have all our rights but will not be subject to any claim or defense you have against us.
- ARTICLE 2A:** You agree this Lease is a "finance lease" as defined in Article 2A of the Uniform Commercial Code. You waive all rights and remedies conferred upon a lessee by Article 2A (508-522) of the UCC. You have received a copy of the Supply Contract or been informed of the identity of the Supplier and you may have rights under the Supply Contract and may contact the Supplier for a description of those rights.
- CREDIT INFORMATION:** You authorize us or any of our affiliates to obtain credit bureau reports, and make other credit inquiries that we deem necessary.
- CHOICE OF LAW: THIS LEASE WILL BE GOVERNED BY CONNECTICUT LAW. YOU CONSENT TO JURISDICTION IN THE STATE OR FEDERAL COURTS IN CONNECTICUT AND WAIVE ANY RIGHT TO A TRIAL BY JURY.**
- MISCELLANEOUS:** This Lease is the parties' entire agreement and can be amended only in writing signed by both parties. This Lease may be executed in counterparts (manually or by electronic means) and, when transmitted to us shall be binding upon you for all purposes. This Lease is not binding on us until we sign it. You agree not to raise as a defense to the enforcement of this Lease that it was executed or transmitted to us by electronic means. You will use the Equipment only for business purposes and not for personal, family or household use. The USA PATRIOT Act requires us to obtain, verify, and record information that identifies you thus we ask for your name, address and other information or documents that substantiate your identity.

ACCEPTED BY LESSEE:

[Signature] Print Name: Michael B. Baker Title: President
Lessee Authorized Signature E-Mail Address: Date: 01/22

Tax ID Number:

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

SIGNED Print Name: E-Mail Address:

Accepted by: The Office Works Inc. By: Title: Date: The Office Works (LEASE 01 2-7-2019)



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

Lease Application No.: _____ or Lease No.: _____

- (1) Toshiba e-Studio 6516ACT color multifunction copy system
- (1) Toshiba e-Studio 3518A multifunction copy system
- (1) Kyocera M2640 multifunction copy system

LESSEE: Bloomfield Health Care Center

THE OFFICE WORKS INC.

BY: [Signature] *for Bloomfield*
PRINT NAME: Michael Bohan
TITLE: President
DATE: 6/1/12

BY: _____
PRINT NAME: _____
TITLE: _____
DATE: _____

General Information and Questionnaire
Accounting Basis

Name of Facility Bloomfield Health Care Center of C	License No. 913-C	Report for Year Ended 9/30/2022	Page 7	of 37
The records of this facility for the period covered by this report were maintained on the following basis: <input checked="" type="radio"/> Accrual <input type="radio"/> Cash <input type="radio"/> Modified Cash				
Is the accounting basis for this period the same as for the previous period? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain.				
Independent Accounting Firm				
Name of Accounting Firm 1 Marcum LLP 2 MARTIN FRIEDMAN CPA 3 4		Address (No. & Street, City, State, Zip Code) 555 Long Wharf Drive, New Haven, CT 06511 2600 NOSTRAND AVE. BROOKLYN, NY 11210		
Services Provided by This Firm (<i>describe fully</i>)				
1	Financial Statements, Tax return and related cost report filings	\$	28,685	
2	EE RETENTION CREDIT	\$	6,000	
3		\$		
4		\$		
			Charge for Services Provided	
			\$	34,685
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. <input checked="" type="radio"/> Yes <input type="radio"/> No Page 15 Line 1d				
Legal Services Information				
Name of Legal Firm or Independent Attorney 1 Rogin Nassau 2 Jackson Lewis 3 GOLDMAN GRUDER & WOOD 4 Various 5			Telephone Number 860-256-6300 914-872-8060 203-899-8900 Various	
Address (<i>No. & Street, City, State, Zip Code</i>) 1 185 Asylum Street, Hartford, CT 06103 2 44 South Broadway 14th floor, White Plains, NY 10601 3 200 Connecticut Ave., Norwalk CT 06854 4 Various 5				
Services Provided by This Firm (<i>describe fully</i>)				
1	Mortgage Refinancing (Disallowed on Pg 28)	\$	2,483	
2	HR Matters	\$	45,357	
3	Collections (Disallowed on Pg 28)	\$	11,732	
4	Various Estate and Conservatorship Services (Disallowed on Pg 28)	\$	2,569	
5		\$		
			Charge for Services Provided	
			\$	62,141
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. <input checked="" type="radio"/> Yes <input type="radio"/> No Page 15 Line 1e				

Schedule of Resident Statistics

Name of Facility Bloomfield Health Care Center of CT, LLC			License No. 913-C		Report for Year Ended 9/30/2022				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	120	120			120	120							
B. On last day of THIS report period	120	120							120	120			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	88	88			88	88							
B. As of midnight of THIS report period	95	95							95	95			
3. Total Number of Days Care Provided During Period													
A. Medicare	1,871	1,871			1,425	1,425			446	446			
B. Medicaid (Conn.)	29,680	29,680			21,725	21,725			7,955	7,955			
C. Medicaid (other states)													
D. Private Pay	1,978	1,978			1,519	1,519			459	459			
E. State SSI for RCH													
F. Other (Specify) Managed Care	1,701	1,701			1,296	1,296			405	405			
G. Total Care Days During Period (3A thru F)	35,230	35,230			25,965	25,965			9,265	9,265			
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	15	15			15	15							
5. Total Resident Days (3G + 4A + 4B)	35,245	35,245			25,980	25,980			9,265	9,265			

Schedule of Resident Statistics (Cont'd)

Name of Facility Bloomfield Health Care Center of CT, LLC			License No. 913-C			Report for Year Ended 9/30/2022			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)				
N/A													
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days								CCNH	RHNS	(Specify)			
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	6		83		6								
Per Diem Rate													
a. One bed rm.	Various		310.73		425.00								
b. Two bed rms.	Various		310.73		395.00								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								2,782	2,782				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other								4,456	4,456				
D. Total Physical Therapy Treatments								7,238	7,238				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								449	449				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other								539	539				
D. Total Speech Therapy Treatments								988	988				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								2,770	2,770				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other								5,031	5,031				
D. Total Occupational Therapy Treatments								7,801	7,801				

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2022	10	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
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)	5,771	64				
2. Administrator(s) (Complete also Sec. III of Schedule A1)	154,720	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	246,439	9,527				
5. Dietary Service						
a. Head Dietitian	40,721	914				
b. Food Service Supervisor	67,768	2,166				
c. Dietary Workers	443,851	23,356				
6. Housekeeping Service						
a. Head Housekeeper	52,106	2,104				
b. Other Housekeeping Workers	269,487	14,545				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	73,172	2,080				
b. Other Maintenance Workers	74,517	4,165				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	145,447	6,770				
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	282,320	4,112				
b. RN						
1. Direct Care	511,078	10,185				
2. Administrative**	156,714	3,766				
c. LPN						
1. Direct Care	997,715	28,983				
2. Administrative**						
d. Aides and Attendants	1,622,033	81,331				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	103,009	5,600				
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	140,925	2,778				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	120,966	4,311				
<i>A-13. Total Salary Expenditures</i>	5,508,759	208,837				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
	-					
Admissions (\$24,193 Disallowed Relating to Marketing)	\$ 120,966	4,311				
Total	\$ 120,966	4,311	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
	-					
IV Nursing Consultant (Disallowed on Pg 28a)	\$ 12,549	136				
Total	\$ 12,549	136	\$ -	-	\$ -	-

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

Name of Facility				License No.	Report for Year Ended			Page	of	
Bloomfield Health Care Center of CT, LLC				913-C	9/30/2022			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Marvin J. Ostreicher	5,771			Non Discriminatory	Supervises operations, deals with DNS & Financial Mgmt	64	A1	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.

	TOTAL	BEDS	AllocatedBenefits	Total w/ Bnft
Augusta	38.75	72	5.41	44.16
Belair	45.50	102	7.67	53.17
Bethel	37.25	161	12.10	49.35
Bloomfield	54.75	120	9.02	63.77
Brattleboro	38.75	80	6.01	44.76
Brentwood	40.75	78	5.86	46.61
Brewer	39.75	111	8.34	48.09
Bristol	37.75	132	9.92	47.67
Cambridge	42.75	160	12.03	54.78
Catskill	37.75	136	10.22	47.97
Colony	47.75	92	6.92	54.67
Country	51.75	111	8.34	60.09
Dover	47.50	112	8.42	55.92
Eastside	44.50	69	5.19	49.69
Eliot	47.00	114	8.57	55.57
Glen Falls	38.00	120	9.02	47.02
Hebrew Home	63.75	257	19.32	83.07
Huntington	40.50	320	24.05	64.55
Kennebunk	46.25	78	5.86	52.11
Ludlowe	37.00	144	10.82	47.82
Maple View	56.75	120	9.02	65.77
Marlborough	40.25	120	9.02	49.27
Maywood	42.00	120	9.02	51.02
Milford	42.50	120	9.02	51.52
Newton Wellseley	49.75	110	8.27	58.02
Norway	41.75	70	5.26	47.01
Poughkeepsie	42.00	200	15.03	57.03
Regency	43.50	130	9.77	53.27
Reservoir	45.75	144	10.82	56.57
Riverside	61.75	345	25.93	87.68
Rutland	41.50	125	9.40	50.90
Sachem	50.00	111	8.34	58.34
Sands Point	48.50	180	13.53	62.03
Utica	45.75	117	8.79	54.54
Village Crest	42.00	95	7.14	49.14
Water's Edge	42.50	150	11.28	53.78
Westgate	44.50	104	7.82	52.32
Winship	45.75	72	5.41	51.16
Vacation	328.00			
Sick	0.00			
Personal	0.00			
Holiday	48.00			
Total	2080.25	5,002	376	2,080.25

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
Bloomfield Health Care Center of CT, LLC				913-C	9/30/2022			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Portia Bachman	154,720			Non Discriminatory	Administrator	2,080	A2			
Section IV - Assistant Administrators										

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

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

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

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	9/30/2022	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	9,247	480				
3. Pharmacist	11,083	111				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	200,185	2,959				
b. Other						
6. Social Worker	578	11				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	43,200	199				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	51,419	884				
b. Other						
10. Occupational Therapist						
a. Resident Care	218,885	5,293				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	127,827	1,756				
2. Administrative***						
b. LPN						
1. Direct Care	222,726	4,222				
2. Administrative***						
c. Aides	232,883	7,524				
d. Other						
12. Other (Specify)						
See Attached Schedule	12,549	136				
B-13 Total Fees Paid in Lieu of Salaries	1,130,582	23,575				

* 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 Bloomfield Health Care Center of CT, LLC		License No. 913-C	Report for Year Ended 9/30/2022	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Gerident Solutions, P.O. Box 290539, Wethersfield, CT 06129	Dentist	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Procure LTC of CT, 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist / IV Nursing Consultant	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
Preferred Therapy-809 Main St., E.Hartford,CT, 06108	PT, OT, ST	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
Starling Physicians PC 2110 SILAS DEANE HIGHWAY ROCKY HILL CT 06067	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Regency House of Wallingford, Inc. 181 East Main Street, Wallingford CT, 06492	Social Service Consultant	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
SDX/SWALLOWING DIAGNOSTICS 21 WATERVILLE RD AVON CT 06001	Speech Therapy	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
PREFERRED PROFESSIONAL SERVICES 850 Silas Deane Hwy Wethersfield, CT 06109	RNs / LPNs/ CNAs	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
INTELYCARE INC PO BOX 200413 PITTSBURGH PA 15262	RNs / LPNs/ CNAs	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
MAS MEDICAL STAFFING PO BOX 4473 HOUSTON TX 77210	RNs / LPNs/ CNAs	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Five Star Care, 713 Suffolk Ave, Brentwood, NY 11717	LPNs/ CNAs	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
The Nurse Network, 653 Main St, Plantsville, CT 06479	LPNs/ CNAs	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Regency House of Wallingford, Inc. 181 East Main Street, Wallingford CT, 06492	IV Nursing Consultant	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
		<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"/>		
		<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
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2022		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 236,563	236,563			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 56,523	56,523			
4. Social Security (F.I.C.A.)	\$ 407,843	407,843			
5. Health Insurance	\$ 500,134	500,134			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 137,242	137,242			
8. Uniform Allowance	\$ 29,935	29,935			
9. Other (<i>Specify</i>) See Attached Schedule	\$ 27,290	27,290			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 115,790	115,790			
d. Accounting and Auditing	\$ 34,685	34,685			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 62,141	62,141			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 25,710	25,710			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 34,261	34,261			
2. Cellular Phones	\$ 907	907			
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	\$ 661,877	661,877			
Subtotal	\$ 2,330,901	2,330,901			

* 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)
	-		
Union Training	\$ 24,051		
Background Checks	3,239		
Total	\$ 27,290	\$ -	\$ -

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2022		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:		2,330,901	2,330,901		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 510	510			
3. Gifts to Staff and Residents	\$ 21,416	21,416			
4. Employee Travel	\$ 835	835			
5. Education Expenses Related to Seminars and Conventions	\$ 4,951	4,951			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 394	394			
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 1,200	1,200			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 41,020	41,020			
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	\$ 3,259	3,259			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 8,527	8,527			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 4,338	4,338			
10. Contributions*** See Attached Schedule	\$ 1,250	1,250			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 133,710	133,710			
12. Administrative Management Services**	\$ 603,558	603,558			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 314,596	314,596			
C-14 Total Administrative & General Expenditures	\$ 3,470,465	3,470,465			

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
	-		
Promotional Advertising (Disallowed on Pg 28)	\$ 33,076		
Marketing Supplies / Purchased Services (Disallowed on Pg 28)	7,944		
Total Other Advertising	\$ 41,020	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
	-		
CAHCF Dues	\$ 8,527		
Total Dues	\$ 8,527	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
	-		
Political Contributions (Disallowed on Pg 28)	\$ 1,250		
Total Contributions	\$ 1,250	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
	-		
Licenses and Permits-Bloomfield-Administration	\$ 2,569		
Penalties-Bloomfield-Administration (Disallowed on Pg 28a)	12		
Bank Charges-Bloomfield-Administration	19,519		
Strike Expense-Bloom-Administration	257,403		
Misc. Expense-Bloom-Administration (Disallowed on Pg 28a)	1,324		
Prior Period Expense-Bloomfield-Administration (Disallowed on Pg 28a)	33,769		
Total Other Administrative and General	\$ 314,596	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of CT, LL	913-C	9/30/2022	17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
National Healthcare Associates, Inc.	603,558	Management Fees	Page 16, Line M11/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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2022	18	37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 311,150	311,150		
2. Non-Food Supplies	\$			
3. Other (Specify) _____	\$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 20,399	20,399		
c. Other (Specify) _____ Other Supplies / Equipment Rentals	\$ 28,292	28,292		
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 359,841	359,841		
Item	Total	CCNH	RHNS	(Specify)
2E. Dietary Questionnaire				
F. Resident Meals: Total no. of meals served per day:*				
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
Bloomfield Health Care Center of CT, LLC		913-C	9/30/2022	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. \$	10,424	10,424	
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) Supplies / Diapers		\$	49,159	49,159	
3D. Total Laundry Expenditures (3a + b + c)		\$	59,583	59,583	
3E. Laundry Questionnaire					
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
Bloomfield Health Care Center of CT, LLC		913-C	9/30/2022		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. \$	29,489	29,489			
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. \$					
C. Other (<i>Specify</i>)		\$				
4D. Total Housekeeping Expenditures (4a + b + c)		\$ 29,489	29,489			
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy	\$	221,447	221,447			
2. Purchased from	\$					
b. Medicine Cabinet Drugs	\$	15,885	15,885			
c. Medical and Therapeutic Supplies	\$	101,991	101,991			
d. Ambulance/Limousine***	\$	616	616			
e. Oxygen						
1. For Emergency Use	\$					
2. Other***	\$	6,165	6,165			
f. X-rays and Related Radiological Procedures***	\$	11,166	11,166			
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$					
h. Laboratory***	\$	17,643	17,643			
i. Recreation	\$	24,688	24,688			
j. Direct Management Services*	\$					
k. Indirect Management Services*	\$					
l. Other (Specify)**** See Attached Schedule	\$	70,473	70,473			
5M. Total Resident Care Expenditures (5a - 5j)		\$ 470,074	470,074			

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
	-		
Flu Vaccine-Bloom-Medical Services	\$ 3,690		
IV Thy Supplies-Bloomfield-Rehab Tpy and Ancllry (Disallowed on Pg 29a)	7,533		
Equip Rental-Bloomfield-Nursing (Disallowed on Pg 29a)	22,038		
Equip Rental-Bloomfield-Rehab Tpy and Ancllry (Disallowed on Pg 29a)	10,148		
Equip Rental-Bloomfield-Respiratory (Disallowed on Pg 29a)	27,064		
Total Other Resident Care	\$ 70,473	\$ -	\$ -

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

Name of Facility Bloomfield Health Care Center of CT, LLC			License No. 913-C	Report for Year Ended 9/30/2022	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	
ADM Environmental Group	Avenue, Brooklyn, Ny 11230	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Waster Service/ Monthly Recycling Service	14,227				22	6f
MANHATTAN TECH SUPPORT	55 W 39TH ST, NEW YORK, NY 10018	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Computer Maintenance System	38,703				16	m11
XTREME LANDSCAPING	40 Stark Drive East Granby, CT 06026	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Landscaping/ Snow Removal	15,505				22	6f
EMCORE SERVICES	30 Lindeman Drive Trumbull, CT 06611	<input type="radio"/>	<input checked="" type="radio"/>	N/A	HVAC	20,803				22	6f
SMART CARE EQUIPMENT	P.O. Box 74008980 Chicago, IL 60674-8980	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Dietary Equipment Repair	20,147				18	2b
		<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"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Bloomfield Health Care Center of CT, LLC	913-C	9/30/2022			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$					
b. Heat	\$ 57,798	57,798				
c. Light & Power	\$ 111,365	111,365				
d. Water	\$ 36,475	36,475				
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$ 52,232	52,232				
f. Other <i>(itemize)</i> See Attached Schedule	\$ 138,621	138,621				
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 396,491	396,491				
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$					
b. Building & Building Improvements	\$ 247,095	247,095				
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 70,248	70,248				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 317,343	317,343				
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 58,921	58,921				
d. Other <i>(Specify)</i>	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 58,921	58,921				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 840,000	840,000				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 91,710	91,710				
c. Personal property taxes	\$ 14,570	14,570				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,322,544	1,322,544				

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
	-		
Supplies-Bloomfield-Maintenance	\$ 22,617		
Purch Services-Bloomfield-Maintenance	47,191		
Purch Services-Bloomfield-Security	12,605		
Ground Services-Bloomfield-Maintenance	15,505		
Pest Control-Bloom-Maintenance	3,304		
Carting-Bloomfield-Maintenance	35,571		
Equip Rental-Bloomfield-Maintenance	1,828		
Total Other Repairs and Maintenance	\$ 138,621	\$ -	\$ -

Depreciation Schedule

Name of Facility		License No.		Report for Year Ended			Page	of					
Bloomfield Health Care Center of CT, LLC		913-C		9/30/2022			23	37					
Property Item		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals				
A. Land Improvements													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal													
B. Building and Building Improvements													
1. Acquired prior to this report period													
		5,657,365		5,657,365	4,961,152	S/L	Various	247,095					
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal													
247,095													
C. Non-Movable Equipment													
1. Acquired prior to this report period													
		36,366		36,366	36,366	S/L	Various						
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal													
		Is a mileage logbook maintained?	Date of Acquisition		Historical Cost	Less	Cost to Be	Accumulated	Method of	Useful	Depreciation	Totals	
		Yes	No	Month	Year	Exclusive of Land	Salvage Value	Depreciated	Beginning of Year's Operations	Computing Depreciation	Life	for This Year	
D. Movable Equipment													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a.													
b.													
c.													
d.													
2. Movable Equipment													
				Var	Var	687,747		687,747	380,110	S/L	Various	58,753	
a. Acquired prior to this report period													
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
				Var	Var	52,193		52,193		S/L	Various	10,764	
c. Administrative													
				Var	Var	7,730		7,730		S/L	Various	731	
d. Standard Resident													
e. Specialized Resident													
						59,923		59,923				11,495	
Total Acquired during this report period													
D-3. Subtotal													
70,248													
E. Total Depreciation													
317,343													

Schedule of Land Improvements Acquired during this report period

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

*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 Improvement		\$ -		\$ -
Deletions:				
Total deletions for Building Improvement		\$ -		\$ -

*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 Equipmen		\$ -		\$ -
Deletions:				
Total deletions for Non-Movable Equipmen		\$ -		\$ -

*Ties to Page 23, Line C3
 **Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report peric

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
Additions:					
10/8/2021	Dell Latitude Laptops x 1	Administrative	\$ 1,592	3	\$ 531
10/15/2021	ViewBladder 10 Kit Scanner	Administrative	4,324	5	865
10/22/2021	Dell Latitude Laptop x 1	Administrative	1,106	5	221
11/1/2021	24 Dell Optiplex 5000 Series"	Administrative	9,937	3	3,312
11/8/2021	Power Eagle 1020 Extractor	Administrative	3,575	5	715
12/20/2021	Dell Latitude Laptops x 1	Administrative	1,469	3	490
2/28/2022	Dell Laptops x 1	Administrative	1,190	3	397
3/1/2022	Dell Latitude laptop	Administrative	1,190	3	397
3/23/2022	PTAC A/C system	Administrative	7,179	15	479
4/8/2022	Dell Latitude Laptop & Monitor	Administrative	1,732	3	577
4/26/2022	Dell Latitude Laptop & Monitor	Administrative	1,416	3	472
6/3/2022	Movin Cool Unit (A/C)	Administrative	7,960	10	796
6/29/2022	Reach in Refrigerator	Administrative	6,313	10	631
7/8/2022	35 Electric Bed in Cherry"	Standard Resident	2,550	12	213
9/14/2022	Floor Burnisher High Speed	Administrative	1,418	5	284
9/21/2022	Patient Power Lift	Standard Resident	1,284	10	128
9/27/2022	35 BRNWOOD BDEND/patient bed"	Standard Resident	3,896	10	390
9/29/2022	Dell Laptop & LG Monitor	Administrative	1,792	3	597
Total additions for Movable Equipmen			\$ 59,923		\$ 11,495
Deletions:					
Total deletions for Movable Equipmen			\$ -		\$ -

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/16/2021	Backflow replacement hot water	\$ 3,015	3	\$ 1,005
10/18/2021	Installed the new relief valve	1,413	3	471
10/18/2021	Replace motor (Jenco Ex. Fan 18	1,487	3	496
11/30/2021	Installed Backflows for Ice Ma	3,917	3	1,306
2/8/2022	Rpl Domestic Water Piping	8,207	15	547
7/1/2022	Commerical Vinyl Tile	1,857	10	186
Total additions for Leasehold Improvemem		\$ 19,896		\$ 4,011
Deletions:				
Total deletions for Leasold Improvemem		\$ -		\$ -

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility Bloomfield Health Care Center of CT, LLC			License No. 913-C		Report for Year Ended 9/30/2022			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							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	Var	Var	Various	1,003,362	640,960	S/L	Various	54,910	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	Var	Var	Various	19,896		S/L	Various	4,011	
C-4. Subtotal									58,921
D. Total Amortization									58,921

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Asset Type	Description	Date In Service	Method	Life	Historical Cost	2020 A/D	2021 Deprec.	2021 A/D	2022 Deprec.	2022 A/D	NBV
LEASEHOLD IMPROVEMENTS											
LJ	Prior Period Acquisitions (Per 9/30/19 CR)	Various	S/L	Various	865,552	577,260	43,949	621,209	40,486	661,695	203,857
2019 Additions											
LJ	Roofing Replacements	10/15/2018	S/L	10	4,632	926	463	1,389	463	1,852	2,780
LJ	HVAC - Installed new assemblie	1/3/2019	S/L	15	5,028	670	335	1,005	335	1,340	3,688
LJ	HVAC-Changed actuator	1/3/2019	S/L	15	4,349	580	290	870	290	1,160	3,189
LJ	HVAC-Ceiling Fan Heater Repair	2/28/2019	S/L	15	8,073	1,076	538	1,614	538	2,152	5,921
LJ	HVAC-Ceiling Fan Heater Repair	2/28/2019	S/L	15	8,073	1,076	538	1,614	538	2,152	5,921
LJ	Roofing Replacements	3/3/2019	S/L	10	2,251	450	225	675	225	900	1,351
LJ	Roofing Replacements	6/1/2019	S/L	10	2,375	476	238	714	238	952	1,423
LJ	Power Supply on Fire Alarm	9/29/2019	S/L	10	3,880	776	388	1,164	388	1,552	2,328
LJ	New Flex Control Panel & Float	9/30/2019	S/L	15	6,522	870	435	1,305	435	1,740	4,782
2020 Additions											
LJ	LCN door closer	12/1/2019	S/L	10	1,519	127	152	279	152	431	1,088
LJ	XCU1 Compressor Replacement	7/9/2020	S/L	15	12,462	208	831	1,039	831	1,870	10,592
LJ	Replace thermal expansio Valve	8/19/2020	S/L	10	2,972	50	297	347	297	644	2,328
LJ	Replace exhaust fan motors	8/31/2020	S/L	10	2,017	34	202	236	202	438	1,579
LJ	Replace Jenco Ex Fan#16	8/31/2020	S/L	10	2,547	42	255	297	255	552	1,995
LJ	Installed new sealite-HVAC	9/30/2020	S/L	5	1,740	29	348	377	348	725	1,015
2021 Additions											
LJ	PK5 Replacement	11/30/2020	S/L	5	18,335	-	3,361	3,361	3,667	7,028	11,306
LJ	Replace Evaporator Coil	11/30/2020	S/L	10	14,803	-	1,357	1,357	1,480	2,837	11,966
LJ	HVAC various improvements	11/30/2020	S/L	10	7,110	-	652	652	711	1,363	5,747
LJ	New Trane 2 ton package AC Sys	12/18/2020	S/L	10	9,199	-	767	767	920	1,687	7,513
LJ	Replace combustion motor	12/31/2020	S/L	5	1,192	-	199	199	238	437	755
LJ	Plumbing & HWH piping parts	3/31/2021	S/L	10	1,681	-	98	98	168	266	1,415
LJ	New Main Sign	5/1/2021	S/L	10	4,322	-	180	180	432	612	3,709
LJ	PK 9 Replacement Project	8/31/2021	S/L	10	12,730	-	212	212	1,273	1,485	11,245
2022 Additions											
LJ	Backflow replacement hot water	10/16/2021	S/L	3	3,015	-	-	-	1,005	1,005	2,010
LJ	Installed the new relief valve	10/18/2021	S/L	3	1,413	-	-	-	471	471	942
LJ	Replace motor Jenco Ex. Fan#8	10/18/2021	S/L	3	1,487	-	-	-	496	496	991
LJ	Installed Backflows for Ice Ma	11/30/2021	S/L	3	3,917	-	-	-	1,306	1,306	2,611
LJ	Rpl Domestic Water Piping	2/8/2022	S/L	15	8,207	-	-	-	547	547	7,660
LJ	Commerical Vinyl Tile	7/1/2022	S/L	10	1,857	-	-	-	186	186	1,671
TOTAL LEASEHOLD IMPROVEMENTS					1,023,258	584,650	56,310	640,960	58,921	699,881	323,377
Building Improvements											
Bldg Imp	Prior Period Acquisitions (Per 9/30/18 CR)	Various	S/L	Various	5,657,365	4,961,152	-	4,961,152	247,095	5,208,247	449,118
TOTAL Building Improvements					5,657,365	4,961,152	-	4,961,152	247,095	5,208,247	449,118
NON-MOVABLE EQUIPMENT											
NME	Prior Period Acquisitions (Per 9/30/18 CR)	Various	S/L	Various	36,366	35,890	476	36,366	-	36,366	-
TOTAL NON-MOVABLE EQUIPMENT					36,366	35,890	476	36,366	-	36,366	-
MOVABLE EQUIPMENT											
MME	Prior Period Acquisitions (Per 9/30/18 CR)	Various	S/L	Various	558,520	298,603	55,486	354,089	36,076	390,165	168,355
2019 Additions											
MME	Table Base & Top	11/30/2018	S/L	10	1,097	220	110	330	110	440	657
MME	Dining Armchair	11/30/2018	S/L	10	5,005	1,002	501	1,503	501	2,004	3,001
MME	Video Entry System	11/30/2018	S/L	5	2,270	908	454	1,362	454	1,816	454
MME	HP260 G3 Desktop Mini PC	1/31/2019	S/L	3	776	518	258	776	-	776	(1)
MME	Install Aiphone Intercom Syste	2/28/2019	S/L	10	5,929	1,186	593	1,779	593	2,372	3,557
MME	HP 260 G3 Desktop Mini PC	2/28/2019	S/L	3	561	374	187	561	-	561	(0)
MME	HP 260 G3 Desktop Mini PC	2/28/2019	S/L	3	776	518	258	776	-	776	(1)
MME	LATI 7490 Laptop	2/28/2019	S/L	3	1,422	948	474	1,422	-	1,422	(0)
MME	Chair, Table & Couch	5/21/2019	S/L	10	9,893	1,978	-	1,978	-	1,978	7,915
MME	2 x MCQUAY PTAC installation	8/31/2019	S/L	5	9,974	3,990	1,995	5,985	1,995	7,980	1,994
2020 Additions											
MME	Relief Max Mattress x 1	10/1/2019	S/L	5	1,010	202	202	404	202	606	404
MME	Monitor Vial spot Oxi Temp	11/5/2019	S/L	6	2,034	311	339	650	339	989	1,045
MME	Reduce Max Mattress	12/1/2019	S/L	5	718	120	144	264	144	408	310
MME	Wheelchair & Elev. Legrests	12/1/2019	S/L	5	727	121	145	266	145	411	316
MME	Latitude 5400 I5 Laptop	2/29/2020	S/L	3	1,229	273	410	683	410	1,093	136
MME	Victory Electro Hand Sprayer	4/17/2020	S/L	10	1,072	54	107	161	107	268	804
MME	KIT BPT/THERMOXIM SPTVTL	4/22/2020	S/L	10	5,172	259	517	776	517	1,293	3,880
MME	3 Parameter Temp Pulse Oximete	4/30/2020	S/L	7	3,416	244	488	732	488	1,220	2,196
MME	PVC MINI Isolation Station	4/30/2020	S/L	10	1,212	61	121	182	121	303	910
MME	Smart Buy Eilitedesk Desktop	4/30/2020	S/L	3	968	161	323	484	323	807	161
MME	5 Liter Oxygen Concentrator	4/30/2020	S/L	3	609	102	203	305	203	508	101
MME	Steamer, Convection, Boilerles	5/20/2020	S/L	10	6,240	260	624	884	624	1,508	4,732
MME	COVID- 32 Class 720P HD LEDTV*	5/31/2020	S/L	5	606	51	121	172	121	293	314
MME	Mattress-Panacea Support Foam	7/21/2020	S/L	5	519	26	104	130	104	234	285
MME	IT Equipments	8/11/2020	S/L	5	1,560	52	312	364	312	676	884
MME	Laundry Parts-Control & Carton	9/30/2020	S/L	5	1,876	31	375	406	375	781	1,095
MME	Mattress	9/30/2020	S/L	5	936	16	187	203	187	390	546
2021 Additions											
MME	P3500S ID Coor Printer Identif	2/1/2021	S/L	5	1,617	-	216	216	323	539	1,079

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

Asset Type	Description	Date In Service	Method	Life	Historical Cost	2020	2021	2021	2022	2022	NBV	
						A/D	Deprec.	A/D	Deprec.	A/D		
MME	16CH Turbo HD IPR & 2MP Camera	3/12/2021	S/L	5	2,783	-	325	325	557	882	1,901	
MME	Dell 3000 Series Laptop	4/12/2021	S/L	3	1,206	-	201	201	402	603	603	
MME	Dell 24 Optiplex 7000 Series"	4/13/2021	S/L	3	5,121	-	853	853	1,707	2,560	2,560	
MME	Dell Optiplex Desktop	5/21/2021	S/L	3	1,114	-	155	155	371	526	589	
MME	Dell Optiplex Desktop	5/25/2021	S/L	3	1,127	-	157	157	376	533	595	
MME	Wheelchair Scale	6/23/2021	S/L	5	1,328	-	89	89	266	355	974	
MME	Patient Monitors w/NIBP x 3	6/23/2021	S/L	7	6,300	-	300	300	900	1,200	5,100	
MME	ELOView Control Managed Device	6/28/2021	S/L	3	2,986	-	332	332	995	1,327	1,660	
MME	Portable Air Conditioner Heavy	7/7/2021	S/L	10	5,480	-	137	137	548	685	4,795	
MME	Dell Laptop	7/8/2021	S/L	3	1,457	-	121	121	486	607	850	
MME	Dell Laptop	7/9/2021	S/L	3	1,430	-	119	119	477	596	834	
MME	MX95 Security License	7/9/2021	S/L	3	8,083	-	674	674	2,694	3,368	4,716	
MME	Monitor and Software License	7/16/2021	S/L	3	4,307	-	359	359	1,436	1,795	2,512	
MME	Dell Desktop	7/19/2021	S/L	3	1,240	-	103	103	413	516	723	
MME	Emergency Crash Cart	7/26/2021	S/L	10	2,508	-	63	63	251	314	2,194	
MME	Pellet Ice Maker	8/31/2021	S/L	10	6,062	-	101	101	606	707	5,355	
MME	Dell Desktop	8/31/2021	S/L	3	1,259	-	70	70	420	490	769	
MME	Air cooled condensing unit	9/30/2021	S/L	15	16,103	-	89	89	1,074	1,163	14,940	
2021 Disposals												
MME	Disposal of Chair, Table & Couch				(9,893)	-		(1,978)	-	(1,978)	(7,915)	
2022 Additions												
MME	Dell Latitude Laptops x 1	10/8/2021	S/L	3	1,592	-	-	-	531	531	1,061	
MME	ViewBladder 10 K1 Scanner	10/15/2021	S/L	5	4,324	-	-	-	865	865	3,459	
MME	Dell Latitude Laptop x 1	10/22/2021	S/L	5	1,106	-	-	-	221	221	885	
MME	24 Dell Optiplex 5000 Series"	11/1/2021	S/L	3	9,937	-	-	-	3,312	3,312	6,625	
MME	Power Eagle 1020 Extractor	11/8/2021	S/L	5	3,575	-	-	-	715	715	2,860	
MME	Dell Latitude Laptops x 1	12/20/2021	S/L	3	1,469	-	-	-	490	490	979	
MME	Dell Laptops x 1	2/28/2022	S/L	3	1,190	-	-	-	397	397	793	
MME	Dell Latitude laptop	3/1/2022	S/L	3	1,190	-	-	-	397	397	793	
MME	PTAC A/C system	3/23/2022	S/L	15	7,179	-	-	-	479	479	6,700	
MME	Dell Latitude Laptop & Monitor	4/8/2022	S/L	3	1,732	-	-	-	577	577	1,155	
MME	Dell Latitude Laptop & Monitor	4/26/2022	S/L	3	1,416	-	-	-	472	472	944	
MME	Movin Cool Unit (A/C)	6/3/2022	S/L	10	7,960	-	-	-	796	796	7,164	
MME	Reach in Refrigerator	6/29/2022	S/L	10	6,313	-	-	-	631	631	5,682	
MME	35 Electric Bed in Cherry"	7/8/2022	S/L	12	2,350	-	-	-	213	213	2,337	
MME	Floor Burnisher High Speed	9/14/2022	S/L	5	1,418	-	-	-	284	284	1,134	
MME	Patient Power Lift	9/21/2022	S/L	10	1,284	-	-	-	128	128	1,156	
MME	35 BRNWOOD BDEND/patient bed"	9/27/2022	S/L	10	3,896	-	-	-	390	390	3,506	
MME	Dell Laptop & LG Monitor	9/29/2022	S/L	3	1,792	-	-	-	597	597	1,195	
TOTAL MOVABLE EQUIPMENT					747,670		317,587	69,501	380,110	70,248	450,358	297,312
TOTAL ASSETS PER CR SCHEDULE					7,464,658		5,894,279	126,287	6,018,588	376,264	6,394,852	1,069,806
TOTAL ASSETS PER TRIAL BALANCE					1,807,293		1,187,649	129,169	1,187,649	129,169	1,187,649	619,644
LESS REALTY ASSETS					(5,657,365)		(4,961,152)	0	(4,961,152)	(247,095)	(5,208,247)	(449,118)
ROUNDING												
VARIANCE					0		(254,522)	(2,882)	(130,213)	-	(1,044)	1,044
TOTAL REALTY ASSETS PER SCHEDULE					5,657,365							
TOTAL REALTY ASSETS PER REALTY TB					7,189,076							
HISTORICAL VARIANCE ROLLED FORWARD*					1,531,711							

F/S vs C/R NBV - Page 31, Line B9 (1,044)
F/S vs C/R Depreciation - Page 36, Line F1 (247,095)

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

Name of Facility Bloomfield Health Care Center of CT,	License No. 913-C	Report for Year Ended 9/30/2022	Page 25	of 37
11. Property Questionnaire				
Part A				
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				
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
1. Financing				
a. Type of Financing (e.g., fixed, variable)		Fixed		
b. Date Mortgage Obtained		07/01/02		
c. Interest Rate for the Cost Year		733.00%		
d. Term of Mortgage (number of years)		15		
e. Amount of Principal Borrowed		8,226,480		
f. Principal balance outstanding as of 09/30/22		1,672,235		
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.

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	9/30/2022		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)

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

Name of Facility		License No.		Report for Year Ended			Page	of
Bloomfield Health Care Center of C		913-C		9/30/2022			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)				\$	18,106	18,106		
Admin / Computer Loan Interest								
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	18,106	18,106		
14. Insurance								
a. Insurance on Property (buildings only)				\$	15,433	15,433		
b. Insurance on Automobiles				\$				
c. Insurance other than Property (as specified above)								
1. Umbrella (Blanket Coverage)				\$				
2. Fire and Extended Coverage				\$				
3. Other (Specify)				\$	86,051	86,051		
Liability / Crime Insurance								
14d. Total Insurance Expenditures (14a + b + c)				\$	101,484	101,484		
15. Total All Expenditures (A-13 thru C-14)				\$	12,867,418	12,867,418		

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	9/30/2022	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 24,193	24,193		
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.	13	b10a	Occupational Therapy	\$ 218,885	218,885		
7.			Other - See attached Schedule	\$ 12,549	12,549		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 115,790	115,790		
10.			Accounting	\$			
10a.	15	1e	Legal	\$ 16,784	16,784		
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	L3	Gifts, flowers and coffee shops	\$ 21,416	21,416		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.	16	L4	Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$ 28	28		
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m2/3	Unallowable Advertising *	\$ 41,020	41,020		
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m10	Fund Raising / Contributions	\$ 1,250	1,250		
21.	16	m12	Unallowable Management Fees	\$ 306,566	306,566		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 71,366	71,366		
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)				\$ 829,847	829,847		

* All except "Help Wanted"

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	l2o	Admissions Salary relating to Marketing	\$ 24,193		
Total Other Salaries Adjustment			\$ 24,193	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	b12o	IV Nursing Consultant	\$ 12,549		
Total Other Fees Adjustments			\$ 12,549	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
15	lA1	Workers Comp Retro Expense	\$ 31,680		
16	m13	Penalties-Bloomfield-Administration	12		
16	m13	Misc. Expense-Bloom-Administration	1,324		
16	m13	Prior Period Expense-Bloomfield-Administration	33,769		
15	Var	Benefits Associated with Marketing Salary	4,581		
Total Other A&G Adjustments			\$ 71,366	\$ -	\$ -

**Bloomfield Health Center for Nursing & Rehab
 Calculation of Allowable Management Fee
 September 30, 2022**

<u>Description</u>	<u>Amount</u>	
Management fees Charged	603,558	Page 16, Line m12
Accounting Charges	34,685	Page 15, Line 1d
Total Management Fees Per Agreement	638,243	
Patient Days	35,245	Page 8 of C/R
Imputed Days - 90% Occupancy (365/365 Days)	39,420	Calculation
Amount Per Patient Day (Greater of 90% or Actaul Days)	\$ 16.19	
PPD Allowance Per Client 9/30/21	7.84	
2022 CPI Increase %	1.07	J.01b
PPD Allowance 9/30/2022	8.41	
Amount over (Under)	\$ 7.7769	
Total Days	39,420	
Disallowed Management Fee	\$ 306,566	

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	9/30/2022	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 829,847	829,847		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$ 221,447	221,447		
28.			Ambulance/Limousine	\$ 616	616		
29.			X-rays, etc	\$ 11,166	11,166		
30.			Laboratory	\$ 17,643	17,643		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$ 6,165	6,165		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 95,235	95,235		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 1,458	1,458		
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	\$ 223,163	223,163		
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
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)				\$ 1,406,740	1,406,740		

*** 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	5l	IV Thy Supplies-Bloomfield-Rehab Tpy and Ancllry	\$ 7,533		
20	5l	Equip Rental-Bloomfield-Rehab Tpy and Ancllry	10,148		
20	5l	Equip Rental-Bloomfield-Respiratory	27,064		
20	5l	Equip Rental-Bloomfield-Nursing	22,038		
20	5i	Cable Television Disallowance	7,855		
20	5c	Med B Nursing Supplies	20,597		
Total Other Ancillary Costs			\$ 95,235	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Non Allowable Depreciation on Movable Equipment	\$ 1,458		
Total Excess Movable Equipment Depreciation			\$ 1,458	\$ -	\$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

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

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30	IV 8	Medical Records Revenue	\$ 99		
30	IV 8	Refunds / Rebates	1,390		
30	IV 8	Strike Reimbursement	221,674		
Total Other Adjustments			\$ 223,163	\$ -	\$ -

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

National Health Care Associates, Inc. (CT)
Cable TV Disallowance
September 30, 2022

Pg. 29b

Total Cable TV Expense	15,055	TB Linked
Total Monthly Fee Allowed	\$ 600	
Total Months	12	
Total Allowable Expense	<u>\$ 7,200</u>	
Partial Year Cost Report (365 out of 365 Days)	\$ 365	
Days in Cost Report Year	365	
Partial Year Allowable %	<u>100.00%</u>	
Revised Allowable Cost	\$ 7,200	
Disallowed Expense	<u><u>\$ 7,855</u></u>	{a}

Tickmark
{a}

Ties to page 29a

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Bloomfield Health Care Center of CT, LL913-C		9/30/2022		30	37
Item	Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 10,987,140	10,987,140			
b. Medicaid Room and Board Contractual Allowance **	\$ (2,814,550)	(2,814,550)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 754,326	754,326			
b. Medicare Room and Board Contractual Allowance **	\$ (587,112)	(587,112)			
4. a. Private-Pay Residents and Other	\$ 2,207,090	2,207,090			
b. Private-Pay Room and Board Contractual Allowance **	\$ (213,748)	(213,748)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 143,890	143,890			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (210,685)	(210,685)			
c. Prescription Drugs - Non-Medicare	\$ 188,468	188,468			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (193,430)	(193,430)			
2. a. Medical Supplies - Medicare	\$ 2,629	2,629			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (2,629)	(2,629)			
c. Medical Supplies - Non-Medicare	\$ 3,407	3,407			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (3,407)	(3,407)			
3. a. Physical Therapy - Medicare	\$ 345,166	345,166			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (126,160)	(126,160)			
c. Physical Therapy - Non-Medicare	\$ 241,599	241,599			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (211,711)	(211,711)			
4. a. Speech Therapy - Medicare	\$ 119,355	119,355			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (27,815)	(27,815)			
c. Speech Therapy - Non-Medicare	\$ 113,647	113,647			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (99,177)	(99,177)			
5. a. Occupational Therapy - Medicare	\$ 343,499	343,499			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (137,580)	(137,580)			
c. Occupational Therapy - Non-Medicare	\$ 288,286	288,286			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (255,611)	(255,611)			
6. a. Other (<i>Specify</i>) - Medicare	\$ 780,987	780,987			
b. Other (<i>Specify</i>) - Non-Medicare	\$ 165,964	165,964			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 11,801,838	11,801,838			
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$ 3,588	3,588			
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$ 383	383			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 268,742	268,742			
V. Total Other Revenue (1 thru 8)	\$ 272,713	272,713			
VI. Total All Revenue (III +V)	\$ 12,074,551	12,074,551			

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
		-		
30 II 6a	Medicare A NTA Contra-Bloomfield	\$ 264,150		
30 II 6a	Medicare A Nsng Comp Contra-Bloomfield	424,315		
30 II 6a	Medicare Pt A IV Therapy-Bloomfield	68,173		
30 II 6a	Medicare Pt A Lab-Bloomfield	13,859		
30 II 6a	Medicare Pt A X-Bloomfield	10,845		
30 II 6a	Medicare Pt B Prior Period-Bloomfield	(355)		
Total Other Resident Revenue - Medicare		\$ 780,987	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
		-		
30 II 6b	Medicaid IV Therapy-Bloomfield	\$ 756		
30 II 6b	Medicaid Lab-Bloomfield	6,255		
30 II 6b	Medicaid X-Bloomfield	34		
30 II 6b	Medicaid C/A Prior Period-Bloomfield	(136,620)		
30 II 6b	Private Lab-Bloomfield	171		
30 II 6b	Comm Ins Lab-Bloomfield	1,196		
30 II 6b	Comm Ins X-Bloomfield	2,230		
30 II 6b	Mgd Medicare NTA Contra-Bloomfield	15,418		
30 II 6b	Mgd Medicare Nsng Comp Contra-Bloomfield	24,878		
30 II 6b	Mgd Medicare IV Therapy-Bloomfield	5,927		
30 II 6b	Mgd Medicare Lab-Bloomfield	9,479		
30 II 6b	Mgd Medicare Specialty Beds-Bloomfield	5,321		
30 II 6b	Mgd Medicare X-Bloomfield	8,884		
30 II 6b	Mgd Medicare Prior Period-Bloomfield	(780)		
30 II 6b	Patient Revenue Capitation -Bloomfield	222,815		
Total Other Resident Revenue		\$ 165,964	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
			-		
30 IV 5	Interest on Money Market Account	440,401	\$ 383		
Total Interest Income			\$ 383	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
		-		
30 IV 8	Medical Records Revenue (Disallowed on Pg 29a)	\$ 99		
30 IV 8	Stimulus Revenue	44,435		
30 IV 8	Refunds / Rebates (\$1,390 Disallowed on Pg 29a)	2,534		
30 IV 8	Strike Reimbursement (Disallowed on Pg 29a)	221,674		
Total Other Revenue		\$ 268,742	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, I	913-C	9/30/2022	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (on hand and in banks)			\$	690,188
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,172,281
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4 Inventories			\$	40,118
5. Prepaid Expenses			\$	112,330
a. _____				
b. _____				
c. _____				
d. See Schedule		112,330		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (itemize)			\$	395
Due For Cr Crd Colct-Bloomfiel		395		

See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	2,015,312
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 1,023,258		\$	323,377
	Accum. Depreciation 699,881	Net		
5. Non-Movable Equipment	*Historical Cost 36,366		\$	
	Accum. Depreciation 36,366	Net		
6. Movable Equipment	*Historical Cost 747,670		\$	297,312
	Accum. Depreciation 450,358	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (itemize)			\$	(1,045)
F/S vs C/R NBV		(1,045)		
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	619,644

* 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	
31	A5	Prepaid Workers Comp-Bloomfield	\$ 15,494
31	A5	Prepaid Gen. Ins-Bloomfield	24,943
31	A5	Prepaid Expense Other-Bloomfield	23,864
31	A5	Prepaid Real Estate Taxes-Bloomfield	23,967
31	A5	Prepaid Personal Property Taxes-Bloomfield	10,408
31	A5	Prepaid Mgmt Assets-Bloomfield	13,654
Total Prepaid Expenses			\$ 112,330

Schedule of Other Current Assets (Itemize) 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 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	
Total Other Current Liabilities (Itemize)			\$ -

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

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

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	9/30/2022	32	37
Account			Amount	
Total Brought Forward:			\$	2,634,956
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements			*Historical Cost _____	
Accum. Depreciation _____			Net	
3. Buildings			*Historical Cost <u>5,657,365</u>	
Accum. Depreciation <u>5,208,247</u>			Net	
			\$	449,118
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)			\$	449,118
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 (<i>itemize</i>)			\$	
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address		Amount	Loan Date	
7. Other Assets (<i>itemize</i>)			\$	
Security Deposits-Bloomfield		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)			\$	3,095,574

* 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
Bloomfield Health Care Center of CT, LLC		913-C	9/30/2022	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	436,976
2. Notes Payable (<i>itemize</i>)				\$	76,241
Notes Payable ST4-Bloomfield					2,258
Notes/Loans Payable S/T-Bloomfield					73,983
See Schedule					
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	24,341
Name of Lender		Purpose	Amount	Date Due	
		Equipment Obligation	24,341		
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	329,433
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>)				\$	586,483
Unclaimed ADP checks-Bloomfield				7,448	Accrued Pension-Bloomf 137,242
Due to HMS-Bloomfield				81,103	Accrued Worker's Comp 63,168
Patients Fund-Bloomfield				79,156	
Accrued Expenses-Bloomfield				218,366	See Schedule
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	1,453,474

* 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 Bloomfield Health Care Center of CT, LLC		License No. 913-C	Report for Year Ended 9/30/2022	Page 34	of 37
Account				Amount	
Total Brought Forward:				1,453,474	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)				\$ 37,653	
Name of Lender	Purpose	Amount	Date Due		
	Equipment Obligation LT	37,653			
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$ 7,838,427	
Name and Address of Lender	Amount	Loan Date			
Due to Realty / Related	7,838,427				
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 284,075	
Notes/Loans Payable L/T-Bloomfield		284,075			
See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 8,160,155	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 9,613,629	


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	9/30/2022	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	449,118
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			\$	449,118
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(6,421,401)
6. Gain or Loss for Period			\$	(545,772)
	10/1/2021	thru	9/30/2022	
7. Total Net Worth			\$	(6,967,173)
C. Total Reserves and Net Worth			\$	(6,518,055)
D. Total Liabilities, Reserves, and Net Worth			\$	3,095,574

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	9/30/2022	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2021			\$	(6,434,191)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	12,074,551
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	12,620,323
D. Net Income or Deficit			\$	(545,772)
E. Balance			\$	(6,979,963)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
Total Expenses Per Page 27	\$12,867,418			
F/S vs C/R Depreciation	(247,095)			
Total Expenses Per FS	\$12,620,323			
2. Other <i>(itemize)</i>				
Prior Period Adjustments		12,790		
F-3. Total Additions			\$	12,790
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. Balance at End of Period			\$	(6,967,173)
	09/30/22			

I. Preparer's/Reviewer's Certification

Name of Facility Bloomfield Health Care Center of CT, LLC	License No. 913-C	Report for Year Ended 9/30/2022	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)		
Preparer/Reviewer Certification				
<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 PRINCIPAL	Date Signed 2/9/23		
Printed Name of Preparer Matthew S. Bavolack				
Address 555 Long Wharf Drive, New Haven, CT 06511		Phone Number 203-781-9600		
Contacted Person Regarding Additional Information Needed Regarding This Report John Phelps		Phone Number 516-705-4813		
Contact Email Address jphelps@nathealthcare.com				