State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2015

Name of Facility (as licensed) Bloomfield Health Care Center of CT, LLC		
Address (No. & Street, City, State, Zip Code) 355 Park Ave Bloomfield,CT 06002		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	9134			07-5138

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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CSP-1 Rev.9/2002

General Information

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Bloomfield Health Care Center of CT, LLC	9134	9/30/2015	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Bloomfield Health Care Center of CT, LLC [facility name], for the cost report period beginning October 1, 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) Karen Chadderton			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 10/1/2014	To 9/30/2015
Address of Facility 355 Park Ave Bloomfield,CT 06002				
Report Prepared By Blum Shapiro & Company, P.C.	Phone Number 860-561-4000		Date 2/8/2016	

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
860-242-8595	9/30/2015	2	37

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

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	9134			07-5138

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Karen Chadderton	001221

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

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

Name of Partners/Members	Business Address	Title	% Owned
Marvin J. Ostreicher	355 Park Ave Bloomfield, CT 06002	President	0.5
Agnes Zitter	355 Park Ave Bloomfield, CT 06002		0.5

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	9134	9/30/2015	3A	37

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

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

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

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General Information and Questionnaire
Individual Proprietorship

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

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

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

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

If "Yes," provide the following information:

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

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	9134	9/30/2015	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ☐ Yes ☑ No — If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? ☑ Yes ☐ No — If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties: Yes	No	%**	Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report: Page #	Line #	Cost Reported	Actual Cost to the Related Party
Preferred Therapy Solutions	850 Silas Deane Highway, Wethersfield, CT 06109	☑	☐	24%	PT,OT,ST Services/Consulting	13	5a,9a,10a,12	559,336	531,792
NOA Diagnostics	6851 Jericho Turnpike, Suite 150 Syosset, NY 11791	☑	☐	79%	Radiology	20	5f	10,282	9,443
National Health Care Associates - Aetna	850 Silas Deane Highway, Wethersfield, CT 06109	☐	☑		Health Insurance Trust***	15	1a5	545,346	545,346
Marlborough Health Care	85 Stage Harbor Rd, Marlborough, Ct 06447	☐	☑		Bank Charges	16	13	2,919	2,919
National Health Care Associates	46 Stauderman Ave, Lynbrook, NY 11563	☐	☑		Banking Transactions	16	13	12,286	12,286
Bloomfield Healthcare Realty	46 Stauderman Ave, Lynbrook, NY 11563	☐	☑		Rent	22	9	560,000	560,000
National Health Care Associates	46 Stauderman Ave, Lynbrook, NY 11563	☐	☑		Shared Expenses	16	12	422,503	422,503
850 Silas Deane Realty	850 Silas Deane Highway, Wethersfield, Ct 06109	☐	☑		Shared Expenses	16	12	1,577	1,577
Stauderman Realty	46 Stauderman Ave, Lynbrook, NY 11563	☐	☑		Shared Expenses	16	12	4,902	4,902
Procare LTC Pharmacy of CT	1492 Highland Ave Cheshire CT 06410	☑	☐	83%	Drugs/OTC's/Supplies/Consult/Fees	20/13	5a2,b,j/B3,12	300,917	282,425

* Use additional sheets if necessary.
** Provide the percentage amount of revenue received from non-related parties.
*** Consolidated for all National Healthcare CT Facilities, control and ownership pass upon transfer of funds to insurance company manager. Information required by previous state auditor.

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General Information and Questionnaire
Basis for Allocation of Costs

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

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

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

1. In the preparation of this Report, were all costs allocated as required? ⊙ Yes ○ No

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

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

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

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

⊙ Yes ○ No

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

N/A

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers: Yes	Related * to Owners, Operators, Officers: No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Reliable Health Systems, Nostrand Ave, Brooklyn, NY 11230	○	⊙	Computer Equipment	10/01/08	60 / ongoing	17,635	17,635
Wells Fargo Financial Leasing, PO Box 6434, Carol Stream, IL 60197-6434	○	⊙	Copier	10/01/12	36	5,170	5,170
Honda Financial Services P.O. Box 165378, Irving, TX 75016	○	⊙	Auto Lease - Transferred from related party, Riverside Health Care Center Inc. during 2015	01/25/13	36	4,065	4,065
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total ***** 26,870

* 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.

Honda Leadership Leasing®

HONDA Financial Services

Lease Date: 01/25/2013

CLOSED-END VEHICLE LEASE AGREEMENT — NEW JERSEY

LESSEE(S) (Print Name & Address)	VEHICLE GARAGING ADDRESS (if different)	LESSOR (Dealer)
Name of Lessee: RIVERSIDE HEALTH CARE CENTER INC.	Name of Driver:	Name of Lessor: JOYCE MOTORS CORP.
Street Address: 745 MAIN STREET	Street Address:	Street Address: 3166 ROUTE 10 WEST
City: EAST HARTFORD	City:	City: DENVILLE
State, Zip: CT 06108	State, Zip:	State, Zip: NJ 07834-
County: FAIRFIELD	County:	Dealer Phone Number: (973)361-3000
Name of Co-Lessee:	Driver Phone Number:	Dealer Number:

By signing this Lease, Lessee(s) ("I", "my", "me") agree to lease the Vehicle, described below, according to the terms on both sides of this Lease. I accept delivery of the Vehicle and acknowledge that it is in good operating order, equipped as described and has the odometer reading recorded below. "Lessor" refers to the Lessor ("Dealer") named above and Assignee. Assignee is Honda Lease Trust. American Honda Finance Corporation (AHFC) shows as the administrator of the lease on behalf of Honda Lease Trust. American Honda Finance Corporation is doing business as Honda Financial Services ("HFS").

Assignee: **Honda Lease Trust**, 201 Little Falls Drive, Wilmington, DE 19808, (800) 916-9930 **LEASE TERM:** 36 **MONTHS.**

VEHICLE DESCRIPTION

New/ Used	Year/Make/Model	Number of Engine Cylinders	Body Style	Vehicle Identification Number	Odometer Reading	Primary Use:
N	2013 HONDA CR-V	4	5DR 4WD	5J6RM4H50DL032335	199	☒ Personal, Family, or Household ☐ Business, Commercial, Agricultural, or Lessee is an organization or governmental entity

Including Standard Manufacturer Installed Features (unless replaced by upgraded equipment) and the Following Dealer Installed Options:

___ Air Conditioning ___ Leather Interior ___ Power Moonroof ___ Custom Wheels ___ Rear Wing Spoiler ___ Alarm System

Audio System Includes: ___ AM/FM Stereo ___ AM/FM Stereo with Cassette Player ___ Cassette Player ___ CD Changer ___ CD Player

Transmission: ___ Automatic ___ Manual Brakes and Steering Mechanism: ___ Power ___ Manual

Other Dealer Installed Options: _____

Manufacturer's Suggested Retail Price (New Vehicle Only) $ 26976.00

FEDERAL CONSUMER LEASING ACT DISCLOSURES

AMOUNT DUE AT LEASE SIGNING (Itemized Below)*: $ 710.98

MONTHLY PAYMENTS/SINGLE PAYMENT

My first monthly payment of $ 338.75 is due on 01/25/13

followed by 35 payments of $ 338.75 due on the 25th of each month. The total of my monthly payments is $ 12195.00.

My single payment of $ N/A is due on N/A

OTHER CHARGES (not part of my monthly payment)

Disposition Fee (if I do not purchase the Vehicle) ..... $ 0

Total ..... $ 0

TOTAL OF PAYMENTS (The amount I will have paid by the end of the Lease.): $ 12567.23

ITEMIZATION OF AMOUNT DUE AT LEASE SIGNING

Amount Due at Lease Signing		
Capitalized Cost Reduction (Amount Paid in Cash)	$	N/A
Sales/Use Tax on Amount Paid in Cash	+	N/A
Capitalized Cost Reduction (Credit for Net Trade-In Allowance)	+	N/A
Sales/Use Tax on Credit for Net Trade-In Allowance	+	N/A
Advance Monthly Payment (1st Month)	+	338.75
Advance Single Payment (if Single Payment Lease)	+	N/A
Refundable Security Deposit	+	N/A
Initial Title Fees	+	25.00
Initial Registration Fees	+	325.00
Other: N/A	+	N/A
Other: N/A	+	N/A
Other: N/A	+	N/A
Other: N/A	+	N/A
Other:	+	22.23
TOTAL	= $	710.98

How the Amount Due at Lease Signing will be Paid		
Credit for Net Trade-In Allowance Year ____ Make ____	$	N/A
Rebates:	+	N/A
Noncash Credits:	+	N/A
Amount Paid By: N/A	+	N/A
Amount to be Paid in Cash:	+	710.98
TOTAL	= $	710.98

MY MONTHLY PAYMENT/SINGLE PAYMENT IS DETERMINED AS SHOWN BELOW:

GROSS CAPITALIZED COST	$	26374.33	For an itemization of this amount, please check this box: ☐ The agreed upon value of the Vehicle ($ 25779.33) and any items I pay for over the Lease Term (such as taxes, fees, service contracts, insurance, and any outstanding prior credit or lease balance).
CAPITALIZED COST REDUCTION	−	N/A	The amount of any net trade-in allowance, rebate, noncash credit, or cash I pay that reduces the gross capitalized cost.
ADJUSTED CAPITALIZED COST	=	26374.33	The amount used in calculating my base monthly or single payment.
RESIDUAL VALUE	−	17264.00	The estimated value of the Vehicle at the scheduled end of the Lease Term used in calculating my base monthly or single payment.
DEPRECIATION AND ANY AMORTIZED AMOUNTS	=	9110.33	The amount charged for the Vehicle's decline in value through normal use and for other items paid over the Lease Term.

_____ The depreciation and any amortized amounts plus the rent charge.

LEASE PAYMENTS	+	36 — The number of payments required during the term of my Lease.
BASE MONTHLY/SINGLE PAYMENT	=	318.52
MONTHLY SALES/USE TAX	+	20.23
SALES/USE TAX (SINGLE PAYMENT)	+	N/A
OTHER: _____	+	N/A
TOTAL MONTHLY/SINGLE PAYMENT	= $	338.75

EARLY TERMINATION. I may have to pay a substantial charge if I end this Lease early. The charge may be up to several thousand dollars. The actual charge will depend on when the Lease is terminated. The earlier I end the Lease, the greater this charge is likely to be.

EXCESSIVE WEAR AND USE/EXCESS MILEAGE. I may be charged for excessive wear based on Lessor's standards for normal use and for mileage in excess of 12000 miles per year at the rate of 15 cents per mile.

PURCHASE OPTION AT END OF LEASE TERM. I have an option to purchase the Vehicle AS-IS, WHERE-IS at the end of the Lease Term for $7264.00, plus any required taxes and fees and any other amounts then owing.

OTHER IMPORTANT TERMS. Review this Lease for additional information on early termination, purchase options, maintenance responsibilities, warranties, late and default charges, insurance, and any security interests, if applicable.

VEHICLE WARRANTIES

If the Vehicle is new, it is covered by the Manufacturer's New Vehicle Warranty. If the Vehicle is new or used, it is not covered by any other warranty unless identified below:

_____ Remainder of Manufacturer's New Vehicle Warranty.
_____ Manufacturer's Used Vehicle Limited Warranty.
_____ Manufacturer's Extended Warranty.
_____ Other: _____

Lessor assigns to me all of its rights in the above specified warranties. LESSOR LEASES THE VEHICLE "AS-IS" AND MAKES NO WARRANTIES, EXPRESS OR IMPLIED, REGARDING THE VEHICLE AND SPECIFICALLY DISCLAIMS ANY WARRANTIES IMPLIED BY LAW, INCLUDING WITHOUT LIMITATION, THE IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR ANY PARTICULAR PURPOSE.

TOTAL COST OF LEASE

Total Cost of Lease ..... $ 29831.23

Assuming I am not in default under this Lease and exercise the purchase option at the end of the scheduled Lease Term, this amount is the sum of: (a) the total of all payments required at the beginning of the Lease; (b) the total monthly payments due under the Lease; (c) my payment liability at the scheduled end of the Lease (excluding any Excessive Wear and Use amounts or excess mileage charge); and (d) the purchase option price. The Total Cost of Lease does not include the Refundable Security Deposit or any insurance costs.

PRIOR USE OF VEHICLE

If the Odometer reading is in excess of 1,000 miles, the prior use of the Vehicle was:

☐ Personal, Family or Household ☐ Police ☐ Unknown ☐ Livery
☐ Demonstrator ☐ Prior Wreckage ☐ Daily Rental

OPTIONAL SERVICE CONTRACT

An optional service contract promises to perform services or provide benefits relating to the maintenance or repair of the Vehicle. These coverages are not provided by the Lessor. I must pursue all matters relating to these coverages through the provider. The terms and conditions for these coverages are in a separate contract, which I have read and received.

Price: $ N/A Provider: N/A

Price: $ N/A Provider: N/A

If the price of any service contract is not included in the Amount Due at Lease Signing, the price will be included in the Gross Capitalized Cost and will be subject to rent charges.

LATE CHARGE/RETURNED CHECK CHARGE

I will pay a late charge equal to the lesser of **$25** or **5%** of the unpaid portion on any payment that is not received within **15** days after it is due, or such lesser amount as set by law. I will also pay a **$20** charge for any check or similar instrument returned for any reason.

OTHER CHARGES

I understand that the "Other Charges" and "Total of Payments" boxes above do not reflect amounts collected on behalf of third parties (such as property taxes, fines, fees, etc.) or charges imposed if I fail to abide by or modify the terms of this Lease. I am also responsible for these amounts and will refer to all other terms and conditions of this Lease for a description of all charges due.

ESTIMATED FEES AND TAXES DURING LEASE TERM

I agree to pay when due or reimburse Lessor for all title/license/registration/official fees and taxes over the term of my Lease (including any extensions), whether paid at lease signing, included in my monthly payments or assessed otherwise. Lessor estimates this amount to be: ..... $ 2584.79

The actual total of fees and taxes may be higher, or lower, depending upon whether the garaging address of the Vehicle changes, and on the tax rates in effect, or the value of the Vehicle at the time a fee or tax is assessed. Some taxes and fees may come due after the Lease terminates. I agree to pay any such amounts within **10** days of being invoiced. I will be responsible for any fines or penalties if I fail to pay the bill when due.

VEHICLE INSURANCE

I will pay for and maintain during the Lease term, and until the Vehicle is returned to Lessor, insurance on the Vehicle which has the following minimum coverages: (1) Public Liability Insurance that either covers up to **$100,000** for bodily injuries to any one person, **$300,000** for bodily injuries for any one accident, and **$50,000** for property damage, or has a combined single limit of **$300,000** for bodily injuries and property damage for any one accident; and (2) Physical Damage Insurance covering loss or damage to the Vehicle, with deductibles of no more than **$1,000** for collision and upset loss and **$1,000** for comprehensive fire and theft loss. The Policy of Public Liability Insurance must show Assignee as an additional insured. The policy of Physical Damage Insurance must show Assignee as loss payee. I may choose to get the required coverages myself or through any person. The policies must be written by an insurance company acceptable to Lessor. I agree to provide written proof of insurance to Lessor upon request, and authorize Lessor, and its agents, to contact my insurance agent and insurance company to verify coverage as required by this Lease. I further authorize Lessor to endorse my name(s) on any check or draft from my insurance company for any claim. Lessor may change the amounts of required insurance. I acknowledge that the limits required under this Lease may not be sufficient for my needs, and will see my insurance agent for more information. All insurance related information must be addressed to the Assignee, c/o PDP Services, PO. Box 650201, Hunt Valley, Maryland 21065-0201.

GREAT AMERICAN ALLIANCE (Insurance Company Name) CAP3878286 (Policy Number)

HUB INT'L NORTHEAST LTD. (Agent Name) (718)787-3800 (Agent Telephone)

2329 NOSTRAND AVE STE 400 (Agent Address) BROOKLYN (City) NY (State) 11210 (Zip Code)

NOTICES TO LESSEE(S): (1) CAUTION - IT IS IMPORTANT THAT YOU THOROUGHLY READ THIS AGREEMENT BEFORE YOU SIGN IT. (2) YOU WILL NOT SIGN THIS AGREEMENT BEFORE YOU READ BOTH SIDES OF IT OR IF IT CONTAINS ANY BLANK SPACES TO BE FILLED IN. (3) YOU ARE ENTITLED TO AN EXACT COPY OF THE LEASE YOU SIGN. YOU WILL KEEP IT TO PROTECT YOUR LEGAL RIGHTS. NOTICE: THE LESSEE(S) AND THE LESSOR SHALL BE ENTITLED TO REVIEW THIS LEASE FOR ONE BUSINESS DAY BEFORE SIGNING THIS LEASE. BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ BOTH SIDES AND RECEIVED A COMPLETED COPY OF THIS LEASE AGREEMENT.

LESSEE: Riverside Health Care CH DATE: 1-25-13 BY: [signature] TITLE: Administrator

LESSEE: _____ DATE: _____ BY: _____ TITLE: _____

Lessor accepts this Lease and assigns all right, title, and interest in this Lease and the Vehicle described herein, and Lessor's rights under any guaranty signed in connection with this Lease, to Assignee.

4Z7-2180687

,145.00

No Charge

830.00

,975.00

l taxes and
ıot included
il price.

: 207167
40571
HN-4503
50 STATE
NO: 235696
07167

EPA DOT Fuel Economy and Environment

Gasoline Vehicle

Fuel Economy

25 MPG

combined city/hwy

22 city

30 highway

Small SUVs range from 16 to 32 MPG.
The best vehicle rates 112 MPGe.

4.0 gallons per 100 miles

You save $850
in fuel costs over 5 years
compared to the average new vehicle.

Annual fuel cost
$2,150

Fuel Economy & Greenhouse Gas Rating (tailpipe only) 6
1 — 10 Best

Smog Rating (tailpipe only) 5
1 — 10 Best

This vehicle emits 354 grams CO^2 per mile. The best emits 0 grams per mile (tailpipe only). Producing and distributing fuel also create emissions; learn more at fueleconomy.gov.

Actual results will vary for many reasons, including driving conditions and how you drive and maintain your vehicle. The average new vehicle gets 23 MPG and costs $11,600 to fuel over 5 years. Cost estimates are based on 15,000 miles per year at $3.55 per gallon. MPGe is miles per gasoline gallon equivalent. Vehicle emissions are a significant cause of climate change and smog.

fueleconomy.gov
Calculate personalized estimates and compare vehicles

Smartphone QR Code™

PARTS CONTENT INFORMATION

FOR VEHICLES IN THIS CARLINE
U.S./Canadian Parts Content: **65 %**

Major Sources of Foreign Parts Content:
JAPAN 15 %

NOTE: Parts content does not include final assembly, distribution or other non-parts costs.

FOR THIS VEHICLE
Final Assembly Point:
EAST LIBERTY, OHIO USA

Country of Origin: Engine:
U.S.A.

Transmission:
JAPAN

GOVERNMENT 5-STAR SAFETY RATINGS

Overall Vehicle Score ★★★★★

Based on the combine ratings of frontal, side and rollover.
Should ONLY be compared to other vehicles of similar size and weight.

Frontal Crash	Driver	★★★★
	Passenger	★★★★★

Based on the risk of injury in a frontal impact.
Should ONLY be compared to other vehicles of similar size and weight.

Side Crash	Front seat	★★★★★
	Rear seat	★★★★★

Based on the risk of injury in a side impact.

Rollover ★★★★

Based on the risk of rollover in a single vehicle crash.

Star Ratings range from 1 to 5 stars (★★★★★) with 5 being the highest.
Source: National Highway Traffic Safety Administration (NHTSA)
www.safercar.gov or 1-888-327-4236

NAFD

REORDER FROM: NJCAR SERVICES (609) 683-5058

SPECIFY STOCK - NAF-65-2 2 PART OR NAF-65-3 3 PART

Willcox NY

ODOMETER DISCLOSURE STATEMENT

HONDA

JOYCE MOTORS CORP.

Route 10 Telephone (973) 361-3000

DENVILLE, N.J. 07834

HONDA

Federal law (and State law, if applicable) requires that you state the mileage upon transfer of ownership. Failure to complete or providing a false statement may result in fines and/or imprisonment.

I _____ state that the odometer now
(TRANSFEROR'S NAME - PRINT)

reads 34512 (no tenths) miles and to the best of my knowledge that it reflects the actual mileage of the vehicle described below, unless one of the following statements is checked.

☐ (1) I hereby certify that to the best of my knowledge the odometer reading reflects the amount of mileage in excess of its mechanical limits.

☐ (2) I hereby certify that the odometer reading is NOT the actual mileage. WARNING – ODOMETER DISCREPANCY.

MAKE Honda

MODEL CRV BODY TYPE SUV

VEHICLE IDENTIFICATION NUMBER 5J6RE4H39AL022118

YEAR 2010

TRANSFEROR'S NAME Riverside Health Care
(PRINTED NAME)

TRANSFEROR'S ADDRESS 745 Main St
(STREET)

E. Hartford, CT 06108
(CITY) (STATE) (ZIP CODE)

TRANSFEROR'S NAME X _____
(SIGNATURE)

DATE OF STATEMENT 1-25-13

TRANSFEREE'S NAME Joyce Honda

TRANSFEREE'S ADDRESS _____
(STREET)

_____ _____ _____
(CITY) (STATE) (ZIP CODE)

TRANSFEREE'S NAME X _____
(SIGNATURE)

_____
(PRINTED NAME)

FORM # NAF-65-2 2 PART
NAF-65-3 3 PART

HONDA

2013 CR-V 5DR AWD EX

EXT: MOUNTAIN AIR M. ENGINE NUMBER: K2
INT: BEIGE

STANDARD EQUIPMENT AT NO EXTRA COST

*** TECHNICAL FEATURES ***
- 185hp 2.4-Liter DOHC 16-Valve I-VTEC 4-Cylinder Engine
- 5-Speed Automatic Transmission with Grade Logic Control
- Real Time AWD with Intelligent Control System
- 4-Wheel Disc Brakes
- Front MacPherson Strut Suspension
- Rear Multi-Link Suspension
- Drive-by-Wire Throttle System
- Electric Power-Assisted Rack-and-Pinion Steering
- Front and Rear Stabilizer Bars
- Immobilizer Theft-Deterrent System

*** SAFETY FEATURES ***
- Driver's and Front Passenger's Dual-Stage Airbags (SRS)
- Driver's and Front Passenger's Side Airbags
- Side Curtain Airbags with Rollover Sensor
- Vehicle Stability Assist (VSA)
- Anti-Lock Braking System (ABS)
- Electronic Brake Distribution (EBD)
- Brake Assist
- Side-Impact Door Beams
- Tire Pressure Monitoring System
- ACE Body Structure
- Front and Rear Crumple Zones
- LATCH System for Child Seats

*** INTERIOR FEATURES ***
- AM/FM/CD Audio System with 6 Speakers
- Steering Wheel-Mounted Controls
- Bluetooth Audio
- Bluetooth HandsFreeLink
- Pandora Internet Radio Interface
- USB Audio Interface
- SMS Text Messaging Functionality
- Intelligent Multi-Information Display (i-MID) w/ Rear Wide-View Camera
- Air Conditioning with Air Filtration System
- Fold-Down Rear Seat Center Armrest
- 60/40 Split Fold-Down Rear Seatback
- Retractable Cargo Area Cover
- Power Windows and Door Locks
- Driver's Auto Up/Down Window
- Illuminated Visor Vanity Mirrors
- 12-Volt Power Outlets
- Cruise Control
- Exterior Temperature Gauge
- Compass
- Floor Mats
- Front Center Console
- Sunglasses Holder with Conversation Mirror
- Maintenance Minder System

*** EXTERIOR FEATURES ***
- Power Moonroof with Tilt Feature
- 17" X 6.5" Alloy Wheels
- P225/65 R17 All-Season Tires
- Fog Lights
- Auto-On/Off Headlights
- Variable Intermittent Windshield Wipers
- Expanded View Driver's Mirror
- Rear Privacy Glass
- Power Door Mirrors
- Rear Wiper with Washer
- Rear Window Defroster
- Remote Entry with Security System

Manufacturer's Suggested Retail Price **$2**

Full Tank of Fuel

KEY STANDARD FEATURES
***Rearview Camera**
***Bluetooth HandsFreeLink**
***USB Audio Interface**
***Side Curtain Airbags with Rollover Sensor**

Destination and Handling

TOTAL VEHICLE PRICE
(includes Pre-Delivery Service)

$2

License and title fees, state and lo dealer options and accessories are in the manufacturer's suggested re

JOYCE HONDA
418 ROUTE 46
ROCKAWAY, NJ 07866

ORIG. DL
REF.NO:
HN CODE
EMISSION CONTROL
DEALER:

PORT OF ENTRY: EAST LIBERTY
DELIVERY POINT: JERSEY
SHIP#:
ROW/SPACE: 901-008
TRANS.METHOD: F10 RIDGEFIELD HTS

VIN: 5J6RM4H50DL032335

State of Connecticut
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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of C	9134	9/30/2015	7	37

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Blum Shapiro	29 S. Main St., West Hartford, CT 06127
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Compilation, preparation of Medicare and Medicaid cost reports, and year end tax services	$ 22,700
2		$
3		$
4		$
	Charge for Services Provided	$ 22,700

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 Treasurer, State of Connecticut	(860) 702-3000
2 State Marshall	
3 Ben Milstein	
4 Goldman Gruder & Wood	(203) 899-8900
5 Rogin Nassau, LLC	(860) 278-7480

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

1 55 Elm Street, Hartford, CT. 06106
2
3
4 200 Connecticut Avenue, Norwalk, CT. 06854
5 185 Asylum Street, 22nd Floor, Hartford, CT. 06103-3460

Services Provided by This Firm (*describe fully*)

1	Labor	$ 600
2	Labor	$ 180
3	Labor	$ 150
4	Collections	$ 16,665
5	Reorganization/Refinance	$ 750
	Charge for Services Provided	$ 18,345

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

⊙ Yes ○ No Page 15, line 1e

State of Connecticut
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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	9134	9/30/2015	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	120	120			120	120			120	120		
B. On last day of THIS report period	120	120			120	120			120	120		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	105	105			105	105			98	98		
B. As of midnight of THIS report period	101	101			98	98			101	101		
3. Total Number of Days Care Provided During Period												
A. Medicare	3,832	3,832			2,920	2,920			912	912		
B. Medicaid (Conn.)	32,490	32,490			24,638	24,638			7,852	7,852		
C. Medicaid (other states)												
D. Private Pay	1,098	1,098			860	860			238	238		
E. State SSI for RCH												
F. Other (Specify)	929	929			895	895			34	34		
G. Total Care Days During Period (3A thru F)	38,349	38,349			29,313	29,313			9,036	9,036		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	9	9			9	9						
B. Other Bed Reserve Days	10	10			9	9			1	1		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	38,368	38,368			29,331	29,331			9,037	9,037		

***OTHER DAYS BREAKOUT:**

Bloomfield Health Care Center of CT, LLC
2015 Cost Report - Page 8 attachment

Page 8, Line 3F: Total Number of Other Days Care Provided During the Period

Managed Care	790
Hospice	139
VA	-

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	9134	9/30/2015	9	37

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

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	6	84		11				
Per Diem Rate								
a. One bed rm.	PPS	240.48		404.00				
b. Two bed rms.	PPS	240.48		375.00				
c. Three or more bed rms.	PPS	240.48		n/a				

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	1,370	1,370		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	1,229	1,229		
C. Other	8,108	8,108		
D. ***Total Physical Therapy Treatments***	10,707	10,707		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	368	368		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	224	224		
C. Other	933	933		
D. ***Total Speech Therapy Treatments***	1,525	1,525		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,652	1,652		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	1,515	1,515		
C. Other	9,493	9,493		
D. ***Total Occupational Therapy Treatments***	12,660	12,660		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	9134	9/30/2015	10	37

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)	143,910	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	162,631	8,610				
5. Dietary Service						
a. Head Dietitian	31,561	863				
b. Food Service Supervisor	51,739	2,080				
c. Dietary Workers	347,425	21,200				
6. Housekeeping Service						
a. Head Housekeeper	51,472	1,966				
b. Other Housekeeping Workers	202,946	14,569				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	80,445	3,189				
b. Other Maintenance Workers	41,036	3,184				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	138,963	8,141				
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	197,396	4,258				
b. RN						
1. Direct Care	527,366	13,799				
2. Administrative**	194,600	4,915				
c. LPN						
1. Direct Care	1,032,452	36,365				
2. Administrative**						
d. Aides and Attendants	1,723,686	106,793				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	120,762	5,620				
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	189,836	6,111				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	5,238,226	243,742				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
IV Nursing	$ 2,075	Disallowed				
Therapy Consulting - Nursing	$ 30,832	Disallowed				
Therapy Consulting - Rehab Therapy and Ancillary	$ 10,546	Disallowed				
Total	$ 43,453	Disallowed	$ -	-	$ -	-

State of Connecticut
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CSP-11 Rev. 10/2005

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	9134	9/30/2015	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, 184 Wildacre Ave, Lawrence, NY 11559				same as employees	Supervises operations, deals with DNS & financial management	61	p.16/ m12	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.

MARVIN J. OSTREICHER
TIME STUDY
Y/E SEPTEMBER 2015

	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	TOTAL
Augusta	3.00	8.50	7.00	4.00	7.50	7.50	1.50	4.50	7.50	5.50	4.50	6.50	**67.50**
Belair	5.00	5.50	7.00	3.00	5.50	4.50	2.50	2.00	3.00	5.00	6.50	5.00	**54.50**
Bloomfield	3.50	2.50	5.00	4.50	4.00	11.50	3.50	7.00	6.00	2.50	3.50	7.00	**60.50**
Brattleboro	5.50	4.00	3.00	4.00	4.50	4.50	1.00	3.50	8.00	3.00	4.50	7.00	**52.50**
Brentwood	2.50	9.50	2.50	7.00	3.00	7.00	7.50	3.50	3.00	4.00	2.50	4.00	**56.00**
Brewer	9.50	16.00	4.50	4.50	8.50	5.50	3.50	4.00	2.50	4.50	7.50	10.00	**80.50**
Bristol	3.50	2.00	4.50	12.50	6.50	3.00	3.50	6.50	8.50	4.00	1.00	4.50	**60.00**
Cambridge	5.50	4.00	5.00	16.00	5.00	6.00	1.50	7.00	4.50	3.00	3.50	8.50	**69.50**
Catskill	2.50	5.00	8.50	6.50	3.00	6.00	0.50	6.00	13.50	4.00	3.50	6.50	**65.50**
Cold Spring Hills	0.50	1.50	7.50	5.00	8.50	5.00	3.00	4.00	6.50	2.50	2.00	3.00	**49.00**
Colony	6.00	4.00	9.00	2.00	6.50	7.00	6.00	1.00	4.00	5.00	6.50	5.50	**62.50**
Country	7.00	8.50	3.00	7.00	3.50	6.00	4.00	6.50	9.00	5.00	5.50	10.50	**75.50**
Dover	2.00	0.50	9.50	5.00	2.50	4.00	2.00	1.00	4.50	6.00	1.50	3.50	**42.00**
Eastside	4.00	6.00	5.00	7.50	8.00	5.00	2.50	2.50	7.50	3.50	4.00	3.00	**58.50**
Eliot	0.50	5.00	9.00	4.50	2.00	2.00	2.50	2.50	6.50	1.50	4.50	2.50	**43.00**
Glen Falls	7.50	2.50	4.50	4.50	6.50	7.50	8.50	2.50	7.50	3.50	1.00	6.00	**62.00**
Hudson	1.00	7.00	12.50	2.50	6.00	1.50	4.00	0.50	12.00	4.50	2.50	5.50	**59.50**
Huntington	3.00	1.00	4.50	3.50	3.50	3.50	4.50	0.50	4.50	2.50	2.50	1.00	**34.50**
Kennebunk	1.00	6.50	6.50	2.00	2.00	7.50	3.00	0.50	5.50	2.50	12.00	0.00	**49.00**
Ludlowe	6.00	6.00	6.00	3.50	3.50	0.50	3.00	3.00	6.50	5.50	7.00	5.00	**55.50**
Maple View	4.50	5.50	9.50	3.00	6.00	7.50	6.50	5.50	2.00	9.00	3.50	5.00	**67.50**
Marlborough	0.50	1.00	3.00	5.50	2.00	2.50	3.50	0.50	3.00	4.00	1.00	2.00	**28.50**
Maywood	6.00	3.00	5.50	4.50	3.50	3.00	2.50	3.50	5.50	3.50	0.00	5.00	**45.50**
Milford	2.50	2.50	3.00	0.50	4.00	7.00	4.00	1.00	2.00	2.50	1.00	7.00	**37.00**
Newton Wellseley	4.50	4.50	3.00	4.00	3.00	7.50	2.50	0.00	2.00	3.00	0.00	1.50	**35.50**
Norway	5.50	2.00	2.50	2.00	3.50	5.50	5.00	3.50	1.50	5.00	5.50	4.50	**46.00**
Poughkeepsie	8.50	11.00	3.50	4.00	3.50	7.00	5.50	4.00	14.00	9.00	2.50	9.00	**81.50**
Regency	1.00	3.50	5.50	1.50	3.50	5.50	4.50	1.50	1.50	2.50	1.00	2.50	**34.00**
Reservoir	3.00	3.00	6.00	0.50	1.00	3.50	9.00	3.00	3.50	3.50	1.00	5.50	**42.50**
Riverside	3.00	6.50	4.50	1.50	5.50	2.00	5.50	4.00	4.00	4.50	7.00	2.00	**50.00**
Ross	7.00	5.50	3.50	5.50	6.00	5.00	6.50	6.50	4.00	2.50	4.50	2.00	**58.50**
Rutland	1.00	4.00	5.50	0.50	3.00	2.50	2.00	0.50	2.50	1.50	1.00	1.50	**25.50**
Sachem	4.50	2.50	5.00	4.00	2.50	7.00	2.50	2.50	2.00	3.00	5.50	2.50	**43.50**
Sands Point	0.50	3.00	4.00	0.50	6.50	7.00	6.50	0.50	2.50	2.50	2.50	2.50	**38.50**
Utica	2.00	4.50	3.50	4.50	4.50	6.00	3.00	0.50	6.00	6.50	2.50	4.00	**47.50**
Village Crest	0.50	3.00	4.50	3.50	4.50	7.00	9.50	3.00	2.50	5.00	4.00	0.50	**47.50**
Water's Edge	1.50	2.50	2.50	4.00	2.00	3.50	2.50	1.50	2.00	3.50	8.50	4.50	**38.50**
Westgate	1.00	2.00	3.50	7.50	4.50	3.00	3.50	0.00	1.00	0.00	2.00	4.50	**32.50**
Winship	5.50	4.50	9.50	4.00	4.00	3.00	4.00	1.00	3.50	4.00	1.50	11.00	**55.50**
Vacation	48.00	0.00	0.00	24.00	0.00	0.00	24.00	48.00	0.00	24.00	40.00	0.00	**208.00**
Sick	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
Personal	0.00	0.00	0.00	8.00	8.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**16.00**
Holiday	16.00	0.00	0.00	0.00	0.00	0.00	8.00	8.00	0.00	0.00	0.00	0.00	**32.00**
Total	**205.50**	**179.50**	**211.50**	**202.00**	**181.00**	**200.00**	**188.50**	**167.00**	**195.50**	**176.50**	**180.50**	**181.50**	**2269.00**

State of Connecticut
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CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	9134	9/30/2015	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* **										
Penni Martin (10/1/2014 - 10/16/2014)	Employee of managem			same as employees	Management and Supervision of a healthcare facility	80	a2			
Karen Chadderton (10/17/2014 - 9/30/2015)	143,910			same as employees	Management and Supervision of a healthcare facility	2,000	a2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	9134	9/30/2015	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	8,839	Disallowed				
3. Pharmacist	10,454	77				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	204,328	3,616				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	36,300	108				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting	200	1				
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	73,365	1,218				
b. Other						
10. Occupational Therapist						
a. Resident Care	275,777	6,214				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	5,108	89				
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	43,453	Disallowed				
B-13 Total Fees Paid in Lieu of Salaries	657,824	11,323				

* 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
Bloomfield Health Care Center of CT, LLC	9134	9/30/2015	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Gerident Solutions, P.O. Box 290539, Wethersfield, CT 06129	Dentist	○	⊙	
Procare LTC of CT, 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist / Consulting Nursing	⊙	○	Common Ownership
Preferred Thearpy-809 Main St., E.Hartford,CT, 06108	PT, ST, OT and Consulting Rehab	⊙	○	Common Ownership
Dr Santo Buccheri - 357 Franklin Ave, Hartford, CT 06114	Medical Director	○	⊙	
Arhim Akwasi, MD, 35 Jolley Drive, Suite 201, Bloomfield CT 06002	Medical Staff Meetings	○	⊙	
Swallowing Diagnostics - PO Box 484, Avon, CT 06001	ST	○	⊙	
Ready Nurse, 2602 Highland Blvd, N.Palm Harbor, FL 34684	RN	○	⊙	
The Nurse Network, 653 Main St, Plantsville, CT 06479	RN	○	⊙	
IV Excellence - LLC 32 Falls Ave, Oakville, CT	IV Therapy	○	⊙	
		○	○	
		○	○	
		○	○	
		○	○	
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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
Bloomfield Health Care Center of CT, LLC	9134	9/30/2015	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	307,540	307,540		
2. Disability Insurance	$				
3. Unemployment Insurance	$	94,621	94,621		
4. Social Security (F.I.C.A.)	$	392,565	392,565		
5. Health Insurance	$	560,462	560,462		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$				
(not-owners and not-operators)					
8. Uniform Allowance	$	29,336	29,336		
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	22,700	22,700		
e. Legal (*Services should be fully described on Page 7)*	$	18,345	18,345		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	27,916	27,916		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	22,075	22,075		
2. Cellular Phones	$	2,973	2,973		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$	285	285		
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	733,010	733,010		
Subtotal	$	2,211,828	2,211,828		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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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	9134	9/30/2015	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,211,828	2,211,828		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	2,484	2,484		
3. Gifts to Staff and Residents	$	1,015	1,015		
4. Employee Travel	$	5,435	5,435		
5. Education Expenses Related to Seminars and Conventions	$	2,727	2,727		
6. Automobile Expense (*not purchase or depreciation*)	$	318	318		
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	571	571		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	23,627	23,627		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	4,193	4,193		
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	8,904	8,904		
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	259	259		
10. Contributions***	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$	428,982	428,982		
13. Other (*Specify*)	$	105,746	105,746		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,796,089	2,796,089		

* 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	$ 23,627		
Total Other Advertising	$ 23,627	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 8,189		
Other - COC dues for Karen Chadderton	$ 400		
ACHCA	$ 315		
Total Dues	$ 8,904	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank charges - disallowed	$ 21,810		
Licenses & permits	$ 972		
Miscellaneous expenses - disallowed	$ 5,856		
Financial Management	$ 20,000		
Penalties - disallowed	$ 15		
Consulting Fees - Fiscal	$ 12,994		
Background Check - Security	$ 199		
Crime Insurance - disallowed	$ 392		
Purchased Services - Fiscal Operations	$ 34,092		
Background Check - Admin	$ 3,874		
In Service -Administration	$ 1,916		
Sales Tax	$ 23		
IT Services - Administration	$ 3,603		
Total Other Administrative and General	$ 105,746	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of CT, LL	9134	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 #
National Healthcare Associates, Inc.	428,982	See Attached	page 16, line M12

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

NHCA Manage

Report Date :10/1/2014 - 09/30/2015

		120 Bloomfield	132 Bristol	160 Cambridge	144 Ludlowe	120 Maple View Manor	120 Marlborough	120 Milford	95 New Milford	130 Regency	345 Riverside	150 Water's Edge
	Intercompany adjustments (Troy)	(2,575.61)	(2,832.59)	(3,433.76)	(3,090.74)	(2,575.61)	(2,575.61)	(2,575.61)	(2,039.27)	(2,790.15)	(7,405.04)	(3,219.22)
310000-0000-00-000-0	Prior Period-National Healthcare Management- - -	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
400000-0000-00-000-0	Salary-National Healthcare Management- - -	282,655.95	310,874.90	376,848.26	339,185.53	282,655.95	282,655.95	282,655.95	225,193.75	306,200.82	812,641.54	353,304.40
400010-0000-00-000-0	Vacation-NY-Nat. Mgmt.- - -	1,567.09	1,722.79	2,088.64	1,880.49	1,567.09	1,567.09	1,567.09	1,241.08	1,697.60	4,505.76	1,958.10
401000-0000-04-000-0	FICA-National Healthcare Management-Fiscal Ope- -	18,621.21	20,480.28	24,826.55	22,345.41	18,621.21	18,621.21	18,621.21	14,742.89	20,172.35	53,536.57	23,275.64
401100-0000-04-000-0	FUI-National Healthcare Management-Fiscal Oper- -	454.22	499.51	605.53	545.03	454.22	454.22	454.22	359.66	492.04	1,305.89	567.74
401101-0000-00-000-0	FUI - NY-National Healthcare Management- - -	(3.74)	(4.11)	(4.99)	(4.49)	(3.74)	(3.74)	(3.74)	(2.96)	(4.05)	(10.75)	(4.68)
401200-0000-04-000-0	SUI-National Healthcare Management-Fiscal Oper- -	1,653.60	1,818.56	2,204.44	1,984.27	1,653.60	1,653.60	1,653.60	1,309.24	1,791.30	4,754.08	2,066.78
401202-0000-00-000-0	SUI - CT-National Healthcare Management- - -	(102.62)	(112.86)	(136.81)	(123.15)	(102.62)	(102.62)	(102.62)	(81.25)	(111.17)	(295.05)	(128.27)
401250-0000-00-000-0	NY MTA Tax-Nat. Mgmt.- - -	518.54	570.35	691.33	622.33	518.54	518.54	518.54	410.56	561.75	1,490.90	648.13
401300-0000-04-000-0	Health Insurance-National Healthcare-Fiscal Op- -	22,866.50	25,147.97	30,485.17	27,439.83	22,866.50	22,866.50	22,866.50	18,104.85	24,771.16	65,742.55	28,580.53
401400-0000-04-000-0	Workers Compensation-National Health-Fiscal Op- -	20.84	22.93	27.79	25.01	20.84	20.84	20.84	16.50	22.59	59.94	26.05
401600-0000-04-000-0	Disability Expense-National Healthca-Fiscal Op- -	502.39	552.47	669.75	602.81	502.39	502.39	502.39	397.73	544.21	1,444.30	627.88
401700-0000-04-000-0	Pension-National Healthcare Manageme-Fiscal Op- -	4,667.41	5,133.07	6,222.49	5,600.86	4,667.41	4,667.41	4,667.41	3,695.46	5,056.17	13,419.02	5,833.72
401800-0000-04-000-0	Employee Benefits - Other-National H-Fiscal Op- -	682.30	750.45	909.66	818.76	682.30	682.30	682.30	540.18	739.16	1,961.70	852.91
402000-0000-04-000-0	Holiday Expense-National Healthcare -Fiscal Op- -	1,473.35	1,620.36	1,964.25	1,768.02	1,473.35	1,473.35	1,473.35	1,166.53	1,596.08	4,235.95	1,841.54
410000-0000-04-000-0	Supplies-National Healthcare Managem-Fiscal Op- -	3,105.44	3,415.57	4,140.54	3,726.84	3,105.44	3,105.44	3,105.44	2,459.03	3,364.44	8,929.00	3,881.87
410000-0000-08-000-0	Supplies-National Healthcare Managem-Maintenan- -	15.27	16.78	20.36	18.33	15.27	15.27	15.27	12.09	16.54	43.90	19.09
410000-0000-09-000-0	Supplies-National Healthcare Managem-Housekeep- -	33.37	36.69	44.48	40.04	33.37	33.37	33.37	26.44	36.15	95.94	41.70
410000-0000-12-000-0	Supplies-National Healthcare Manageme-Security- -	2.53	2.79	3.38	3.04	2.53	2.53	2.53	2.01	2.74	7.28	3.17
411000-0000-04-000-0	Food-National Healthcare Management-Fiscal Ope- -	19.64	21.61	26.19	23.57	19.64	19.64	19.64	15.55	21.28	56.46	24.55
431000-0000-03-000-0	Consulting Fees-National Healthcare -Administr- -	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
431000-0000-04-000-0	Consulting Fees-National Healthcare -Fiscal Op- -	7,030.70	7,732.13	9,373.07	8,436.78	7,030.70	7,030.70	7,030.70	5,566.63	7,616.30	20,213.47	8,787.48
432000-0000-03-000-0	Accounting Fees-National Healthcare -Administr- -	2,283.74	2,511.85	3,044.88	2,740.45	2,283.74	2,283.74	2,283.74	1,807.96	2,473.99	6,565.68	2,854.65
433000-0000-03-000-0	Legal Fees-National Healthcare Manag-Administr- -	1,771.23	1,947.98	2,361.37	2,125.50	1,771.23	1,771.23	1,771.23	1,402.38	1,918.79	5,092.41	2,213.88
433100-0000-03-000-0	Legal Fees - Labor-National Healthca-Administr- -	(611.80)	(672.84)	(815.64)	(734.16)	(611.80)	(611.80)	(611.80)	(484.40)	(662.76)	(1,758.96)	(764.68)
440000-0000-03-000-0	Purch Services-National Healthcare M-Administr- -	8,257.92	9,082.05	11,009.45	9,909.64	8,257.92	8,257.92	8,257.92	6,538.34	8,946.10	23,742.37	10,321.68
440000-0000-08-000-0	Purch Services-National Healthcare M-Maintenan- -	688.71	757.44	918.16	826.58	688.71	688.71	688.71	545.29	746.15	1,980.08	860.81
440000-0000-09-000-0	Purch Services-National Healthcare M-Housekeep- -	900.89	990.69	1,200.92	1,080.87	900.89	900.89	900.89	713.22	975.72	2,589.66	1,125.86
440000-0000-12-000-0	Purch Services-National Healthcare Ma-Security- -	53.36	58.71	71.17	64.05	53.36	53.36	53.36	42.29	57.83	153.47	66.73
440001-0000-08-000-0	Ground Services-Nat. Mgmt.-Maintenance- -	366.53	403.10	488.63	439.78	366.53	366.53	366.53	290.28	397.06	1,053.73	458.14
441000-0000-03-000-0	Computer Expense-National Healthcare-Administr- -	5,676.21	6,242.55	7,567.30	6,811.14	5,676.21	5,676.21	5,676.21	4,494.20	6,148.82	16,319.02	7,094.38
442000-0000-08-000-0	Pest Control-Nat. Mgmt.-Maintenance- -	20.00	21.95	26.65	23.98	20.00	20.00	20.00	15.81	21.62	57.43	24.95
452000-0000-25-000-0	Equipment Rental-National Healthcare-Fiscal Op- -	2,706.81	2,976.72	3,608.72	3,248.36	2,706.81	2,706.81	2,706.81	2,143.04	2,932.26	7,782.25	3,383.22
452100-0000-25-000-0	Equipment Rental - Interes-National -Fiscal Op- -	(1,194.52)	(1,313.70)	(1,592.51)	(1,433.42)	(1,194.52)	(1,194.52)	(1,194.52)	(945.77)	(1,294.02)	(3,434.31)	(1,493.01)
461000-0000-03-000-0	Telephone-National Healthcare Manage-Administr- -	2,712.85	2,983.31	3,616.64	3,255.35	2,712.85	2,712.85	2,712.85	2,147.76	2,938.63	7,799.37	3,390.65
461100-0000-03-000-0	Telephone - Cell-National Healthcare-Administr- -	2,006.26	2,206.37	2,674.65	2,407.48	2,006.26	2,006.26	2,006.26	1,588.40	2,173.30	5,767.96	2,507.54
462000-0000-25-000-0	Electric-National Healthcare Manageme-Property- -	1,529.87	1,682.44	2,039.55	1,835.81	1,529.87	1,529.87	1,529.87	1,211.25	1,657.25	4,398.44	1,912.13
463000-0000-25-000-0	Gas-National Healthcare Management-Property- -	443.34	487.58	591.08	532.03	443.34	443.34	443.34	351.02	480.27	1,274.68	554.15
466000-0000-25-000-0	Water-National Healthcare Management-Property- -	72.43	79.68	96.60	86.95	72.43	72.43	72.43	57.36	78.50	208.30	90.55
471000-0000-25-000-0	Rent-National Healthcare Management-Property- -	6,469.09	7,114.48	8,624.40	7,762.81	6,469.09	6,469.09	6,469.09	5,121.91	7,007.84	18,598.85	8,085.55
472000-0000-25-000-0	Personal Property Taxes-National Hea-Fiscal Op- -	516.53	567.96	688.58	619.75	516.53	516.53	516.53	408.91	559.46	1,484.89	645.51
473000-0000-04-000-0	Real Estate Taxes-National Healthcar-Fiscal Op- -	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
473000-0000-25-000-0	Real Estate Taxes-National Healthcar-Fiscal Op- -	3,426.41	3,768.25	4,568.02	4,111.67	3,426.41	3,426.41	3,426.41	2,712.89	3,711.81	9,851.10	4,282.62
484000-0000-04-000-0	Amort Exp - LHI-National Healthcare -Fiscal Op- -	1,327.68	1,460.13	1,770.03	1,593.23	1,327.68	1,327.68	1,327.68	1,051.22	1,438.25	3,817.12	1,659.43
484100-0000-04-000-0	Amortization Exp- LHI ALL-Nat. Mgmt.-Fiscal Op- -	13.35	14.69	17.82	16.04	13.35	13.35	13.35	10.59	14.51	38.39	16.71
486000-0000-04-000-0	Dep Exp - Moveable Equip-National He-Fiscal Op- -	7,709.31	8,478.48	10,277.90	9,251.17	7,709.31	7,709.31	7,709.31	6,103.96	8,351.46	22,164.73	9,635.76
491000-0000-03-000-0	Dues and Subscriptions-National Heal-Administr- -	257.10	282.74	342.75	308.54	257.10	257.10	257.10	203.56	278.48	739.13	321.30
500000-0000-03-000-0	Licenses and Permits-National Health-Administr- -	21.32	23.43	28.41	25.57	21.32	21.32	21.32	16.88	23.08	61.27	26.63
501000-0000-03-000-0	Advertising Employment-National Heal-Administr- -	8,395.23	9,232.87	11,192.42	10,074.37	8,395.23	8,395.23	8,395.23	6,647.11	9,094.54	24,136.88	10,493.18
501100-0000-03-000-0	Advertising Promotional-National Hea-Administr- -	7,253.58	7,977.65	9,670.79	8,704.30	7,253.58	7,253.58	7,253.58	5,742.94	7,857.89	20,854.26	9,066.65
503000-0000-03-000-0	Interest-National Healthcare Managem-Administr- -	403.92	470.31	570.07	513.28	403.92	403.92	403.92	338.59	463.27	1,229.67	534.49
503500-0000-03-000-0	Penalties-National Healthcare Manage-Administr- -	3.16	133.97	162.47	146.25	3.16	3.16	3.16	96.41	131.87	350.19	152.24
503600-0000-03-000-0	Bank Charges-Nat. Mgmt.-Administration- -	931.40	1,024.35	1,241.72	1,117.67	931.40	931.40	931.40	737.43	1,008.96	2,677.79	1,164.16
504000-0000-03-000-0	Postage-National Healthcare Manageme-Administr- -	984.22	1,082.49	1,312.19	1,181.11	984.22	984.22	984.22	779.28	1,066.23	2,829.69	1,230.12
509000-0000-03-000-0	Seminars-National Healthcare Managem-Administr- -	2,053.89	2,258.79	2,738.16	2,464.68	2,053.89	2,053.89	2,053.89	1,626.20	2,224.99	5,905.05	2,567.16
510000-0000-03-000-0	Liability Insurance-National Healthc-Administr- -	2,748.78	3,022.96	3,664.56	3,298.53	2,748.78	2,748.78	2,748.78	2,176.33	2,977.70	7,902.80	3,435.67
511000-0000-03-000-0	Auto Insurance-National Healthcare M-Administr- -	963.25	1,059.28	1,284.11	1,155.92	963.25	963.25	963.25	762.68	1,043.51	2,769.34	1,203.91
512000-0000-03-000-0	Umbrella Insurance-National Healthca-Administr- -	790.75	869.69	1,054.24	948.94	790.75	790.75	790.75	626.14	856.65	2,273.52	988.38
513000-0000-03-000-0	Crime Insurance-National Healthcare -Administr- -	23.14	25.48	30.93	27.80	23.14	23.14	23.14	18.37	25.12	66.63	28.94
517000-0000-03-000-0	Wor`kmans Comp Insurance-National	391.28	430.37	521.69	469.60	391.28	391.28	391.28	309.82	423.89	1,125.10	489.10
520000-0000-03-000-0	Auto Expense-National Healthcare Man-Administr- -	38.53	42.39	51.40	46.24	38.53	38.53	38.53	30.50	41.81	110.77	48.10
520100-0000-03-000-0	Auto Lease Expense-National Healthca-Administr- -	2,696.65	2,965.51	3,595.01	3,235.78	2,696.65	2,696.65	2,696.65	2,134.84	2,921.04	7,752.31	3,369.97
521000-0000-03-000-0	Travel Expense-National Healthcare M-Administr- -	4,708.93	5,179.26	6,278.29	5,650.74	4,708.93	4,708.93	4,708.93	3,728.03	5,101.27	13,538.39	5,885.96
522000-0000-03-000-0	Hotel Expense-National Healthcare Ma-Administr- -	4,686.54	5,154.73	6,248.54	5,623.81	4,686.54	4,686.54	4,686.54	3,710.28	5,076.90	13,473.77	5,858.17
540000-0000-31-000-0	Donations-National Healthcare Manage-Misc. Exp- -	54.63	60.08	72.83	65.55	54.63	54.63	54.63	43.25	59.18	157.05	68.28
541000-0000-03-000-0	Misc. Expense-Nat. Mgmt.-Administration- -	136.48	150.07	181.96	163.77	136.48	136.48	136.48	108.05	147.83	392.41	170.59
541000-0000-31-000-0	Misc. Expense-National Healthcare Ma-Misc. Exp- -	594.10	653.34	792.13	712.97	594.10	594.10	594.10	470.42	643.67	1,708.20	742.55
541001-0000-03-000-0	Political Contributions-Nat. Mgmt.-Administrat- -	5.46	6.01	7.28	6.56	5.46	5.46	5.46	4.33	5.92	15.71	6.83
542000-0000-31-000-0	Corporate Tax - State-National Healt-Misc. Exp- -	199.40	219.30	265.85	239.31	199.40	199.40	199.40	157.90	216.00	573.31	249.23
543000-0000-31-000-0	Corporate Tax - Federal-National Hea-Misc. Exp- -	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
544000-0000-25-000-0	Sales Tax - Conn.-National Healthcar-Fiscal Op- -	285.82	6,189.53	7,502.39	6,752.24	285.82	285.82	285.82	4,454.53	6,095.81	16,176.78	7,033.01
	Sum	428,982.14	477,834.12	579,240.88	521,357.16	428,982.14	428,982.14	428,982.14	345,388.48	470,655.76	1,249,100.09	543,050.94
	Page 16 line m12 on Cost Report	428,982.00	477,834.00	579,241.00	521,357.00	428,982.00	428,982.00	428,982.00	345,388.00	470,656.00	1,249,100.00	543,051.00
	Variances	0.14	0.12	(0.12)	0.16	0.14	0.14	0.14	0.48	(0.24)	0.09	(0.06)

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

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of CT, LLC	9134	9/30/2015	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	272,972	272,972		
2. Non-Food Supplies	$	26,012	26,012		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	29,222	29,222		
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	328,206	328,206		

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

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

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.
** 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
Bloomfield Health Care Center of CT, LLC	9134	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. $	10,551	10,551		
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)*	$	1,299	1,299		
c. Management Services**	$				
d. Other (*Specify*) Diapers $47,116, Supplies $5,584	$	52,700	52,700		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	64,550	64,550		

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
Bloomfield Health Care Center of CT, LLC	9134	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.	$	28,500	28,500		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*		$				
d. Other (*Specify*)		$	252	252		
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	28,752	28,752		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from PCA		$	224,768	224,768		
b. Medicine Cabinet Drugs		$	22,538	22,538		
c. Medical and Therapeutic Supplies		$	134,609	134,609		
d. Ambulance/Limousine***		$	12,991	12,991		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	16,450	16,450		
f. X-rays and Related Radiological Procedures***		$	19,830	19,830		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	21,302	21,302		
i. Recreation		$	32,122	32,122		
j. Other (Specify)**** See Attached Schedule		$	59,814	59,814		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	544,424	544,424		

* 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)
Equipment Rental - Nursing	$ 17,524		
Equip Rental - Rehab/Therapy	$ 17,229		
Flu Vaccine	$ 6,869		
IV Thy Supplies - Rehab Therapy and Ancillary	$ 13,566		
Nursing Purchased Services	$ 4,626		
Total Other Resident Care	$ 59,814	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	9134	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
ADM Environmental Group	Avenue, Brooklyn, NY 11230	○	⊙		Waste Service/ Monthly Recycling Service	26,874			22	6f
ADP	P.O. Box 842875, Boston, MA 02284	○	⊙		Payroll Processing	12,114			16	m13
Evergreen Lawn Care	5 Partridge Lane New Milford, CT 06776	○	⊙		Landscaping/Snow Removal	20,718			22	6f
MJ Daly & Sons	110 Mattatuck HTS, Waterbury, CT 06705	○	⊙		HVAC	17,524			22	6A
Proline	P.O Box 150473, Hartford, CT 06145	○	⊙		Dietary Repairs & Maintenance	22,947			18	2b
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of CT, LLC	9134	9/30/2015	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	60,467	60,467		
b. Heat	$	65,666	65,666		
c. Light & Power	$	104,626	104,626		
d. Water	$	21,210	21,210		
e. Equipment Lease (*Provide detail on page 6*)	$	26,870	26,870		
f. Other (*itemize*)	$	64,844	64,844		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	343,683	343,683		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	1,155	1,155		
d. Movable Equipment	$	25,783	25,783		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	26,938	26,938		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	51,893	51,893		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	51,893	51,893		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	560,000	560,000		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	142,728	142,728		
c. Personal property taxes	$	7,506	7,506		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	789,065	789,065		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Pest Control	$ 5,956		
Plowing/Landscaping	$ 20,718		
Security	$ 8,314		
Carting	$ 29,856		
Total Other Repairs and Maintenance	$ 64,844	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	9134	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								
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					
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	60,024		60,024	52,618	SL	30	1,155	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								1,155

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					1,122,534		1,122,534	416,014	SL	Various	22,407	
b. Disposals (attach schedule)					(133,695)		(133,695)	(131,047)	SL	Various		
c. Acquired during this report period (attach schedule)					38,812		38,812		SL	Various	3,376	
D-3. Subtotal												25,783
E. ***Total Depreciation***												26,938

Bloomfield Health Care Center of CT, LLC
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Schedule of Land Improvements Acquired during this report period

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

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

Schedule of Building Improvements Acquired during this report period

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

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

Schedule of Non-Movable Equipment Acquired during this report period

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
11/10/2014	Kit BP/Therm	$ 2,044	5	$ 375	
11/30/2014	Circulator	$ 2,802	5	$ 514	
11/30/2014	Electronic Mixing Value	$ 5,511	5	$ 1,010	
2/18/2015	Vacuum	$ 2,624	15	$ 117	
2/28/2015	Tv's	$ 888	5	$ 118	
2/28/2015	Relief Max Mattress	$ 1,010	5	$ 135	
3/18/2015	Bed	$ 938	5	$ 109	
3/31/2015	Reliant Lift Actuator	$ 1,354	10	$ 79	
3/31/2015	Relief Max Mattress	$ 1,010	5	$ 118	
4/30/2015	PC's	$ 898	5	$ 90	
4/30/2015	PC's	$ 898	3	$ 90	
4/30/2015	Monitors	$ 207	5	$ 21	
4/30/2015	Monitors	$ 207	3	$ 21	
5/31/2015	Reliant Electric Power Lift	$ 1,744	10	$ 73	
5/31/2015	Relief Max Mattress	$ 1,010	5	$ 84	
6/29/2015	Computer Equipment	$ 717	5	$ 48	
6/30/2015	Monitors	$ 262	5	$ 17	
6/30/2015	Reliant Battery Pack	$ 868	10	$ 29	
6/30/2015	PC's	$ 809	5	$ 54	
7/16/2015	Reliant Lift Charger	$ 1,327	10	$ 33	
7/31/2015	PC's	$ 931	5	$ 47	
7/30/2015	AC	$ 626	5	$ 31	
7/30/2015	Duplex Scanner	$ 914	5	$ 46	
8/31/2015	Washing Machine	$ 1,820	10	$ 30	
8/31/2015	Compresser	$ 3,017	12	$ 42	
9/30/2015	Monitors & PC's	$ 803	5	$ 13	
9/30/2015	Monitors	$ 164	3	$ 5	
9/30/2015	Motor & Impeller	$ 3,408	10	$ 28	
Total additions for Movable Equipment		$ 38,812		$ 3,376	*
Deletions:					
9/30/2015	Hoyer Lift / Hydraulic	$ 694	7	$ 694	
9/30/2015	Motor & Peller	$ 1,328	7	$ 1,328	
9/30/2015	A/C	$ 769	7	$ 769	
9/30/2015	A/C	$ 769	7	$ 769	
9/30/2015	Motor	$ 2,310	7	$ 2,310	
9/30/2015	Oximeter	$ 600	7	$ 600	
9/30/2015	Sales Tax on 11 - Oximeter	$ 36	7	$ 36	
9/30/2015	Printer & Install	$ 10,493	7	$ 10,493	
9/30/2015	National HCA Assets	$ 5,091	7	$ 5,091	
9/30/2015	National MME	$ 47	7	$ 47	
9/30/2015	National Assets	$ 5,421	7	$ 5,421	
9/30/2015	Mattress	$ 717	5	$ 717	
9/30/2015	Mattress	$ 717	5	$ 717	
9/30/2015	Recliner	$ 477	5	$ 477	
9/30/2015	A/C	$ 795	5	$ 795	
9/30/2015	Bed	$ 4,440	5	$ 4,440	
9/30/2015	Wandering Resident's Sys	$ 979	5	$ 979	
9/30/2015	Computer	$ 1,068	5	$ 1,068	
9/30/2015	Computer	$ 1,042	5	$ 1,042	
9/30/2015	Computer	$ 1,301	5	$ 1,301	
9/30/2015	Laserjet Printer	$ 1,118	5	$ 1,118	
9/30/2015	Office Furniture	$ 2,076	5	$ 2,076	
9/30/2015	Vinyl Mat	$ 1,271	5	$ 1,271	
9/30/2015	Tax on 45 - Cubicle Curtains	$ 53	5	$ 53	
9/30/2015	Disposer	$ 1,057	5	$ 1,057	
9/30/2015	Tax on 48 - Floor Machine	$ 95	5	$ 95	
9/30/2015	Tax on 51- Pulse Oximeter	$ 30	5	$ 30	
9/30/2015	Tax on 53 - Pulse Oximeter	$ 30	5	$ 30	
9/30/2015	Smart Alarms	$ 695	5	$ 695	
9/30/2015	Cabinet	$ 730	5	$ 730	
9/30/2015	Computer	$ 1,268	5	$ 1,268	
9/30/2015	Digital Scale	$ 2,251	5	$ 2,251	
9/30/2015	Digital Scale	$ 836	5	$ 836	

9/30/2015	Edger	$	620	5	$ 620
9/30/2015	Network	$	2,870	5	$ 2,870
9/30/2015	Snow Blower	$	2,628	5	$ 2,628
9/30/2015	Specialty Mattresses	$	26,553	5	$ 26,553
9/30/2015	Wound Treatment Machine	$	2,120	5	$ 2,120
9/30/2015	Relief Max Mattresses	$	6,042	5	$ 6,042
9/30/2015	Polynnium Bed Ends	$	3,466	5	$ 3,466
9/30/2015	Tax on 109 - Bed Ends	$	208	5	$ 208
9/30/2015	BOSTON DRAG APHASIA EXAM KIT	$	598	5	$ 598
9/30/2015	1997 MME (7 YRS)	$	3,239	7	$ 3,239
9/30/2015	1998 MME (7 YR)	$	10,984	7	$ 10,984
9/30/2015	1998 MME 7 YR (CONTINUED)	$	583	7	$ 583
9/30/2015	1999 MME 7 YR	$	246	7	$ 246
9/30/2015	1999 MME (7 YR)	$	1,200	7	$ 1,200
9/30/2015	1999 MME (7 YR)	$	497	7	$ 497
9/30/2015	1999 MME 7 YR	$	700	7	$ 700
9/30/2015	1999 MME (7 YR)	$	2,555	7	$ 2,555
9/30/2015	MME 1999 (7 YR)	$	483	7	$ 483
9/30/2015	1999 MME (7 YR)	$	1,966	7	$ 1,966
9/30/2015	1999 MME (7 YR)	$	775	7	$ 775
9/30/2015	Motor Removal / Replacement	$	1,004	5	$ 1,004
9/30/2015	Printer	$	899	5	$ 899
9/30/2015	VAC	$	704	5	$ 704
9/30/2015	Bariatric Bed Mattress	$	1,521	5	$ 1,521
9/30/2015	Computer Related	$	2,826	5	$ 2,826
9/30/2015	Disposal In-Sink Erator	$	2,863	5	$ 2,863
9/30/2015	Motor	$	675	5	$ 675
9/30/2015	Hi Lo Motors for Beds	$	1,089	5	$ 1,089
9/30/2015	Dryer Motor	$	904	5	$ 904
9/30/2015	Walker	$	812	5	$ 812
10/1/2014	Power Lift	$	1,462	5	$ 97
	Plug to tie				$ (1,283)
Total deletions for Movable Equipment		$	133,695		$ 131,047 **

***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:				
11/30/2014	Cabinets & Shelves & Wardrobes	$ 41,613	15	$ 2,312
1/29/2015	Waste Sink	$ 1,146	20	$ 43
2/26/2015	Handle sets	$ 1,601	20	$ 214
2/26/2015	Intercom	$ 1,547	10	$ 103
3/19/2015	Carpeting	$ 88,283	5	$ 10,300
4/30/2015	Smoke Detector	$ 1,256	10	$ 63
8/27/2015	Carpeting	$ 4,068	5	$ 136
9/22/2015	Sanding, Painting, & other work	$ 4,500	10	$ 38
9/30/2015	Sidwalk and Curbing Work	$ 2,500	15	$ 14
9/30/2015	Paving for Parking Lot	$ 1,138	15	$ 6
9/30/2015	Wall Coverings	$ 2,400	5	$ 40
9/30/2015	Smoke Detector	$ 913	10	$ 8
9/30/2015	Carpeting	$ 870	15	$ 5
Total additions for Leasehold Improvement		$ 151,835		$ 13,280 *
Deletions:				
9/30/2015	Emergency Stop Switch	$ 1,011	15	$ 101
	Plug to tie			$ 2,298
Total deletions for Leasehold Improvement		$ 1,011		$ 2,399 **

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	9134	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.									
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			5-20	609,577	250,512	SL		38,613	
2. Disposals (attach schedule)			5-20	(1,011)	(2,399)	SL			
3. Acquired during this report period									
(attach schedule)			5-20	151,835		SL		13,280	
C-4. Subtotal									51,893
D. ***Total Amortization***									51,893

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT,	9134	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	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	120
6. Square Footage	
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	07/01/02			
c. Interest Rate for the Cost Year	7.33%			
d. Term of Mortgage (number of years)	15			
e. Amount of Principal Borrowed	8,226,480			
f. Principal balance outstanding as of 9/30/15	3,926,089			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of CT	9134	9/30/2015	26 | 37

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

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of (	9134	9/30/2015	27 | 37

Item	Rate	Amount	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*) $			5,450	5,450		
A. Item	Rate	Amount				
Equipment Loan- Leasehold Im	5.00%	5,450				
Lender						
M & T Bank						
Address of Lender						
PO Box 62176, Baltimore, MD, 21264						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $			5,450	5,450		
12. D. Other Interest Expense (*Specify*) $			965	965		
Interest - Admin $367; Liability Ins Financing $566; Intere						
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $			6,415	6,415		
14. Insurance						
a. Insurance on Property (buildings only) $			9,563	9,563		
b. Insurance on Automobiles $						
c. Insurance other than Property (as specified above)						
1. Umbrella (*Blanket Coverage*) $			8,139	8,139		
2. Fire and Extended Coverage $						
3. Other (*Specify*) $			32,614	32,614		
Liability Insurance $31,668; Boiler Insurance $946						
14d. ***Total Insurance Expenditures (14a + b + c)*** $			50,316	50,316		
15. ***Total All Expenditures (A-13 thru C-14)*** $			10,847,550	10,847,550		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of CT, LLC	9134	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.	10	12M	Salaries not related to Resident Care $	13,472	13,472		
3.			Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	10a	Occupational Therapy $	275,777	275,777		
7.			Other - See attached Schedule $	71,431	71,431		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $				
10.	15	1e	Accounting & Legal $	18,345	18,345		
11.			Telephone $				
12.	15	1h2	Cellular Telephone $	1,533	1,533		
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.	16	L6	Automobile Expense (e.g. personal use) $	318	318		
18.	16	m3	Unallowable Advertising * $	23,627	23,627		
19.	15	1j	Income Tax / Corporate Business Tax $	285	285		
20.			Fund Raising / Contributions $				
21.	16	m12	Unallowable Management Fees $	163,961	163,961		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	42,962	42,962		
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) $	611,711	611,711		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B2	Dentist	$ 8,839		
13	B12	Therapy Consulting - Rehab Therapy and Ancillary	$ 10,546		
13	B12	IV Nursing	$ 2,075		
13	B12	Therapy Consulting - Nursing	$ 30,832		
13	B8a	Excess Disallowed of Medical Director Salary	$ 19,139		
Total Other Fees Adjustments			$ 71,431	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
15		Benefits on Salaries not Related to Resident Care	$ 3,561		
16	M13	Misc. Exp	$ 5,856		
16	M13	Bank Charge	$ 21,810		
16	M13	Crime Insurance	$ 392		
16	M13	Penalties	$ 15		
16	L3	Gifts	$ 1,015		
16	M8	Other - COC dues for Karen Chadderton	$ 400		
15	1g	Overstatement of Expense - Supplies - Fiscal Operations	$ 1,572		
16	m13	Overstatement of Expense - Purchased Services - Fiscal Operations	190		
18	2a1	Overstatement of Expense - Food - Dietary	2,685		
18	2a1	Overstatement of Expense - Food Supplements - Dietary	761		
18	2a2	Overstatement of Expense - Supplies - Dietary	3,586		
19	3d	Overstatement of Expense - Diapers - Laundry	1,119		
Total Other A&G Adjustments			$ 42,962	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Bloomfield Health Care Center of CT, LLC	9134	9/30/2015	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	611,711	611,711		
Page 20 - Resident Care Supplies***								
27.	20	5a2	Prescription Drugs	$	224,768	224,768		
28.	20	5d	Ambulance/Limousine	$	12,991	12,991		
29.	20	5f	X-rays, etc	$	19,830	19,830		
30.	20	5h	Laboratory	$	21,302	21,302		
31.	20	5c	Medical Supplies	$	2,555	2,555		
32.	20	5e2	Oxygen (non emergency)	$	16,450	16,450		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	70,902	70,902		
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$	1,138	1,138		
36.			Depreciation on Unallowable Motor Vehicles	$				
37.	22	10c	Unallowable Property and Real Estate Taxes	$	713	713		
38.			Rental of Building Space or Rooms	$				
39.			Other - See Attached Schedule	$	4,065	4,065		
Page 27 - Insurance								
40.			Mortgage Insurance	$				
41.			Property Insurance	$				
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	$	3,493	3,493		
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)***			$	989,918	989,918		

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

Attachment Page 29

Bloomfield Health Care Center of CT, LLC
9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5J	Equipment Rental - Nursing	$ 17,524		
20	5J	Equip Rental - Rehab/Therapy	$ 17,229		
20	5J	Flu Vaccine	$ 6,869		
20	5J	IV Thy Supplies - Rehab Therapy and Ancillary	$ 13,566		
20	5a2 / b	Procare Disallowance Price Markup	$ 1,529		
20	5i	Cable TV Expense - Resident Rooms	$ 9,029		
20	4a1	Overstatement of Expense - Supplies - Housekeeping	$ 79		
20	5b	Overstatement of Expense - House Drugs	$ 274		
20	5c	Overstatement of Expense - Supplies - Nursing	$ 4,803		
Total Other Ancillary Costs			$ 70,902	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
23	2a	TV and Mattress Disallowed Depreciation Expense	$ 1,138		
Total Excess Movable Equipment Depreciation			$ 1,138	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	6e	Auto Lease	$ 4,065		
Total Other Property Adjustments			$ 4,065	$ -	$ -

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	12D	Interest Expense	$ 933		
30	8	SCA Diaper Rebate	$ 2,077		
30	8	CT Institute of the Blind	$ 20		
30	8	Medical Records	$ 70		
30	8	Other Misc Income	$ 21		
30	IV5	Interest Income	$ 112		
22	6a	Overstatement of Expense - Supplies - Maintenance	$ 260		
Total Other Adjustments			$ 3,493	$ -	$ -

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LL	9134	9/30/2015	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	12,050,406	12,050,406		
b. Medicaid Room and Board Contractual Allowance **	$	(4,381,094)	(4,381,094)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,424,959	1,424,959		
b. Medicare Room and Board Contractual Allowance **	$	406,949	406,949		
4. a. Private-Pay Residents and Other	$	771,098	771,098		
b. Private-Pay Room and Board Contractual Allowance **	$	(159,514)	(159,514)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	109,333	109,333		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(109,333)	(109,333)		
c. Prescription Drugs - Non-Medicare	$	113,088	113,088		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(112,104)	(112,104)		
2. a. Medical Supplies - Medicare	$	1,183	1,183		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	218,670	218,670		
b. Physical Therapy - Medicare Contractual Allowance **	$	(168,980)	(168,980)		
c. Physical Therapy - Non-Medicare	$	164,677	164,677		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(163,933)	(163,933)		
4. a. Speech Therapy - Medicare	$	69,348	69,348		
b. Speech Therapy - Medicare Contractual Allowance **	$	(30,251)	(30,251)		
c. Speech Therapy - Non-Medicare	$	52,585	52,585		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(51,424)	(51,424)		
5. a. Occupational Therapy - Medicare	$	294,413	294,413		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(206,670)	(206,670)		
c. Occupational Therapy - Non-Medicare	$	193,758	193,758		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(192,744)	(192,744)		
6. a. Other *(Specify)* - Medicare	$	25,046	25,046		
b. Other *(Specify)* - Non-Medicare	$	12,152	12,152		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	10,331,618	10,331,618		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	112	112		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	19,112	19,112		
V. Total Other Revenue (1 thru 8)	$	19,224	19,224		
VI. Total All Revenue (III +V)	$	10,350,842	10,350,842		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30, line II6	Medicare A Lab	$ 40,109		
30, line II6	Medicare A X Ray	$ 6,830		
30, line II6	Medicare A Contra	$ (20,194)		
30, line II6	Medicare Pt B Prior Period	$ (1,699)		
Total Other Resident Revenue - Medicare		$ 25,046	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30, line II6	Commerical Insurance - LAB	$ 7,934		
30, line II6	Commerical Insurance - X-RAY	$ 7,315		
30, line II6	Commercial Insurance - Contra Other	$ (15,250)		
30, line II6	Medicaid Lab	$ 436		
30, line II6	Medicaid Contra Other	$ (24,960)		
30, line II6	Commercial Insurance Flu/Pneumonia	$ 1,778		
30, line II6	Commercial Insurance IV Therapy	$ 34,899		
Total Other Resident Revenue		$ 12,152	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
30, line IV5	Interest Income (Money Market)		$ 112		
Total Interest Income			$ 112	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30, line IV8	Prior Period	$ (10,856)		
30, line IV8	Misellaneous Other Income	$ 29,968		
	(SCA Diaper Refund - $2,077; United Health Care $27,780; Medical Records $70;			
	Other $41)			
Total Other Revenue		$ 19,112	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, I	9134	9/30/2015	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 170,502
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 2,571,134
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 31,166
5. Prepaid Expenses				$ 190,485
a. Insurance		23,629		
b. Taxes (personal property & real estate)		86,210		
c. Management Fees		48,268		
d. Other		32,378		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 60,589
Patient Funds		36,244		
Due from Related		24,345		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 3,023,876
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	782,740		$ 482,734
	Accum. Depreciation	300,006	Net	
5. Non-Movable Equipment	*Historical Cost	60,024		$ 6,251
	Accum. Depreciation	53,773	Net	
6. Movable Equipment	*Historical Cost	428,012		$ 117,262
	Accum. Depreciation	310,750	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)				$ 606,247

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, I	9134	9/30/2015	32	37

Account				Amount
			Total Brought Forward:	$ 3,630,123
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost	5,657,365		
	Accum. Depreciation		Net	$ 5,657,365
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost	577,299		
	Accum. Depreciation	577,299	Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$ 5,657,365
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 11,500
Security Deposits		11,500		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 11,500
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 9,298,988

* 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
Bloomfield Health Care Center of CT, LLC	9134	9/30/2015	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 2,389,972
2. Notes Payable (*itemize*)					$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$ 16,237
	Name of Lender	Purpose	Amount	Date Due	
	M&T Bank	Equipment	16,237		
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)					$ 296,030
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 1,930,833
Accrued expenses	94,076	Due to related party	1,629,725		
Revenue assessment	170,788				
Patient personal funds	36,244				
#REF!	#REF!				
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 4,633,072

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LLC	9134	9/30/2015	34	37

Account				Amount
			Total Brought Forward:	4,633,072
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$ 190,250
Name of Lender	Purpose	Amount	Date Due	
M&T Bank	Equipment	29,818		
M&T Bank	Equipment	160,432		
2. Mortgages Payable				$
3. Loans from Owners or Related Parties (*itemize*)				$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (*itemize*)				$ 1,036,295
Due to related party	1,036,295			
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 1,226,545
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 5,859,617

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT,	9134	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	$ 5,657,365
	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	$ 5,657,365
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (1,721,286)
	6. Gain or Loss for Period 10/1/2014 thru 9/30/2015	$ (496,708)
	7. Total Net Worth	$ (2,217,994)
C.	***Total Reserves and Net Worth***	$ 3,439,371
D.	***Total Liabilities, Reserves, and Net Worth***	$ 9,298,988

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT, LL	9134	9/30/2015	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2014			$ (1,807,262)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 10,350,842
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 10,847,550
D.	Net Income or Deficit			$ (496,708)
E.	Balance			$ (2,303,970)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Contributions from members	85,000		
	2. Other (*itemize*)			
	Tax refund	976		
F-3.	Total Additions			$ 85,976
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		$ (2,217,994)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Bloomfield Health Care Center of CT,	9134	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
Blum, Shapiro & Company, P.C.		2/5/16

Printed Name of Preparer
Blum Shapiro & Company, P.C.

Address	Phone Number
29 South Main Street, Suite 400, West Hartford, CT 06127	860-561-4000