State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2015

Name of Facility (as licensed) Bickford Health Care Center		
Address (No. & Street, City, State, Zip Code) 14 Main St Windsor Locks, CT 06096		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2178-C			07-5358

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID

For Department Use Only

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

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General Information

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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Bickford Health Care Center [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Sean Carney			Printed Name (Owner)	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Bickford Health Care Center	Period Covered:		From 10/1/2014	To 9/30/2015
Address of Facility 14 Main St Windsor Locks, CT 06096				
Report Prepared By Cornerstone Accouning Group	Phone Number (860) 877-7472		Date 2/15/2016	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
(860) 623-4351	9/30/2015	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Bickford Health Care Center	14 Main St Windsor Locks, CT 06096

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2178-C			07-5358

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
Sean Carney		1833

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
n/a		

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

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

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Newport/Bickford Inc.	14 Main St. Windsor Locks, CT 06096	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Paul Bobbitt	14 Main St. Windsor Locks, CT 06096	Pres/Treasurer	
David Brown	14 Main St. Windsor Locks, CT 06096	Vice President	
Barbara Bodnar-Linden	14 Main St. Windsor Locks, CT 06096	Secretary	
Mary Hunter	14 Main St. Windsor Locks, CT 06096	Director	
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

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

Owner(s) of Facility
n/a

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General Information and Questionnaire
Related Parties*

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Somerset Management Health Care Group	PO Box 238 Granby, CT 06035	⊙	○		Provides Mgt Services Administrator is relat	P 16 L m12	148,200	148,200
Somerset Management Health Care Group	PO Box 238 Granby, CT 06035	⊙	○		Group Purchasing of Liab/Prof Ins	P 27 L 14a	29,638	29,638
Somerset Management Health Care Group	PO Box 238 Granby, CT 06035	⊙	○		Group Purchasing of D&O Ins	P 27 L 14c3	2,648	2,648
Somerset Management Health Care Group	PO Box 238 Granby, CT 06035	⊙	○		Billing Services	P 16 L m11	11,463	
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

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

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

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

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

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

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

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

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

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General Information and Questionnaire
Accounting Basis

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

	Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1	Cornerstone Accounting Group LLC	PO Box 7 Indian Valley, VA 24105
2	Laydon and Company	PO Box 945 Orange, CT 06477
3	Celtic Consulting	507 East Main St., Suite 308, Torrington CT 06790
4		

Services Provided by This Firm (*describe fully*)

1	Monthly Accounting and Cost Reports	$ 29,223
2	Audit and Tax Return	$ 15,775
3	Consulting on MDS billing	$ 2,500
4		$
		Charge for Services Provided $ 47,498

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

⊙ Yes ○ No — Page 15 Line 1d

Legal Services Information

	Name of Legal Firm or Independent Attorney	Telephone Number
1	Joseph Vitale	
2	Feldman & Hickey	
3		
4		
5		

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

1 422 Highland Ave Suite 13 Chesire CT
2 10 Waterside Dr, Suite 303, Farmington, CT 06032
3
4
5

Services Provided by This Firm (*describe fully*)

1	Collections documents review	$ 963
2	Employment matters	$ 3,483
3		$
4		$
5		$
		Charge for Services Provided $ 4,446

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

⊙ Yes ○ No — Page 15 Line 1e

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	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	48	48			48	48			48	48		
B. On last day of THIS report period	48	48			48	48			48	48		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	41	41			41	41			36	36		
B. As of midnight of THIS report period	44	44			36	36			44	44		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,170	1,170			1,027	1,027			143	143		
B. Medicaid (Conn.)	9,144	9,144			6,618	6,618			2,526	2,526		
C. Medicaid (other states)												
D. Private Pay	2,871	2,871			2,251	2,251			620	620		
E. State SSI for RCH												
F. Other (Specify) Managed Care	1,426	1,426			1,060	1,060			366	366		
G. Total Care Days During Period (3A thru F)	14,611	14,611			10,956	10,956			3,655	3,655		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	14,611	14,611			10,956	10,956			3,655	3,655		

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Schedule of Resident Statistics (Cont'd)

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

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	2	27		15				
Per Diem Rate								
a. One bed rm.		184.26		346.00				
b. Two bed rms.		184.26		336.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	4,165	3,718		447
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	2,485	2,485		
D. ***Total Physical Therapy Treatments***	6,650	6,203		447
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	102	102		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	44	44		
D. ***Total Speech Therapy Treatments***	146	146		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,350	2,350		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	2,925	2,925		
D. ***Total Occupational Therapy Treatments***	5,275	5,275		

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Report of Expenditures - Salaries & Wages

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	86,648	1,969				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	135,904	7,016				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	39,264	1,694				
c. Dietary Workers	170,681	13,146				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	40,184	2,720				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	35,305	2,818				
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	93,108	2,598				
b. RN						
1. Direct Care	311,142	10,850				
2. Administrative**	52,275	1,749				
c. LPN						
1. Direct Care	157,849	7,320				
2. Administrative**						
d. Aides and Attendants	550,915	40,593				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	50,390	3,596				
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	26,888	914				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	1,750,553	96,983				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
-	**0**	**0**	**0**	**0**	**0**	**0**
Total	$ -	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
	0	**0**	**0**	**0**	**0**	**0**
Total	$ -	-	$ -	-	$ -	-

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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
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Sean Carney	86,648			None	Responsible for daily operations.	1,969	A2	Somerset Health Care Management Group	300	Yes
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
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	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	9,452	214				
2. Dentist						
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	149,321	2,530				
b. Other						
6. Social Worker	1,700	20				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	16,950	230				
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	4,873	82				
b. Other						
10. Occupational Therapist						
a. Resident Care	103,445	1,563				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides	546	24				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	286,287	4,663				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Patricia A Jeans	Dietician	○	⊙	
All Star Therapy 21 Waterville Rd Avon, CT 06001	Therapy Services	○	⊙	
Karen Dworski	Social Services	○	⊙	
Richard Cagna	Medical Director	○	⊙	
Kafer MD	Medical Staff	○	⊙	
Ready Nurse Staffing	Nurse Pool	○	⊙	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
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		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
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Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	85,936	85,936		
2. Disability Insurance	$				
3. Unemployment Insurance	$	37,073	37,073		
4. Social Security (F.I.C.A.)	$	130,024	130,024		
5. Health Insurance	$	48,602	48,602		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$				
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	61	61		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	18,000	18,000		
d. Accounting and Auditing	$	47,498	47,498		
e. Legal (*Services should be fully described on Page 7)*	$	4,447	4,447		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	7,361	7,361		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	6,920	6,920		
2. Cellular Phones	$	1,993	1,993		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	281,500	281,500		
Subtotal	$	669,415	669,415		

* 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)
MISC. EMPLOYEE BENEFITS	**61**	**0**	**0**
Total	$ 61	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
	0	**0**	**0**
Total	$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2015	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		669,415	669,415		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	2,613	2,613		
3. Gifts to Staff and Residents	$	962	962		
4. Employee Travel	$	4,802	4,802		
5. Education Expenses Related to Seminars and Conventions	$	4,548	4,548		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	4,298	4,298		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	10,211	10,211		
See Attached Schedule					
4. Fund-Raising***	$	2,376	2,376		
5. Medical Records	$	198	198		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	1,705	1,705		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$				
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions***	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	41,089	41,089		
12. Administrative Management Services**	$	148,200	148,200		
13. Other (*Specify*)	$	18,392	18,392		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	908,809	908,809		

* 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)
	0	**0**	**0**
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
ADVERTISING - PROMOTIONAL	**2,678**	**0**	**0**
CONSULT MARKETING	**6,782**	**0**	**0**
SUPP & EXP - MARKETING	**751**	**0**	**0**
Total Other Advertising	$ 10,211	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
-	**0**	**0**	**0**
Total Dues	$ -	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
	0	**0**	**0**
Total Contributions	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
BANK CHARGES	**2,591**	**0**	**0**
LATE CHARGES	**9,463**	**0**	**0**
RENTAL HOUSE EXPENSES	**5,083**	**0**	**0**
LICENSES	**1,255**	**0**	**0**
Total Other Administrative and General	$ 18,392	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Bickford Health Care Center	2178-C	9/30/2015	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 #
Somerset Health Care Management Group	148,200	Manage Facility including contract negotiations, plant, financial oversight and group purchasing of insurance.	Page 16 Line m12

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

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CSP-18 Rev. 9/2002

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
Bickford Health Care Center	2178-C	9/30/2015	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	95,755	95,755		
2. Non-Food Supplies	$	10,046	10,046		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	105,801	105,801		

		Total	CCNH	RHNS	(Specify)
2F. Dietary Questionnaire					
G. Resident Meals:	Total no. of meals served per day:*	120	120		

H.	Is cost of employee meals included in 2E?	⊙ Yes	○ No		
I.	Did you receive revenue from employees?	⊙ Yes	○ No	If yes, specify amt.	$1,164
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				P 18 L2a1
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	○ Yes	⊙ No	If yes, specify cost.	
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.	
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.	
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.	
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.
** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Name of Facility	License No.	Report for Year Ended	Page of
Bickford Health Care Center	2178-C	9/30/2015	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. $	2,907	2,907		
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. $	1,662	1,662		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	4,569	4,569		
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?		○ Yes	⊙ No	If yes, specify cost.	
H. Did you receive revenue from employees?		○ Yes	⊙ No	If yes, specify amt.	
I. Where is the revenue received reported in the Cost Report?			(Page/Line Item)		
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?		○ Yes	⊙ No	If yes, specify cost.	
K. Did you receive revenue from these people?		○ Yes	⊙ No	If yes, specify amt.	
L. Where is the revenue received reported in the Cost Report?			(Page/Line Item)		

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2015	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	9,634	9,634		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	75,348	75,348		
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	84,982	84,982		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Outside Pharmacy		$	79,137	79,137		
b. Medicine Cabinet Drugs		$	6,263	6,263		
c. Medical and Therapeutic Supplies		$	81,221	81,221		
d. Ambulance/Limousine***		$	4,105	4,105		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	5,469	5,469		
f. X-rays and Related Radiological Procedures***		$	4,403	4,403		
g. Dental (*Not dentists who should be included under salaries or fees)*		$	5,472	5,472		
h. Laboratory***		$	5,532	5,532		
i. Recreation		$	14,115	14,115		
j. Other (Specify)**** See Attached Schedule		$				
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	205,717	205,717		

* 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)
-	0	0	0
-			
-			
Total Other Resident Care	$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2015	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
Heritage Healthcare Services	76 W Rocks Rd Norwalk, CT 06851	○	⊙		Housekeeping Services	75,348			20	4b
Somerset Health Care Management Group	PO Box 238 Granby, CT 06035	⊙	○	Son is Administrator	Billng Services	11,463			16	m11
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Bickford Health Care Center	2178-C	9/30/2015	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	11,861	11,861		
b. Heat	$	21,271	21,271		
c. Light & Power	$	41,119	41,119		
d. Water	$	19,440	19,440		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	24,510	24,510		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	118,201	118,201		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	365	365		
b. Building & Building Improvements	$	135,209	135,209		
c. Non-Movable Equipment	$	4,381	4,381		
d. Movable Equipment	$	13,657	13,657		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	153,612	153,612		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	15,191	15,191		
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	15,191	15,191		
9. Rental payments on leased real property less real estate taxes included in item 10b	$				
10. Property Taxes					
a. Real estate taxes paid by owner	$	59,347	59,347		
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	3,556	3,556		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	231,706	231,706		

* 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)
MAINTENANCE CONTRACT	**442**	**0**	**0**
PURCH SERV - PLANT	**17,085**	**0**	**0**
GROUNDS MAINTENANCE	**5,513**	**0**	**0**
SPRINKLER & FIRE ALARM SYSTEMS	**1,470**	**0**	**0**
Total Other Repairs and Maintenance	$ 24,510	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2015	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	5,469		5,469	1,458	SL	15	365	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								365
B. **Building and Building Improvements**								
1. Acquired prior to this report period	3,738,956		3,738,956	2,256,166	SL	Var	135,209	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								135,209
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	47,099		47,099	21,618	SL	Var	4,208	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	5,691		5,691		SL	Var	173	
C-4. Subtotal								4,381

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					500,594		500,594	440,545	SL	Var	11,777	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					15,476		15,476		SL	Var	1,880	
D-3. Subtotal												13,657
E. ***Total Depreciation***												153,612

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Schedule of Land Improvements Acquired during this report period

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

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

Schedule of Building Improvements Acquired during this report period

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

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

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
7/31/2015	Fire Protection Power Supply	$ 2,055	10	$ 52	
8/14/2015	Computer Network Cable HUB	$ 3,636	5	$ 121	
Total additions for Non-Movable Equipment		$ 5,691		$ 173	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/31/2014	Computers	$ 2,349	5	$ 470	
1/19/2015	DNS PC	$ 1,268	5	$ 190	
2/18/2015	Laptops	$ 1,485	3	$ 330	
2/23/2015	Logo Mat	$ 678	3	$ 151	
6/24/2015	Cisco Wireless Equip	$ 4,154	5	$ 277	
7/1/2015	3 Helios Laptops	$ 4,107	3	$ 342	
7/1/2015	HP 15" Laptop	$ 1,435	3	$ 120	
Total additions for Movable Equipment		$ 15,476		$ 1,880	*
Deletions:					
Total deletions for Movable Equipment		$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report period

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

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2015	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1. Organization Expense	6	96		800,000	358,333				
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1. Refinancing	6	2014	12 mos	18,065	4,105			13,960	
2. Refinancing	5	2015	36 mos	18,467				1,231	
3.									
B-4. Subtotal									15,191
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									15,191

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2015	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	06/06/96
2. Date Structure Completed	07/01/97
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	06/06/96
5. Total Licensed Bed Capacity	48
6. Square Footage	10,266
7. Acquisition Cost	
a. Land	150,000
b. Building	995,459

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)	Variable			
h. Date of Refinancing	05/29/15			
i. New Interest Rate	Var LIBOR + 350 ba			
j. Term of Mortgage (number of years)	36 months			
k. Amount of Principal Borrowed	3,050,000			
l. Principal Outstanding on Note Paid-Off	2,647,500			

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Bickford Health Care Center	2178-C	9/30/2015	26 | 37

Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$	100,326	100,326		
Name of Lender: Webster Bank	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)	$	100,326	100,326		

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Bickford Health Care Center	2178-C	9/30/2015	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	100,326	100,326		
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*) $				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	100,326	100,326		
14. Insurance				
a. Insurance on Property (buildings only) $	29,638	29,638		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $				
2. Fire and Extended Coverage $				
3. Other (*Specify*) $	2,648	2,648		
Surety Bond $716 D&O $1932				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	32,286	32,286		
15. ***Total All Expenditures (A-13 thru C-14)*** $	3,829,237	3,829,237		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Bickford Health Care Center	2178-C	9/30/2015	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 $	4,695	4,695		
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	b10a	Occupational Therapy $	103,445	103,445		
7.			Other - See attached Schedule $	2,234	2,234		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	18,000	18,000		
10.			Accounting & Legal $				
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.	16	1m2/3	Unallowable Advertising * $	10,211	10,211		
19.			Income Tax / Corporate Business Tax $				
20.	16/30	1m4/8	Fund Raising / Contributions $	1,716	1,716		
21.	16	1m11	Unallowable Management Fees $	100,346	100,346		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	9,463	9,463		
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.	29	OutPt	Housekeeping services to employees, guests and others who are not residents $	596	596		
			Subtotal (Items 1 - 26) $	250,706	250,706		

* 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)
P10	A4	10% Marketing Allocation	$ 4,695		
Total Other Salaries Adjustment			$ 4,695	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B5	PT Outpatient Services	$ 2,234	$ -	$ -
Total Other Fees Adjustments			$ 2,234	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
		LATE CHARGES	$ 9,463	$ -	$ -
Total Other A&G Adjustments			$ 9,463	$ -	$ -

Management Fees

2007	42,000	Allowable
CPI	1.0378	
2008	43,588	Allowable
	43,588	
CPI	1.0026	
2009	43,701	Allowable
	43,701	
CPI	1.0273	
2010	44,894	Allowable
	44,894	
CPI	1.0206	
2011	45,819	Allowable
	45,819	
CPI	1.0277	
2012	47,088	Allowable
	47,088	
CPI	1.0097	
2013	47,545	Allowable
	47,545	
CPI	1.0133	
2014	48,177	Allowable
	48,177	
CPI	0.9933	
2015	47,854	Allowable
Per page 16	148,200	
Disallowable	100,346	Page 28 Line 21

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

Name of Facility	License No.	Report for Year Ended	Page of
Bickford Health Care Center	2178-C	9/30/2015	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	250,706	250,706		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $	76,504	76,504		
28.	20	5d	Ambulance/Limousine $	4,105	4,105		
29.	20	5f	X-rays, etc $	4,403	4,403		
30.	20	5h	Laboratory $	5,532	5,532		
31.	20	5c	Medical Supplies $	3,114	3,114		
32.	20	5e2	Oxygen (non emergency) $	5,469	5,469		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $				
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $	142	142		
36.			Depreciation on Unallowable Motor Vehicles $				
37.	29	OutPt	Unallowable Property and Real Estate Taxes $	416	416		
38.	30/16	net	Rental of Building Space or Rooms $	7,217	7,217		
39.			Other - See Attached Schedule $	1,409	1,409		
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.	29	OutPt	Property Insurance $	208	208		
Other - Miscellaneous							
42.			Research or Experimental Activities $				
43.			Radio and Television Revenue $				
44.			Vending Machine Revenue $				
45.			Purchase Discounts and Allowances $				
46.			Duplications of functions or services $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest $				
48.			Interest Income on Accounts Rec $				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $				
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.			***Total Amount of Decrease (Items 1 - 50)*** $	359,225	359,225		

*** 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.

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Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Ancillary Costs			$ -	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	6/11 Dishwasher and Fridge for Rental House	$ 142	$ -	$ -
Total Excess Movable Equipment Depreciation			$ 142	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
29	OutPt	Heat and Light Outpatient Allocation	$ 437		
29	OutPt	Bldg Depreciation Outpatient Allocation	$ 268		
29	OutPt	Interest Outpatient Allocation	$ 704		
Total Other Property Adjustments			$ 1,409	$ -	$ -

Schedule of Other 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			$ -	$ -	$ -

Page	Line		
29	27	Pharmacy Medicare Drugs # 78250-02000	56,853
		Pharmacy Managed Care # 78250-08000	19,651
			76,504
29	31	Medicare Supplies # 78270-02000	3114

Outpatient Clinic Overhead Disallowance

		Square Footage	10266	10194	72
				99.30%	0.70%

Page	Line		Total Costs	SNF	Outpatient	Page / Line Disallowance
10	A6b	Housekeeping salaries and wages	0	0	0	P28 L2
15	1a1-9	Fringe Benefits	0%		0	P28 L2
20	4a1	Housekeeping supplies	9,634	9,566	68	P28 L26
20	4b	Purchased Housekeeping	75,348	74,820	528	P28 L26
22	6b	Heat	21,271	21,122	149	P29 L39
22	6c	Light & Power	41,119	40,831	288	P29 L39
22	7b	Originial Building Only Depreciation	38,257	37,989	268	P29 L39
22	10a	Real Estate Taxes	59,347	58,931	416	P29 L37
26	12a1	Interest Expense	100,326	99,622	704	P29 L39
27	14a	Property Insurance	29,638	29,430	208	P29 L41
		Total Disallowance			2,629	

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Bickford Health Care Center	2178-C	9/30/2015	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	3,167,759	3,167,759		
b. Medicaid Room and Board Contractual Allowance **	$	(1,470,107)	(1,470,107)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	513,785	513,785		
b. Medicare Room and Board Contractual Allowance **	$	65,853	65,853		
4. a. Private-Pay Residents and Other	$	1,470,393	1,470,393		
b. Private-Pay Room and Board Contractual Allowance **	$	(142,450)	(142,450)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	54,088	54,088		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(51,336)	(51,336)		
c. Prescription Drugs - Non-Medicare	$	9,209	9,209		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(9,209)	(9,209)		
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	211,353	211,353		
b. Physical Therapy - Medicare Contractual Allowance **	$	(118,044)	(118,044)		
c. Physical Therapy - Non-Medicare	$	34,857	34,857		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(18,941)	(18,941)		
4. a. Speech Therapy - Medicare	$	7,182	7,182		
b. Speech Therapy - Medicare Contractual Allowance **	$	(3,185)	(3,185)		
c. Speech Therapy - Non-Medicare	$	276	276		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(276)	(276)		
5. a. Occupational Therapy - Medicare	$	168,503	168,503		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(103,039)	(103,039)		
c. Occupational Therapy - Non-Medicare	$	23,238	23,238		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(23,484)	(23,484)		
6. a. Other *(Specify)* - Medicare	$	8,412	8,412		
b. Other *(Specify)* - Non-Medicare	$	25,158	25,158		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	3,819,995	3,819,995		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$	12,300	12,300		
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	75	75		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	1,961	1,961		
V. Total Other Revenue (1 thru 8)	$	14,336	14,336		
VI. Total All Revenue (III +V)	$	3,834,331	3,834,331		

* *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)
	CONTRACTUAL ADJ PART A ANCIL	**8,412**	**0**	**0**
Total Other Resident Revenue - Medicare		$ 8,412	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	CONTRACTUAL ADJ HMO ANCILLARY	**8,031**	**0**	**0**
	RETRO ANCILLARIES	**17,127**	**0**	**0**
Total Other Resident Revenue		$ 25,158	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Investment Account	27,772	**21**	**0**	**0**
	Savings Account	5,369	**8**	**0**	**0**
	Accounts Receivables		**46**	**0**	**0**
Total Interest Income			$ 75	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
P28 L20	FUNDING RAISING INCOME	**660**	**0**	**0**
	MISC INCOME	**186**	**0**	**0**
	UNRESTRICTED DONATIONS	**1,115**	**0**	**0**
Total Other Revenue		$ 1,961	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2015	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 219,885
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,002,363
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 10,725
5. Prepaid Expenses				$ 58,595
a. PREPAID INSURANCE		56,816		
b. PREPAID WATER & SEWER		1,779		
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 1,550
UTILITY DEPOSIT		1,550		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,293,118
B. Fixed Assets				
1. Land				$ 150,000
2. Land Improvements	*Historical Cost	5,469		$ 3,646
	Accum. Depreciation	1,823	Net	
3. Buildings	*Historical Cost	3,738,956		$ 1,347,581
	Accum. Depreciation	2,391,375	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	52,790		$ 26,791
	Accum. Depreciation	25,999	Net	
6. Movable Equipment	*Historical Cost	516,070		$ 61,868
	Accum. Depreciation	454,202	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 1,589,886

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2015	32	37

Account				Amount
			Total Brought Forward:	$ 2,883,004
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost	800,000		
	Accum. Depreciation	358,333	Net	$ 441,667
4. Goodwill (Purchased Only)				$ 17,236
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 458,903
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 3,341,907

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2015	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 662,982
2. Notes Payable (*itemize*)					$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)					$ 136,574
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$ 52,500
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$ 7,995
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 277,674
ACCRUED EXPENSES	39,425	SECURITY DEPOSIT	1,300		
MEDICAID USER FEE PAYABI	71,005	ACCRUED REAL ES'	15,104		
CREDIT BALANCE LIABILITIE	139,783	ACCRUED PERSON/	922		
RESIDENT DEPOSITS	10,135				
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 1,137,725

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2015	34	37

Account	Amount
Total Brought Forward:	1,137,725
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$ 2,542,500
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 2,542,500
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 3,680,225

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2015	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (343,412)
	6. Gain or Loss for Period 10/1/2014 thru 9/30/2015	$ 5,094
	7. Total Net Worth	$ (338,318)
C.	***Total Reserves and Net Worth***	$ (338,318)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 3,341,907

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2015	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2014			$ (343,412)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 3,834,331
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 3,829,237
D.	Net Income or Deficit			$ 5,094
E.	Balance			$ (338,318)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period***	09/30/15		$ (338,318)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2015	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer	
Cornerstone Accounting Group	
Addres Address	Phone Number
PO Box 7 Indian Valley, VA 24105	(860) 877-7472

Level	Item	Reported as