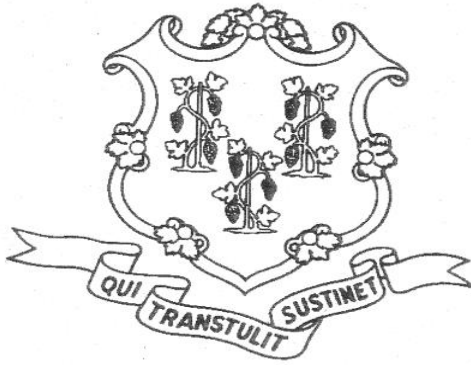


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2016

Name of Facility (as licensed) Bridgeport Health Care Center Inc	
Address (No. & Street, City, State, Zip Code) 600 Bond Street Bridgeport CT 06610	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016

License Numbers:	CCNH 2061C	RHNS	(Specify)	Medicare Provider 07-5370
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Medicaid Provider Numbers:	CCNH 200679	RHNS	ICF-IID
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For Department Use Only

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

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General Information

Name of Facility (as licensed) Bridgeport Health Care Center Inc	License No. 2061C	Report for Year Ended 9/30/2016	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Bridgeport Health Care Center Inc [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 2016, 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) Christopher Massaro			Printed Name (Owner) Miriam Stern		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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 Bridgeport Health Care Center Inc		Period Covered:	From 10/1/2015	To 9/30/2016
Address of Facility 600 Bond Street Bridgeport CT 06610				
Report Prepared By Burg & Weingarten CPA PC		Phone Number 718-845-6141	Date 2/7/2016	
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.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-384-6400		Report for Year Ended 9/30/2016	Page 2	of 37
Name of Facility (as shown on license) Bridgeport Health Care Center Inc		Address (No. & Street, City, State, Zip) 600 Bond Street Bridgeport CT 06610		
License Numbers:	CCNH 2061C	RHNS	(Specify)	Medicare Provider No. 07-5370
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Christopher Massaro		Nursing Home Administrator's License No.:	001425	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name Chaim Stern		License No.:		
Joseph Stern				
Rachel Blass				

General Information and Questionnaire
Corporate Owners

Name of Facility Bridgeport Health Care Center Inc	License No. 2061C	Report for Year Ended 9/30/2016	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation Bridgeport Health Care Center Inc	Business Address 600 Bond St Bridgeport CT 06610	State(s) in Which Incorporated CT		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Names of Stockholders Owning at Least 10% of Shares				
Miriam Stern			65	
Norma Loren			17.5	
Rachel Blass			17.5	

General Information and Questionnaire
Related Parties*

Name of Facility Bridgeport Health Care Center Inc	License No. 2061C	Report for Year Ended 9/30/2016	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Bridgeport Health Care Realty	600 Bond St Bridgeport CT 06610	<input type="radio"/>	<input checked="" type="radio"/>		Rental of Land & Building	P22/9	666,666	307,677
Rachel Blass		<input type="radio"/>	<input checked="" type="radio"/>		Shareholder/Asst Admin	P 10 A3	28,256	
Norma Loren		<input type="radio"/>	<input checked="" type="radio"/>		Shareholder			
Chaim Stern		<input type="radio"/>	<input checked="" type="radio"/>		Asst Admin	P 10 A3	129,032	
Joseph Stern		<input type="radio"/>	<input checked="" type="radio"/>		Asst Admin	P 10 A3	71,088	
Paradise Realty of Waterbury	3845 E Main St Waterbury CT	<input type="radio"/>	<input checked="" type="radio"/>		Loans			
Comprehensive Rehabilitation Services LLC	26 FIREMENS MEMORIAL DRIVE POMONA NY 10970	<input type="radio"/>	<input checked="" type="radio"/>		Therapy	P 13 Lines 5 ,9 & 10		
The Rosegarden Health & Rehabilitation Center LLC	3845 E Main St Waterbury CT	<input checked="" type="radio"/>	<input type="radio"/>	100%	Loans, Allocation of cost			
New Coleman Park Health LLC / Paradise Realty	600 Bond St Bridgeport CT 06610	<input type="radio"/>	<input checked="" type="radio"/>		Loans			

* Use additional sheets if necessary.

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

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
Bridgeport Health Care Center Inc			2061C	9/30/2016			6	37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
Marlin Leasing 300 Fellowship Rd Mount Laurel NJ 08054	<input type="radio"/>	<input checked="" type="radio"/>	Copier Lease	03/01/10	60 months	5,360	2,900	
Pitney Bowes POB 856179 Louisville KY 40285	<input type="radio"/>	<input checked="" type="radio"/>	Mail Machine Equipment	09/28/10	51 months	5,018	2,715	
Great American Leasing PO BOX 606 Cedar Rapids IA 52406	<input type="radio"/>	<input checked="" type="radio"/>	Fax Machines	06/06/12	60 months	2,243	1,213	
Accelerated Care Plus 9855 DOUBLE R BLVD Reno NV 89521	<input type="radio"/>	<input checked="" type="radio"/>	Therapy Equipment	05/01/13	12 months	11,495	11,495	
CCP Solutions LLC 74 Marine Street Farmingdale NY 11735	<input type="radio"/>	<input checked="" type="radio"/>	Copier Lease	07/27/16	39 months	10,629	987	
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
							Total ***	19,310

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes No

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

** Attach copies of newly acquired leases.

*** Amount should agree to Page 22, Line 6e.

General Information and Questionnaire
Accounting Basis

Name of Facility Bridgeport Health Care Center Inc	License No. 2061C	Report for Year Ended 9/30/2016	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Burg & Weingarten CPA PC	149-12 83rd St Howard Beach NY 11414
2 Zimmet Health Care Services Inc	4006 Rt 9 South Morganville NJ 07751
3 Craig J Lubitsky Consulting	225 Pitkin St East Hartford CT 06108
4	

Services Provided by This Firm (*describe fully*)

1 General Accounting, Balance Sheet, Trial Balance, Cost Report	\$ 53,613
2 Medicare Cost Report	\$ 6,898
3 Audit	\$ 3,009
4	\$
	Charge for Services Provided
	\$ 63,520

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

Yes No Page 15 Line 1 D

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Murtha, Cullina LLP	860-240-6000
2 James Stedronsky LLC	860-567-9111
3 Berchem, Moses & Devlin	203-783-1200
4 Green & Sklarz LLC	203-285-8545
5 Rinaldi Linen/ Novack Burnbaum Crystal LLP	203-841-0017/646-912-7549

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

- 1 185 Asylum St Hartford CT 06103
- 2 62 West St Litchfield CT 06759
- 3 75 Broad St Milford CT 06460
- 4 700 State St Suite 100 New Haven CT 66511
- 5 47 Common CT Wtby/ New York NY

Services Provided by This Firm (*describe fully*)

1 Title 19	\$ 828
2 Real Estate Tax Reduction	\$ 3,426
3 All Labor Matters	\$ 94,180
4 IRS	\$ 10,740
5 Legal Service	\$ 524
	Charge for Services Provided
	\$ 109,698

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

Yes No page 15 Line 1 E

Schedule of Resident Statistics

Name of Facility Bridgeport Health Care Center Inc			License No. 2061C			Report for Year Ended 9/30/2016				Page 8		of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	240	240			240	240			240	240			
B. On last day of THIS report period	240	240			240	240			240	240			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	195	195			195	195			194	194			
B. As of midnight of THIS report period	194	194			194	194			194	194			
3. Total Number of Days Care Provided During Period													
A. Medicare	4,181	4,181			3,281	3,281			900	900			
B. Medicaid (Conn.)	64,821	64,821			48,388	48,388			16,433	16,433			
C. Medicaid (other states)													
D. Private Pay	3,079	3,079			2,367	2,367			712	712			
E. State SSI for RCH													
F. Other (Specify)													
G. Total Care Days During Period (3A thru F)	72,081	72,081			54,036	54,036			18,045	18,045			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days	27	27			22	22			5	5			
B. Other Bed Reserve Days	31	31			31	31							
5. Total Resident Days (3G + 4A + 4B)	72,139	72,139			54,089	54,089			18,050	18,050			

Schedule of Resident Statistics (Cont'd)

Name of Facility Bridgeport Health Care Center Inc			License No. 2061C			Report for Year Ended 9/30/2016			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days								CCNH	RHNS	(Specify)			
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	7		179		8								
Per Diem Rate													
a. One bed rm.	Various		247.09		305.00								
b. Two bed rms.	Various		247.09		295.00								
c. Three or more bed rms.	Various		247.09		275.00								
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								3,742	3,742				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								3,721	3,721				
C. Other													
D. Total Physical Therapy Treatments								7,463	7,463				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								1,188	1,188				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								1,505	1,505				
C. Other													
D. Total Speech Therapy Treatments								2,693	2,693				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								2,927	2,927				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								3,036	3,036				
C. Other													
D. Total Occupational Therapy Treatments								5,963	5,963				

Report of Expenditures - Salaries & Wages

Name of Facility Bridgeport Health Care Center Inc	License No. 2061C	Report for Year Ended 9/30/2016	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	125,829	2,120				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	228,376	2,347				
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	356,245	22,708				
5. Dietary Service						
a. Head Dietitian	42,914	2,432				
b. Food Service Supervisor	166,957	7,494				
c. Dietary Workers	529,219	40,990				
6. Housekeeping Service						
a. Head Housekeeper	79,755	2,222				
b. Other Housekeeping Workers	635,570	48,783				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	25,639	1,132				
b. Other Maintenance Workers	127,811	7,609				
8. Laundry Service						
a. Supervisor	19,268	953				
b. Other Laundry Workers	80,029	8,856				
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	169,585	4,224				
b. RN						
1. Direct Care	1,156,962	38,140				
2. Administrative**						
c. LPN						
1. Direct Care	1,974,902	84,574				
2. Administrative**						
d. Aides and Attendants	3,125,643	226,943				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	146,040	8,851				
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	105,788	5,282				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	9,096,532	515,660				

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

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

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

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

Name of Facility				License No.	Report for Year Ended			Page	of	
Bridgeport Health Care Center Inc				2061C	9/30/2016			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										
Norma Loren				Health Ins				Bridgeport Manor		
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.

**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	
Bridgeport Health Care Center Inc				2061C	9/30/2016			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***										
Christopher Massaro	125,829				Administrator	2,120	A.2			
Section IV - Assistant Administrators										
Rachel Blass	28,256				Asst Administrator	53	A.3	Rosegarden, Bridgeport Manor	51	23,973
Chaim Stern	129,032				Asst Administrator	1,147	A.3	Rosegarden, Bridgeport Manor	973	109,474
Joseph Stern	71,088				Asst Administrator	1,147	A.3	Bridgeport Manor, Carlton, Rosegarden	973	60,314

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Bridgeport Health Care Center Inc	2061C	9/30/2016	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	105,635	2,222				
2. Dentist	4,003	60				
3. Pharmacist	1,210	85				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	273,326	5,694				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	32,000	360				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	74,155	1,481				
b. Other						
10. Occupational Therapist						
a. Resident Care	267,419	4,563				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	67,581	1,349				
2. Administrative***						
b. LPN						
1. Direct Care	38,961	1,838				
2. Administrative***						
c. Aides	1,002,629	44,806				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	1,866,919	62,458				

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

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

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

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

Name of Facility Bridgeport Health Care Center Inc		License No. 2061C	Report for Year Ended 9/30/2016	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Eileen Mulrenan 107 Cindy Ln Guilford CT 06437	Dietician	<input type="radio"/>	<input checked="" type="radio"/>		
Comprehensive Rehabilitations 26 Firemens Memorial Dr Suite 205 Pomona NY 10970	Therapy	<input checked="" type="radio"/>	<input type="radio"/>		
Ct Medical Associates 1825 Barnum Ave Stratford CT 06614	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Nutrition Solutions 2 A Pearl Hill St Milford CT 06460	Dietician	<input type="radio"/>	<input checked="" type="radio"/>		
Swallowing Diagnostics 21 Waterville RD Avon CT 06001	Speech Therapy	<input type="radio"/>	<input checked="" type="radio"/>		
Medwiz Pharmacy 240 N Main St Spring Valley NY 10952	Nursing Registry	<input type="radio"/>	<input checked="" type="radio"/>		
Towne Nursing 2110 Boston Ave Bridgeport CT 06610	Nursing Registry	<input type="radio"/>	<input checked="" type="radio"/>		
Omnicare Pharmacy 525 Knotlep Dr Chesire CT 06421	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>		
Omnicare Pharmacy 525 Knotlep Dr Chesire CT 06421	Nursing Registry	<input type="radio"/>	<input checked="" type="radio"/>		
Raintree Healthcare Staffing 116 West 23rd St New York NY 10011	Nursing Registry	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Bridgeport Health Care Center Inc	2061C	9/30/2016	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 393,658	393,658		
2. Disability Insurance	\$ 80,525	80,525		
3. Unemployment Insurance	\$ 148,653	148,653		
4. Social Security (F.I.C.A.)	\$ 684,800	684,800		
5. Health Insurance	\$ 1,845,991	1,845,991		
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 13,998	13,998		
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 300,109	300,109		
8. Uniform Allowance	\$ 19,376	19,376		
9. Other (<i>Specify</i>) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 3,098,568	3,098,568		
d. Accounting and Auditing	\$ 63,520	63,520		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 109,698	109,698		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 37,811	37,811		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 18,135	18,135		
2. Cellular Phones	\$ 9,756	9,756		
i. Appraisal (<i>Specify purpose and attach copy</i>)* Working Capital	\$ 6,384	6,384		
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 406	406		
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$			
2. Other (<i>Specify</i>) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 1,096,533	1,096,533		
Subtotal	\$ 7,927,921	7,927,921		

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page	of	
Bridgeport Health Care Center Inc	2061C	9/30/2016	16	37	
Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		7,927,921	7,927,921		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	5,372	5,372		
3. Gifts to Staff and Residents	\$	6,269	6,269		
4. Employee Travel	\$				
5. Education Expenses Related to Seminars and Conventions	\$	761	761		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	18,117	18,117		
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	6,837	6,837		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** 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	\$	4,752	4,752		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	1,098	1,098		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$	4,869	4,869		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	71,847	71,847		
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$	96,754	96,754		
C-14 Total Administrative & General Expenditures	\$	8,144,597	8,144,597		

* 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)
Total Other Advertising	\$ -	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CT Association Health Care Facilities	\$ 379		
Credit Cards	\$ 604		
Amazon	\$ 6		
Progressive Business	\$ 60		
Nortons	\$ 49		
Total Dues	\$ 1,098	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Talmudic Institute Of Connecticut	\$ 271		
Yeshiva Bais Binyomin	\$ 811		
Yeshiva Tzemach Tzadik	\$ 3,787		
Total Contributions	\$ 4,869	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Charges	\$ 33,326		
Licenses	\$ 6,712		
Non Reimbursable	\$ 56,716		
Total Other Administrative and General	\$ 96,754	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Bridgeport Health Care Center Inc	License No. 2061C	Report for Year Ended 9/30/2016	Page of 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 #

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

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

Name of Facility Bridgeport Health Care Center Inc		License No. 2061C	Report for Year Ended 9/30/2016	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 612,264	612,264		
2.	Non-Food Supplies	\$ 202,346	202,346		
3.	Other (Specify) _____	\$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$			
c. Management Services**		\$			
d. Other (Specify) _____		\$			
2E. Total Dietary Expenditures (2a + b + c + d)		\$ 814,610	814,610		
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? <input type="radio"/> Yes <input checked="" type="radio"/> No					
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input checked="" type="radio"/> Yes <input type="radio"/> No If yes, specify cost. \$500					
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> 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.

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
Bridgeport Health Care Center Inc		2061C	9/30/2016	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. \$	223,954	223,954	
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)		\$	52,416	52,416	
c. Management Services**		\$			
d. Other (Specify)		\$			
3E. Total Laundry Expenditures (3a + b + c + d)		\$	276,370	276,370	
3F. Laundry Questionnaire					
G.	Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
H.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
I.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

* 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.

**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	
Bridgeport Health Care Center Inc	2061C	9/30/2016	20	37	
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care					
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	277,965	277,965		
b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
	Amt. \$				
c. Management Services*	\$				
d. Other (<i>Specify</i>)	\$				
4E. Total Housekeeping Expenditures (4a + b + c + d)	\$	277,965	277,965		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	221,626	221,626		
b. Medicine Cabinet Drugs	\$	18,215	18,215		
c. Medical and Therapeutic Supplies	\$	461,358	461,358		
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other****	\$	22,783	22,783		
f. X-rays and Related Radiological Procedures***	\$	6,459	6,459		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	23,467	23,467		
i. Recreation	\$	55,557	55,557		
j. Other (Specify)***** See Attached Schedule	\$	8,504	8,504		
5K. Total Resident Care Expenditures (5a - 5j)	\$	817,969	817,969		

* 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)
PT Supplies	\$ 13		
IV Supplies	\$ 8,472		
EKG	\$ 19		
Total Other Resident Care	\$ 8,504	\$ -	\$ -

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

Name of Facility Bridgeport Health Care Center Inc			License No. 2061C		Report for Year Ended 9/30/2016				Page of 21 37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
ADL Data System	9 Skyline Dr Hawthorne NY 10532	<input type="radio"/>	<input checked="" type="radio"/>		Computer Software Maintenance	37,365			16	11
Smartlinx Solutions	7271-A Investment Dr N Charleston SC 29418	<input type="radio"/>	<input checked="" type="radio"/>		Time Clock Maintenance	15,826			16	11
Kone Elevator	16 Old Forge Road Rocky Hill CT 06067	<input type="radio"/>	<input checked="" type="radio"/>		Elevator Maintenance	23,099			22	6.f
Fire Protection	1701 Highland Ave Chesire CT 06410	<input type="radio"/>	<input checked="" type="radio"/>		Fire Safety	7,980			22	6.f
Interstate Fire & Safety	PO Box 502 Harrison NY 10528	<input type="radio"/>	<input checked="" type="radio"/>		Fire System	5,792			22	6.f
Winter Bros	307 White St Danbury CT 06810	<input type="radio"/>	<input checked="" type="radio"/>		Trash Removal	43,666			22	6.f
Securitas	1 New Haven Ave Milford CT 06460	<input type="radio"/>	<input checked="" type="radio"/>		Security	73,582			22	6.f
Ikes Exterminating	104 Norben Road Monsey NY 10952	<input type="radio"/>	<input checked="" type="radio"/>		Pest Control	8,285			22	6.f
Rinaldi Linen Service	47 Commons Court Waterbury CT 06704	<input type="radio"/>	<input checked="" type="radio"/>		Laundry Service	52,416			19	3.b
Accountemps	2 Corporate Dr Ste 750, Shelton, CT 06484	<input type="radio"/>	<input checked="" type="radio"/>		Employee Service	5,805			16	11
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

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

** Refer to Page 4 for definition of related.

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bridgeport Health Care Center Inc	2061C	9/30/2016	22	37
Item	Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant				
a. Repairs & Maintenance	\$ 140,730	140,730		
b. Heat	\$ 231,092	231,092		
c. Light & Power	\$ 298,320	298,320		
d. Water	\$ 122,749	122,749		
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 19,310	19,310		
f. Other (<i>itemize</i>)	\$ 171,078	171,078		
See Attached Schedule				
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 983,279	983,279		
7. Depreciation (<i>complete schedule page 23*</i>)				
a. Land Improvements	\$			
b. Building & Building Improvements	\$			
c. Non-Movable Equipment	\$			
d. Movable Equipment	\$ 167,972	167,972		
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 167,972	167,972		
8. Amortization (<i>Complete att. Schedule Page 24*</i>)				
a. Organization Expense	\$			
b. Mortgage Expense	\$			
c. Leasehold Improvements	\$ 163,036	163,036		
d. Other (<i>Specify</i>)	\$			
*8e. Total Amortization Costs (8a + b + c + d)	\$ 163,036	163,036		
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 666,666	666,666		
10. Property Taxes				
a. Real estate taxes paid by owner	\$			
b. Real estate taxes paid by lessor	\$ 293,858	293,858		
c. Personal property taxes	\$ 36,376	36,376		
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,327,908	1,327,908		

* 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)
Security Contract Service	\$ 73,582		
Purchase Service	\$ 71,772		
Elevator Service	\$ 23,099		
Short Term Lease	\$ 2,625		
Total Other Repairs and Maintenance	\$ 171,078	\$ -	\$ -

Bridgeport Health Care Center Inc
9/30/2016

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:				
9/30/2016	Beds	\$ 26,166	10	
1/31/2016	Nursing Security	\$ 37,526	5	\$ 5,004
12/31/2015	Furniture	43218	7	4630
8/31/2016	Computers	8930	5	149
5/31/2016	Ice Machine	7333	5	489
3/31/2016	Laundry	1380	15	69
Total additions for Movable Equipment		\$ 124,553		\$ 10,341 *
Deletions:				
9/30/2007	Time Clock	\$ (4,456)		
Total deletions for Movable Equipment		\$ (4,456)		\$ - **

*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:				
5/31/2016	Boiler	\$ 19,648	20 Yrs	\$ 327
1/31/2016	Renovations	\$ 29,402	15 yrs	\$ 1,307
1/31/2016	Laundry	3684	15 yrs	164
10/31/2015	AC/Heating	6913	15 yrs	422
10/31/2015	Roof	9424	10 Yrs	864
9/30/2016	Renovations	485977	15 yrs	
Total additions for Leasehold Improvement		\$ 555,048		\$ 3,084 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
10/19/2010	Cadillac Disposed	0	5yrs	843
8/27/2002	Infinity	54058	5yrs	0
1/10/2003	Toyota Avalon	33036	5yrs	0
7/21/2005	Toyota Avalon	31748	5yrs	0
1/30/2009	Cadillac	43666	5yrs	0
12/30/2012	Lexus	46580	5yrs	9316
Total		209088		10159
Days				
50.00%	Bridgeport Health Care	104544		5080
50.00%	Bridgeport Manor	104544		5080
Total		209088		10159

Annual Report of Long-Term Care Facility

Amortization Schedule*

Name of Facility Bridgeport Health Care Center Inc			License No. 2061C		Report for Year Ended 9/30/2016			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period				6,224,226	3,402,684	S/L	Variot	159,952	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				555,048		S/L	Variot	3,084	
C-4. Subtotal									163,036
D. Total Amortization									163,036

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility Bridgeport Health Care Center Inc	License No. 2061C	Report for Year Ended 9/30/2016	Page 25	of 37																																																																											
11. Property Questionnaire																																																																															
Part A																																																																															
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.																																																																											
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.																																																																															
Description	Total																																																																														
1. Date Land Purchased																																																																															
2. Date Structure Completed																																																																															
3. If NOT Original Owner, Date of Purchase	04/01/90																																																																														
4. Date of Initial Licensure																																																																															
5. Total Licensed Bed Capacity	240																																																																														
6. Square Footage	169,208																																																																														
7. Acquisition Cost																																																																															
a. Land		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Part B - Owner and Related Parties</td> <td style="text-align: center;">1st Mortgage</td> <td style="text-align: center;">2nd Mortgage</td> <td style="text-align: center;">3rd Mortgage</td> <td style="text-align: center;">4th Mortgage</td> </tr> <tr> <td>1. Financing</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">a. Type of Financing (e.g., fixed, variable)</td> <td style="text-align: center;">Variable</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">b. Date Mortgage Obtained</td> <td style="text-align: center;">08/28/07</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">c. Interest Rate for the Cost Year</td> <td style="text-align: center;">4.78%</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">d. Term of Mortgage (number of years)</td> <td style="text-align: center;">15</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">e. Amount of Principal Borrowed</td> <td style="text-align: center;">5.5m</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">f. Principal balance outstanding as of <u> </u>9/30/16</td> <td style="text-align: center;">2,149,746</td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="5" style="text-align: center;">Complete if Mortgage was Refinanced During Current Cost Year</td> </tr> <tr> <td style="padding-left: 20px;">g. Type of Financing (e.g., fixed, variable)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">h. Date of Refinancing</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">i. New Interest Rate</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">j. Term of Mortgage (number of years)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">k. Amount of Principal Borrowed</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">l. Principal Outstanding on Note Paid-Off</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>			Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage	1. Financing					a. Type of Financing (e.g., fixed, variable)	Variable				b. Date Mortgage Obtained	08/28/07				c. Interest Rate for the Cost Year	4.78%				d. Term of Mortgage (number of years)	15				e. Amount of Principal Borrowed	5.5m				f. Principal balance outstanding as of <u> </u> 9/30/16	2,149,746				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 B - Owner and Related Parties	1st Mortgage				2nd Mortgage	3rd Mortgage	4th Mortgage																																																																								
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k. Amount of Principal Borrowed																																																																															
l. Principal Outstanding on Note Paid-Off																																																																															
Part C - Arms-Length Leases for Real Property Improvements Only																																																																															
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease																																																																											

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bridgeport Health Care Center Inc	2061C	9/30/2016	26	37
Item	Total	CCNH	RHNS	(Specify)
12. Interest				
A. Building, Land Improvement & Non-Movable Equipment				
1. First Mortgage	\$			
Name of Lender	Rate			
Address of Lender				
2. Second Mortgage	\$			
Name of Lender	Rate			
Address of Lender				
3. Third Mortgage	\$			
Name of Lender	Rate			
Address of Lender				
4. Fourth Mortgage	\$			
Name of Lender	Rate			
Address of Lender				
B. CHEFA Loan Information				
1. Original Loan Amount	\$			
2. Loan Origination Date				
3. Interest Rate %				
4. Term				
5. CHEFA Interest Expense				
12 B7. Total Building Interest Expense (A1 - A4 + B5)	\$			

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Bridgeport Health Care Center Inc		2061C		9/30/2016		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$ 500	500		
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$ 258	258		
A. Item		Rate	Amount				
Computers		5.42%	98,519				
Lender							
HP							
Address of Lender							
200 Connell Drive Suite 5000 Berkeley Heights NJ 07922							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$ 758	758		
12. D. Other Interest Expense (Specify)				\$ 434,461	434,461		
Insurance, Credit Line, Late Fees, Working Capital							
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$ 435,219	435,219		
14. Insurance							
a. Insurance on Property (buildings only)				\$ 24,201	24,201		
b. Insurance on Automobiles				\$ 11,396	11,396		
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$ 56,827	56,827		
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$ 169,091	169,091		
Package, Boiler, Pension, EPLI, Patient Fund							
14d. Total Insurance Expenditures (14a + b + c)				\$ 261,515	261,515		
15. Total All Expenditures (A-13 thru C-14)				\$ 24,302,883	24,302,883		

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Bridgeport Health Care Center Inc				2061C	9/30/2016	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 3,098,568	3,098,568		
10.			Accounting & Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.			Unallowable Advertising *	\$			
19.	15	1 j	Income Tax / Corporate Business Tax	\$ 406	406		
20.	16	m 10	Fund Raising / Contributions	\$ 4,869	4,869		
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 68,357	68,357		
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)				\$ 3,172,200	3,172,200		

* 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)
Total Other Fees Adjustments			\$ -	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m 13	Non Reimbursable	\$ 56,716		
16	l 2	Travel	\$ 5,372		
16	l 3	Patient Expense	\$ 883		
16	l 3	Other Employee Service	5386		
Total Other A&G Adjustments			\$ 68,357	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Bridgeport Health Care Center Inc			2061C	9/30/2016	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 3,172,200	3,172,200		
Page 20 - Resident Care Supplies***							
27.	20	5 a 2	Prescription Drugs	\$ 221,626	221,626		
28.			Ambulance/Limousine	\$			
29.			X-rays, etc	\$ 6,457	6,457		
30.	20	5 h	Laboratory	\$ 23,467	23,467		
31.	20	5 c	Medical Supplies	\$ 180	180		
32.	20	5 e 2	Oxygen (non emergency)	\$ 22,783	22,783		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 26,719	26,719		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$ 5,080	5,080		
37.	22	10 c	Unallowable Property and Real Estate Taxes	\$ 2,030	2,030		
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 21,115	21,115		
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	\$			
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)			\$ 3,501,657	3,501,657		

*** 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.

Bridgeport Health Care Center Inc
9/30/2016

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5.j	IV Supplies	\$ 8,472		
20	5.j	EKG	\$ 19		
20	5.j	PT Supplies	\$ 13		
20	5.j	Emergency Replace Box	\$ 18,215		
Total Other Ancillary Costs			\$ 26,719	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14 b	Owners Auto Ins	\$ 6,718		
16	16	Auto Expense	\$ 14,397		
Total Other Property Adjustments			\$ 21,115	\$ -	\$ -

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

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Bridgeport Health Care Center Inc	2061C	9/30/2016			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 18,687,093	18,687,093				
b. Medicaid Room and Board Contractual Allowance **	\$ (2,263,766)	(2,263,766)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,464,076	1,464,076				
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$ 1,338,730	1,338,730				
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$					
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$					
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$ 295,268	295,268				
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$ 146,375	146,375				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 139,749	139,749				
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$					
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 441,220	441,220				
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$					
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$ 27,447	27,447				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 20,276,192	20,276,192				
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 (<i>Specify</i>)	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 215,175	215,175				
V. Total Other Revenue (1 thru 8)	\$ 215,175	215,175				
VI. Total All Revenue (III +V)	\$ 20,491,367	20,491,367				

* 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)
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
20 5h	Insurance - Lab	\$ 27,447		
Total Other Resident Revenue		\$ 27,447	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Total Interest Income			\$ -	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Part B Contractual Allowance	\$ (49,909)		
	Insurance Reimbursement	\$ 259,506		
	Gain On Sale - Auto	\$ 5,578		
Total Other Revenue		\$ 215,175	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Bridgeport Health Care Center Inc	2061C	9/30/2016	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	9,387
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,240,022
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	180,485
a. Prepaid Taxes	89,698			
b. Prepaid Insurance	90,787			
c. _____				
d. _____				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

A-9. Total Current Assets (Lines A1 thru 8)			\$	2,429,894
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 <u>6,779,274</u>		\$	3,213,554
	Accum. Depreciation <u>3,565,720</u>	Net		
5. Non-Movable Equipment	*Historical Cost <u>215,445</u>		\$	
	Accum. Depreciation <u>215,445</u>	Net		
6. Movable Equipment	*Historical Cost <u>2,608,929</u>		\$	709,306
	Accum. Depreciation <u>1,899,623</u>	Net		
7. Motor Vehicles	*Historical Cost <u>137,857</u>		\$	30,977
	Accum. Depreciation <u>106,880</u>	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

B-10. Total Fixed Assets (Lines B1 thru 9)			\$	3,953,837

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bridgeport Health Care Center Inc	2061C	9/30/2016	32	37
Account			Amount	
Total Brought Forward:			\$	6,383,731
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements				
	*Historical Cost	594,289		
	Accum. Depreciation	Net	\$	594,289
3. Buildings				
	*Historical Cost	6,834,318		
	Accum. Depreciation	Net	\$	6,834,318
4. Non-Movable Equipment				
	*Historical Cost	Net	\$	
5. Movable Equipment				
	*Historical Cost	Net	\$	
6. Motor Vehicles				
	*Historical Cost	Net	\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	7,428,607
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	Net	\$	
	Accum. Depreciation	Net	\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	
			\$	
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	82,600
	Security Deposits	888		
		81,712		
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	82,600
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	13,894,938

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bridgeport Health Care Center Inc	2061C	9/30/2016	33	37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable			\$	4,891,140
2. Notes Payable (<i>itemize</i>)			\$	823,831
Citicard			6,000	
Omnicare			112,332	
Money Works			234,370	
Working Capital			471,129	
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)			\$	5,219
Name of Lender	Purpose	Amount	Date Due	
Auto Finance	Auto Loan	5,219		
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)			\$	930,439
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$	
6. Accrued Payroll Taxes Payable			\$	524,405
7. Medicare Final Settlement Payable			\$	
8. Medicare Current Financing Payable			\$	
9. Mortgage Payable (<i>Current Portion</i>)			\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)			\$	
11. Accrued Income Taxes*			\$	
12. Other Current Liabilities (<i>itemize</i>)			\$	1,066,931
Accrued Assessment Fund			1,027,246	
Accrued Audit			8,750	
Accrued Water & Sewer			2,167	
Patient Funds			28,768	
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	8,241,965

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Bridgeport Health Care Center Inc		License No. 2061C	Report for Year Ended 9/30/2016	Page 34	of 37
Account				Amount	
Total Brought Forward:				8,241,965	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					
				\$	1,267,978
Name of Lender	Purpose	Amount	Date Due		
Auto Finance	Auto Loan	813			
Peoples Bank	Sprinkler/Work Cap	1,267,165			
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$	1,757,790
Name and Address of Lender	Amount	Loan Date			
Bridgeport Realty	1,757,790				
4. Other Long-Term Liabilities (<i>itemize</i>)				\$	152,742
Citicard		35,167			
Omnicare		117,575			
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$	3,178,510
C. Total All Liabilities (Lines A-13 + B-5)				\$	11,420,475

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bridgeport Health Care Center Inc	2061C	9/30/2016	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	594,289
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	6,834,318
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	7,428,607
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	384,910
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(1,527,538)
6. Gain or Loss for Period	10/1/2015	thru 9/30/2016	\$	(3,811,516)
7. Total Net Worth			\$	(4,954,144)
C. Total Reserves and Net Worth			\$	2,474,463
D. Total Liabilities, Reserves, and Net Worth			\$	13,894,938

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of	
Bridgeport Health Care Center Inc	2061C	9/30/2016	36	37	
Account			Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2015			\$	(1,184,176)	
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	20,491,367	
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	24,302,883	
D. Net Income or Deficit			\$	(3,811,516)	
E. Balance			\$	(4,995,692)	
F. Additions					
1. Additional Capital Contributed <i>(itemize)</i>					
Balance Adjustment	46,548				
2. Other <i>(itemize)</i>					
Paradise of Bridgeport	(5,000)				
F-3. Total Additions			\$	41,548	
G. Deductions					
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$		
Name and Address <i>(No., City, State, Zip)</i>	Title	Amount			
2. Other Withdrawings <i>(Specify)</i>			\$		
Purpose	Amount				
3. Total Deductions			\$		
H. Balance at End of Period			\$	(4,954,144)	
09/30/16					

I. Preparer's/Reviewer's Certification

Name of Facility Bridgeport Health Care Center Inc	License No. 2061C	Report for Year Ended 9/30/2016	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Burg & Weingarten CPA PC				
Address Address			Phone Number	
149-12 83rd Street Howard Beach NY 11414			718-845-6141	

Error Check

Level	Item	Reported as	
	Page 23 - Accumulated Dep. of Movable Eq.	1,904,079 is inconsistent with Page 31	1,899,623