State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2015

Name of Facility (as I	="							
Bidwell Care Center,I								
Address (No. & Stree								
333 Bidwell Street M	anchester, CT (06040						
Type of Facility								
Chronic and C	Convalescent		Rest Home with	ı Nursing				
✓ Nursing Home	only		Supervision on	y	_1	NurseFac-A	Aids	
(CCNH)	•		(RHNS)					
Report for Year Begin	nning		Report for Yea	· Ending				
10/1/2014	٥		9/30/2015					
License Numbers:		CCNH 2148-C	RHNS	Ni	NurseFac-Aids Medicare Pro 07-5314			dicare Provider 07-5314
Medicaid Provider Numbers: CCNH RHNS IC				ICE	F-IID			
Medicald Flovider IV	umbers.	CCH 002012		,	11 10			
		0011 002012						
For Department Use								
Sequence Number	Signed and	Date	Sequence N		Signed a	and Notarize	ed	Date Received
Assigned	Notarized	Received	Assign	ed				

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Bidwell Care Center,LLC	2148-C	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 Bidwell Care Center, 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 2/10/16	Signed (Owner)		2/10/16
Printed Name (Administrator) James Christofori			Printed Name (Owner) Chris Wright		
Subscribed and Sworn to before me: Oames Christoro Address of Notary Public	State of	Date 3/10/16	Signed (Notary Public) Brendo Wa	Notary My C	IRENDA WALSH TownicExpiresectic ut ommission Expires bruary 29, 2020
341 Bidwell S	treet M	lanchest	er, CT 06040		100

(Notary Seal)

State of Connecticut Annual Report of Long-Term Care Facility CSP-1A Rev. 6/95

State of Connecticut **Department of Social Services**

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	tmo	ent		Page 1A	of 37
Name of Facility		Period Cov	ered:	From	То
Bidwell Care Center,LLC				10/1/2014	9/30/2015
Address of Facility 333 Bidwell Street Manchester, CT 06040					
Report Prepared By		Phone Nun		Date	
Denise MacKinnon		860-570-21	40 ext 15		
Item		Total	CCNH	RHNS	NurseFac- Aids
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

		ility Report for Year End	
	860-645-4888	9/30/2015	2 37
Name of Facility (as shown on license)	,	o. & Street, City, State, Zi	
Bidwell Care Center, LLC		Street Manchester, CT 0	
CCNH	RHNS	NurseFac-Aids	Medicare Provider No.
License Numbers: 2148-C			07-5314
Type of Facility (Check appropriate box(es))			
☐ Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Supervision only	=	eFac-Aids
Type of Ownership (Check appropriate box)			
O Proprietorship O LLC O Partnership	O Profit Corp.		O Government O Trust
If this facility opened or closed during report year provi	ide:	Date Opened Date	Closed
Has there been any change in ownership			
or operation during this report year?	O Yes	O No If "Y	es," explain fully.
Administrator			
Name of Administrator		Nursing Home	
James Christofori		Administrator's	1674
	(6.11 as	License No.:	
Other Operators/Owners who are assistant administrate	ors (tuit or part time	License No.:	
Name		Literise 140.	
	C Comment		

General Information and Questionnaire Partners/Members

Name of Facility		License No.	Report for	Year Ended	Page of 3 37
Bidwell Care Center,LLC		2148-C	9/30/2015	C4-4-(-) 1	
Legal Name of Part	nership/LLC	Business A		Which I	/or Town(s) in Registered
Bidwell Care Center,LLC		333 Bidwell Stro Manchester, CT		СТ	
		ivianenesiei, e i	1		
Name of Partners/Members	Business A	ddress		Title	% Owned
Executive Advisors, LLC	341 Bidwell St. Manch	hester, CT 06040	Member		47.5
Apex Advisors, LLC	341 Bidwell St. Manc	hester, CT 06040	Member		47.5
Christopher Wright	341 Bidwell St. Manc	hester, CT 06040	Member		5
:					
			,		
			:		

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General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year	r Ended	Page of
Bidwell Care Center,LLC	2148-C	9/30/2015		3A 37
If this facility is owned or operated as a corp	oration, provide	the following info		
Legal Name of Corporation		ness Address		hich Incorporated
Name of Directors, Officers	Rucir	ness Address	Title	No. Shares
Traine of Directors, Officers	Dush	A STATE OF THE STA		Held by Each
Names of Stockholders Owning at Least				
10% of Shares	ĺ			
			}	
1				
1	I		1	

State of Connecticut

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General Information and Questionnaire Individual Proprietorship

Name of Facility Bidwell Care Center,LLC	License No. 2148-C	Report for Year Ended 9/30/2015	Page of 3B 37
If this facility is owned or operated as an individu	al proprietorship,	provide the following inform	ation:
Ov	wner(s) of Facility		
i			
		,	
		λ	
		_	

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General Information and Questionnaire Related Parties*

Name of Facility Ridwell Care Center I.J.C.		License No	. No. 2148-C	- N	Report for Year Ended 9/30/2015		Page 4	of 37
Are any individuals receiving compensation from the facility related through	ensation from the fa	cility rel	ated thro	ngh		If "Yes," provide the Name/Address and	ie Name/Ado	dress and
marriage, ability to control, ownership, family or business association?	hip, family or busine	ss assoc	iation?	0	Yes © No	complete the information on Page 11 of the report.	nation on Pa	ge 11 of the report.
					and the state of t			
Are any individuals or companies which provide goods or services,	which provide goods	or servi	ces,					
including the rental of property or the loaning of funds to this facility,	he loaning of funds	to this fa	cility, or busin	256	O Ves O No			
related through lanning association, common ownership, contact, or custoss association to any of the owners, operators, or officials of this facility?	common cymersing, serators, or officials	of this fa	acility?	552		If "Yes," provide the following information:	ne following	information:
					3			
		Als	Also Provides	es fe to		Indicate Where Costs are Included		
Name of Related	Business	Non-R	Non-Related Parties	arties	Description of Goods/Services	in Annual Report		Actual Cost to the
Individual or Company	Address	Yes	No	**%	Provided	Page # / Line #	Reported	Related Party
See Attached		0	0					***************************************
		0	0					
	- control	0	0					
		0	0					
		0	0					
	, id	0	0				:	
	and it is a second of the seco	0	0			:		
		0	0					
	and the second s	0	0					
						ì		

^{*} Use additional sheets if necessary.

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

State of Connecticut Annual Report of Long-Term Care Facility CSP-4 Rev. 10/2005

Related Parties*

Marrie or radiny Bidwell Care Center, LLC		Liceliae No.	9/3/2015		4	37
Name of Related	Rusiness	Also Provides Goods/Services to Non- Related Parties	Description of Goods/Services	Indicate Where Costs are Included in Annual Report	Cost	Actual Cost to the Related
Individual or Company		Yes No %**	Provided	Page # / Line #	Reported	Party
Bidwell Care Center, LLC	333 Bidwell St. Manchester, CT 06040		Shared Employees		-	•
Chelsea Place Care Center 11 C	25 Lorraine St. Hartford, CT 06105		Shared Employees		4,802	(4,802)
Chestnut Point Care	171 Main St. East Windsor, CT		Laundry Services	19 3		,
Chestnut Point Care	171 Main St. East Windsor, CT 06088		Shared Employees		-	1
Farmington Care Center,	20 Scott Swamp Rd. Farmington, CT 06032		Bank Fees	16 M	799	(662)
Farmington Care Center,	20 Scott Swamp Rd. Farmington, CT 06032		Shared Employees		4,918	(4,918)
Kettle Brook Care Center,	96 Prospect Hill Rd. East Windsor, CT 06088		Laundry Services	19 3		
Kettle Brook Care Center,	96 Prospect Hill Rd. East Windsor, CT 06088		Shared Employees		•	
den Care Center, LLC	33 Roy St. Meriden, CT		Shared Employees		1	•
Center,	151 Hillside Ave. Hartford, CT 06106		Shared Employees		11,025	(11,025)
Westside Care Center, LLC	349 Bidwell St. Manchester, CT 06040		Shared Employees		15,948	(15,948)
Wintonbury Care Center,	140 Park Ave. Bloomfield, CT 06002		Shared Employees		1	,
Secure Care Center LLC	60 West Street, Rocky Hill, CT 06067		Shared Employees		1,254	(1,254)
Touchnointe therang	171 Main St. East Windsor, CT		TS/T4/TO	13 5,8,10	648,738	(648,738)
Bidwell Realty, LLC	341 Bidwell St. Manchester, CT 06040		Building Lease & Rent	22,22,27 10,9,14	771,189	(771,189)
Care Management I.I.C.	341 Bidwell St. Manchester, CT 06040		Postage & Legal	16, 15 M.E	23,420	(23,420)
iCare Health Management,	341 Bidwell St. Manchester, CT		Shared HEs not nort of memt somt			(143_562)
J.7.	0.000		Management Services. Direct	20 5		(118,393
			Management Services, Indirect	20 5j	42,062	(42,062)
			Management Services, Administrative	16 M12	244,662	(244,662)
						,
						1
0.00						

^{*} Use additional sheets if necessary.

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

General Information and Questionnaire Basis for Allocation of Costs

Name of Facility	License No.		Report for Year Ended	Page	of
Bidwell Care Center,LLC	2148-C		9/30/2015	5	37
If the facility is licensed as CDH and/or RCH of	or provides AID	S or TB	I services with special Medic	caid rates,	costs
must be allocated to CCNH and RHNS as follo	ws:			ALCOHOLO MICHAEL MARKET	
Item			Method of Allocation	on	
Dietary			meals served to residents		
Laundry			pounds processed		
Housekeeping			square feet serviced		~~~
			hours of routine care provid		
Nursing			classification, i.e., Director (
			Nurses, Licensed Practical	Nurses, Ai	des and
		tendants		1 11 F2 A	CII
Direct Resident Care Consultants			f hours of resident care provi	ded by EA	.CH
			(See listing page 13)		
Maintenance and operation of plant		quare fee			
Property costs (depreciation)		juare fee			
Employee health and welfare		ross sala			
Management services			te cost center involved irect and Allocated Costs		
All other General Administrative expenses	1			marridad	
The preparer of this report must answer the fol	llowing question	ns appli	cable to the cost information	provided.	+100 7770
1. In the preparation of this Report, were all or Yes O No If "No," explain fully why such allocation not made.					ition was
costs allocated as required?			not made.		
1					
	and of	took oon	v of appropriate supporting (lata	- AMARIEM -
2. Explain the allocation of related company e	expenses and at	гасп сор	y of appropriate supporting of	iaia.	
3. Did the Facility appropriately allocate and	golf digallow di	rect and	indirect costs to non-nursing	home cos	st centers?
(e.g., Assisted Living, Home Health, Outpa	sen-uisanow ui	Adult D	av Care Services, etc.)	, nome con	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(e.g., Assisted Living, Flome Health, Outpa	mem services,	Adult D			ation was
	• Yes	O No	If "No," explain fully why not made.	such alloc	ation was

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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.

should not be included in these amounts.					Ţ		
Name of Facility		1	License No.	Report for Year Ended	ear Ended		Fage 01
Bidwell Care Center I.I.C.			2148-C	9/30/2015	3		6 37
DIAMOII CALL CONTROL	Related * to	d * to	A CONTRACT OF THE PROPERTY OF	-			.,
	Owners,	lers,				· ·	
	Operators,	ators,				Annual	
	Officers	cers		Date of	Term of	Amount	Amount
Name and Address of Lessor	Yes	No.	Description of Items Leased	Lease**	Lease	of Lease	Claimed
Accelerated Care Plus Corp. 4850	0	0	Omnistim Electrotherapy and Omnisound Theraneutic Ultrasound Equipment	05/18/10	automatic annual	16,602	16,602
Drive MS-100,	0	•	Time Clocks and Payroll Punch Equip	06/01/11	60 Months	8,444	8,444
GE Capital C/O Ricoh USA, P.O.Box 41564, Philadelpha PA 19101	0	0	Copier	10/02/14	42 Months	871	871
GE Capital C/O Ricoh USA, P.O.Box 41564,	0	0	Copier	03/13/14	48 Months	8,896	8,896
Ricoh USA Inc, P.O. Box 827577, Philadelphi, PA 19182	0	0	Copier	08/17/14	(Renewals Until	1,241	1,241
Neopost New England, 25881 Newtwork Place, Chicago,	0	0	Postage meter rental		Monthly	543	619
11, 000 73	0	0					
	0	0					
	0	0					
	0	0					. Time
T Net T - T - T - T - T - T - T - T - T - T	V bases	- Jahio les	O Yes		o No	Total ***	36,733

Is a Mileage Log Book Maintained for All Leased Vehicles?

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

^{**} Attach copies of newly acquired leases.

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

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General Information and Questionnaire Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	01
idwell Care Center,LLC	2148-C	9/30/2015	7	37
he records of this facility for the	he period covered by this re	eport were maintained on the following basis	:	
O Accrual O Cash	O Modified Cash			
the accounting basis for this				
eriod the same as for the	⊙ Yes	If "No," explain.		
revious period?	O No			
Independent Accounting Firm	n			
Name of Accounting Firm		Address (No. & Street, City, State, Zi	p Code)	
O'Connor, Davies LLP		100 Great Meadow Road, Ste 40	1, Wethersfield, CT 06109	
2		100 074111111111111111111111111111111111		
3				
, 1				
Services Provided by This Firm	ı (describe fully)			
Taxes, financial statements, acco	ounting support		\$ 3,7	/12
			\$	
			\$	
			\$	
		and the second s	Charge for Service	s Provided
				712
And Those Charges Baffacted in the E	Synauditure Portion of This Reno	ort? If Yes, Specify Expense Classification and Line N		
Are These Charges Reflected in the E	15D	· · · · · · · · · · · · · · · · · · ·		
Legal Services Information				
Name of Legal Firm or Indepen	ndent Attorney		Telephone Numbe	r
iCare Health Management			860-570-2140	
2 Starble and Harris	,		860-678-7775	
3 Durant Nichols / Robinson	n & Cole, LLP		860-275-8200	
4 Various others (American	Arbitration, Various Arbi	ration, Murtha Cullina)		
5 Starble and Harris, iCare I				
Address (No. & Street, City, St				
1 341 Bidwell Street, Manch	hester CT			
2 32 Main Street, Avon, CT				
3 280 Trumbull St, Hartford	l, CT			
4				•
	& 341 Bidwell Street, Ma	nchester CT		
Services Provided by This Firm	n (describe fully)			
1 Lease and contract issues, gene				489
	ral legal advice, union funds adv	ice		641
3 Employment law, arbitrations, or a second seco	contract negotiations			846
4 Employment Arbitrations, healt	theare law			492
5 Collections				982
			Charge for Servic	es Provided
				451
Are These Charges Reflected in the l	Expenditure Portion of This Rep	ort? If Yes, Specify Expense Classification and Line	No.	
	15E			
⊙ Yes O No				

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Schedule of Resident Statistics

			I iconce Mo				Report fo	Report for Year Ended	, p		Page	of
Name of Facility Bidunal Care Center I I C			21.	2148-C			9/30/2015	5		,	, ∞	37
Didweil Calc Control, Libe	***************************************					Period 10/	Period 10/1 Thru 6/30	30		Period 7/1	Thru 9/30	0
	Total All	Total	Totai RHNS	Total NurseFac-				NurseFac-				NurseFac-
	Levels	Level	Level	Aids	Total	CCNH	RHINS	Aids	Total	CCNH	RHNS	Aids
Certified Bed Capacity On last day of PREVIOUS report period	131	131			131	131			131	131		
B. On last day of THIS report period	131	131			131	131			131	131		
	122	122			122	122			123	123		
B As of midnight of THIS report period	121	121			123	123			121	121		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,093	4,093			3,092	3,092			1,001	1,001		
B. Medicaid (Conn.)	38,735	38,735			29,266	29,266			9,469	9,469		
C. Medicaid (other states)		3										
D. Private Pay	434	434			400	400			34	34		
E. State SSI for RCH												
F. Other (Specify) INSURANCE	490	490			355	355			135	135		
G. Total Care Days During Period (3A thru F)	43,752	43,752			33,113	33,113			10,639	10,639		
Total Number of Days Not Included in Figures in 3G	77											
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	43,752	43,752			33,113	33,113			10,639	10,639		

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CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Faci	lity			Licer	ise No.			1	Report	for Year	Ended		Page	of
Bidwell Care	Center,	LLC		21	148-C					9/30/201	5		9	37
	•	-	in the certified b		pacity du	ring t	the repo	ort yea	ır?	0	Yes	0 1	No	
			f Change		Ch	ange	in Bed	S		Ca	pacity Afte	r Change		
Date of			NurseFac-Aids	·····	Lost			Jaine	d		T			
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	NurseFac- Aids	Reason fo	r Change
											ļ <u>.</u>			
				ļ				ļ						
				 										
			in certified bed 90 days followi			g the	report y	ear (a	s repor	ted in ite	m 4 above)	provide the nur	nber of	
1 4 1			Change in R	eside	nt Days					CC	CNH	RHNS	NurseFa	ic-Aids
1st chan 2nd cha										1				
3rd cha														
4th char														
6. Number	of Resi	dents ar	nd Rates on Sept	embe			ear						0.4 0.4	A \
			Medicare	<u> </u>	Medi	caid		┞		S	elf-Pay		Other Stat	e Assisted
	Item		CCNH		CCNH	R	HNS	С	CNH	R	HNS	NurseFac- Aids	R.C.H.	ICF-MR
No. of I		S	1:	3	105					3 .				
Per Die														98.
	bed rm.			_		-		ļ		-				
	bed rm.			╂				1						
	e or mo	re		1	-1500			l	200.00			٠		
bed	rms,		444.00	1	246,00	<u>. </u>			389.00					
7. Total N	fumber o	of Physic	cal Therapy Trea	ıtmen	ts					ТС	TAL	CCNH	RHNS	NurseFac- Aids
A	. Medic	are - Pa	ırt B								3,969	3,969		
В			clusive of Part E	3)										
			ce Treatments								1,847	1,847		
	2, Re		e Treatments							ļ	9,493	9,493		
			ıl Therapy Treat	tment	S						15,309	15,309		I
8. Total N	lumber o	of Speed	h Therapy Treat	ment	S		<u></u>				196	196		
A	. Medic	eare - Pa	art B)							190	176		
l E	s. Megic	caid (EX	clusive of Part E ice Treatments)										
			e Treatments								353	353		
	C. Other		O TIOUMONIS			•	-2		•••		974	974		
Ţ.). Total	Speech	Therapy Treati	nents							1,523	1,523		
			pational Therapy											
Į A	A. Medic	care - Pa	art B								3,090	3,090		
I			clusive of Part I	3)										
			nce Treatments								1,840	1,840		
			e Treatments						****	 	8,631	8,631		
	C. Othèr	Occur	ational Therapy	Trea	tments						13,561			
1	J. X ()(U)	Jeenpi	py											

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Report of Ex	License No.	Daran	Report for Year		Page	of
Name of Facility Bidwell Care Center,LLC	2148-C		9/30/2015	Liided	10	37
Are time records maintained by all individuals receiving cor	npensation?	•	Yes		No	
			Total Cost as	nd Hours	T	
	000 117	**	DAING	T.T	NurseFac- Aids	House
Item	CCNH	Hours	RHNS	Hours	Aius	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)	140,189	2,154	·			
3. Assistant Administrator (Complete also Sec. IV						
of Schedule A1)						
4. Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)	114,111	6,360				
5. Dietary Service	24.094	1,030			4	
a. Head Dietitian b. Food Service Supervisor	34,984 45,627				1	
c. Dietary Workers	470,798					1
6. Housekeeping Service	1	,				
a. Head Housekeeper	A SECTION OF THE PROPERTY OF T	Contraction of the Contraction o	102 00000000000000000000000000000000000			
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	42,863				***	
b. Other Maintenance Workers	40,307	2,476	1			
Laundry Service a. Supervisor						
b. Other Laundry Workers	1	****				
Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						1
b. Other Accountants 12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	165,135	3,29	1	TO STATE OF THE PARTY OF THE PA	200 00000000000000000000000000000000000	
b. RN						
1. Direct Care	547,832	13,120	5			
2. Administrative**	291,099	7,57	2			
c. LPN						
1. Direct Care	1,109,730	36,07	3	<u> </u>		+
2. Administrative**	1,814,902	100,35	5	<u> </u>		
d. Aides and Attendants e. Physical Therapists	1,814,702	100,55.	~			
f. Speech Therapists						
g. Occupational Therapists				<u> </u>		
h. Recreation Workers	172,20	1 8,43	6			
i. Physicians						
1. Medical Director		1		 		-
Utilization Review Resident Care***		+	+	 	+	
4. Other (Specify)						
,, one (specify)			The manufactual and the second of the second	A CONTRACTOR OF THE PROPERTY O		
j. Dentists						
k. Pharmacists			1	-		+
1. Podiatrists	158,23	5 5,91	1			
m. Social Workers/Case Management	158,23	3,91	7			<u> </u>
n. Marketing o. Other (Specify)						
See Attached Schedule	45,56	1 3,08				
A-13. Total Salary Expenditures	5,193,58					1

^{*} 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)

	CCI	NH	RH	NS	NurseFa	ıc-Aids
Position	\$	Hours	\$	Hours	\$	Hours
UNIT SECRETARIES SALARIES	\$ 989	73			\$	Principles in
MEDICAL RECORDS SALARIES	\$ 1,271	93			\$ -	
CENTRAL SUPPLY SALARIES	\$ 43,301	2,917			\$ -	
					735 a 25 A 35 B	
			A Section 1			
			* * * * * * * * * * * * * * * * * * *		The Charles of the Control	
				V v v v v v v v v v v v v v v v v v v v		
						Assault Santa
	1.11		in un ann		s -	
Total	\$ 45,561	3,082	\$		13	

Schedule of Other Fees (Page 13)

	CC	NH	RH	NS	NurseF	ac-Aids
Service	\$	Hours	\$	Hours	S	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$ 26,366	1,068			\$ -	
ADMISSIONS C/S LABOR	\$ 26,042	570			\$ -	
CENTRAL SUPPLY CONTRACT SERVICE	\$ 2,889	74			\$	
ADMINISTRATIVE CONTRACT SERVICE LABOR	\$ 89,725	2,312			\$	
RESPIRATORY THERAPY CONTRACT SERVICES	\$ 35,778	792			\$	
	14 1 1					
	4 - 1 - 1 - 1 - 1					
	THE RESERVE					Vivin Nove
	22-2-10-2					
				The Bridge		
		N. 1				
		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \				
Total	\$ 180,801	4,816	\$ -	-	\$	

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties*

		7	resistan	T CYTTITION 7	Assistant Aminansuator	-	7 7 1		Doge	J.
Name of Facility				License No.		Keport for	Report for Year Ended		1 450	5 8
Bidwell Care Center, LLC				2148-C		9/30/2015				37
A Company of the Comp		Salary Paid	p							
Name	CCNH	RHNS	NurseFac- Aids	Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Linc Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
Section I - Operators/Owners							-			
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).								Š		
				. Address					-	i
1,777						,		- Address		

^{*} 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.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties*

1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		(I icense Mo		Report for Year Ended	ear Ended		Page	Jo
Name of Facility (as licensed)				LICELISC (VO.		Tobour 101) :	27
Bidwell Care Center, LLC				2148-C	200	9/30/2015			71	37
(A)	W	Salary Paid	q							
				Fringe Benefits and/or Other		Total	Line Where		Total	,
Name	CCNH	RHNS	NurseFac- Aids	Payments (describe fully)	Full Description of Services Rendered	Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours Worked	Compensation Received
Section III - Administrators***										
James Christofori (10/1/2014-3/8/2015)	116.622			same as employees less union funds	Administrator	1,818 A2	A2			
				same as						
David Sones (03/09/15 - 05/06/15)	23,567			employees less union funds	Administrator	336 A2	A2			
										·
Section IV - Assistant							3			
Administrators							ļ			
				ب						
		}			į					
							;			
		,			7, 7, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	7			-	

*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.

Annual Report of Long-Term Care Facility

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility Bidwell Care Center,LLC	License No. 2148	-C	Report for Y 9/30/2015	ear Ended	Page 13	of 37
Sidwell Care Center, LDC	2110		Total Cost a	and Hours		
		- THE STREET	Total Sobri	7.00		
					NurseFac-	
Item	CCNH	Hours	RHNS	Hours	Aids	Hours
*B. Direct care consultants paid on a fee	CCITA	11001				
for service basis in lieu of salary			100			
(For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist	8,771	223				
4. Podiatrist	0,772					
5. Physical Therapy						
a. Resident Care	299,383	3,915				AND THE PROPERTY OF THE PARTY O
b. Other						
6. Social Worker	313	Training				
7. Recreation Worker	17,220	31	<u> </u>			
8. Physicians						
a. Medical Director (entire facility)	44,600	391				10000
b. Utilization Review	(i,je s e					
(Title 18 and 19 only) monthly meeting						GOVERN ACCESSION OF THE PARTY O
c. Resident Care**						
d. Administrative Services facility						
1 Infection Control Committee						III III III III III III III III III II
(Quarterly meetings)				<u> </u>		
2. Pharmaceutical Committee						
(Quarterly meetings) 3. Staff Development Committee						
(Once annually)				Ì		
e. Other (Specify)			100			
Physician Care Contract Services	22,398	147				
9. Speech Therapist						
a. Resident Care	52,898	716	2207-005/197003999-000100-00001-005-00-0			
b. Other						
10. Occupational Therapist			1000000			
a. Resident Care	268,964	3,554		w 0.222.2200		
b. Other						
11. Nurses and aides and attendants					10000	
a. RN	100					
1. Direct Care	15,790	139		ELA BERESTINES INVESTOR PROPERTY CONTRACTOR		
2. Administrative***	51,955	414	-			
b. LPN						
1. Direct Care	2,844	68	The second secon			
2. Administrative***	1					
c. Aides	(483)	(36	5)]		
d. Other	1					
12. Other (Specify)						
See Attached Schedule	180,801	4,816			111111111111111111111111111111111111111	
B-13 Total Fees Paid in Lieu of Salaries	965,453	14,378				

^{*} 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		License No.		Report for	Year Ended	Page	of
Bidwell Care Center,LLC		2148-C		9/30/2015		14	37
				to Owners,			1 1 .
Name & Address of Individual	Full Expla	nation of Service		rs, Officers	Expla	nation of Re	elationship
	DL	acy Consulting	Yes	No			
Omnicare	Pnarma	acy Consulting	0	0			
Tocuhpoints Therapy		Therapy	•	0	Common Own		
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Share	d Employees	•	0	Common Own	ership	
Healthdrive Physician Services	Audiology,	Dental and Podiatry	0	0			
Ready Nurse, Nurse Network	Nursing po	ol (RN, LPN,CNA)	0	0			
Dr. Paulekas Wayne	Med	ical Director	0	•			
Dr. Bogacki Robert	Med	ical Director	0	0		-	
Healthcare Services Group	Housekeepin	g & Laundry Contract	0	0			
	:		0	0			
			0	0			
			0	0			
			0	0			
			0	0			
	\		0	0			
			0	0			-VI-11
			0	0			
	,		0	0			
			0	0			
		,	0	0			
			0	0			
			0	0			
			0	0			

^{*} Use additional sheets if necessary.

^{**} Refer to Page 4 for definition of related.

Annual Report of Long-Term Care Facility CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility License No.	[]	Report for Ye	ar Ended	Page	of
Bidwell Care Center,LLC 2148-C]	9/30/2015		15	37
Item -		Total	CCNH	RHNS	NurseFac- Aids
	-	(Otal	CCMI	KIIII	TRIGS
			100	1000	100
a. Employee Health & Welfare Benefits	\$	168,502	168,502		
Workmen's Compensation Dischility Insurance	\$	100,502	100,502		
2. Disability Insurance	φ				
3. Unemployment Insurance	\$	483,549	483,549		
4. Social Security (F.I.C.A.)	\$				
5. Health Insurance	D	836,436	836,436		
6. Life Insurance (employees only)					
(not-owners and not-operators)	\$	272.227	070 205		
7. Pensions (Non-Discriminatory)	\$	272,325	272,325		
(not-owners and not-operators)					
8. Uniform Allowance	\$				
9. Other (Specify)	\$	35,658	35,658		
See Attached Schedule		4.0			
b. Personal Retirement Plans, Pensions, and	\$				
Profit Sharing Plans for Owners and					
Operators (Discriminatory)*					Tage of the same o
c. Bad Debts*	\$	134,424	134,424		
d. Accounting and Auditing	\$	3,712	3,712		
e. Legal (Services should be fully described on Page 7)	\$	37,451	37,451		
f. Insurance on Lives of Owners and	\$				
Operators (Specify)*		100			
g. Office Supplies	\$	19,167	19,167		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	20,664	20,664		
2. Cellular Phones	\$	1,433	1,433		
i. Appraisal (Specify purpose and	\$				
attach copy)*			Date of		
(macro dapy)		44.75	5 C 6 C		
i. Corporation Business Taxes (franchise tax)	\$	252	252		
k. Other Taxes (Not related to property - See Page 22)					
1. Income*	\$		AND THE PERSON NAMED IN COLUMN TO SHARE THE PERSON NAMED IN COLUMN		manufactor and an analysis of the second and the se
2. Other (Specify)	\$				
See Attached Schedule	*				
	\$	919,667	919,667		
3. Resident Day User Fee					

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

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

Bidwell Care Center,LLC 9/30/2015

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	NurseFac- Aids
JNION TRAINING	\$ 35,658		\$ -
Fotal	\$ 35,658	\$ -	\$

Schedule of Other Taxes

			NurseFac-
Description	CCNH	RHNS	Aids
2000			
Total	\$	\$ -	\$ -

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

Name of Facility	License No.	J	Report for Y	ear Ended	Page	of
Bidwell Care Center,LLC 2148			9/30/2015		16	37
		T				
						NurseFac-
Item			Total	CCNH	RHNS	Aids
	ls Brought Forward	l:	2,933,240	2,933,240		
Travel and Entertainment		American				Parties County
Resident Travel and Entertainment		\$				
2. Holiday Parties for Staff		\$				
3. Gifts to Staff and Residents		\$				
4. Employee Travel		\$	698	698		
5. Education Expenses Related to Seminars ar		\$	3,081	3,081		
6. Automobile Expense (not purchase or depr		\$	3,231	3,231		
7. Other (Specify)		\$	803	803		
See Attached Schedule		Salar				
m. Other Administrative and General Expenses						
1. Advertising Help Wanted (all such expense	(s)	\$	5,402	5,402		
2. Advertising Telephone Directory (all such		\$				
3. Advertising Other (Specify)***		\$	34,032	34,032		
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 servi-						
7. Postage		\$	5,519	5,519		
* 8. Dues and Membership Fees to Professional		\$	8,917	8,917		
Associations (Specify)				100		
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other Non-A	Allowable Org,***	\$				
9. Subscriptions		\$	373	373		
10. Contributions***		\$	2,387	2,387		
See Attached Schedule						
11. Services Provided by Contract (Specify and	l Complete	\$	119,554	119,554		
Schedule C-2, Page 21 for each firm or inc	lividual)					
12. Administrative Management Services**		\$	244,663	244,663		
13. Other (Specify)		\$	26,385	26,385		
See Attached Schedule						
C-14 Total Administrative & General Expenditures		\$	3,388,284	3,388,284		

^{*} 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		CCNII	RHNS	NurseFac- Aids
MEALS		\$ 803	1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1	\$ -
		133.500	1.5	
		13,55,500,500,50	7.1.	
1:		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1.00	1.1
			4915 1 1510	44-50-54
		American P	115 SEC. (\$14)	153,535
11111				APARTS I
Total Other Tra	vel and Entertainment	\$ 803	\$ -	\$

Schedule of Other Advertising

Description	CCNH	RHNS	NurseFac- Aids
COMMUNICATIONS SPECIAL EVENTS	\$ 34,032	Parate and	\$
	in enterings)	THE CASE OF SA	Asset
	11.11	13, 1	134.14
Total Other Advertising	\$ 34,032	\$ -	\$ -

Schedule of Dues

Description			CCNH	RHNS	NurseFac- Aids
Dues		to the state of th	N. A. P. P. C. L.		
CAHCF Dues			\$ 8,916.72	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	\$ -
OTHER DUES	A SECTION AND A SECTION ASSESSMENT				10 110
	<u> </u>				
					14.4
		:			
			1 1		
	and the second second				
			13.5		
Total Dues			\$ 8,917	\$ -	\$

Schedule of Contributions

Description	CCNH	RHNS	NurseFac- Aids
CHARITABLE CONTRIBUTIONS	\$ 2,387		\$
Total Contributions	\$ 2,387	\$ -	\$

Schedule of Other Administrative and General

Description	CCNH	RHNS	NurseFac- Aids
Deacripton	* *****		
SOCIAL SERVICE SUPPLIES	\$		\$
SOC SVC MINOR EQUIPMENT	\$ 287		\$ -
ADMINISTRATIVE MINOR EQUIPMENT	\$ 1,457		\$ -
EMPLOYEE RELATIONS	\$ 7,731		\$
EMPLOYEE RELATIONS-OTHER	\$ 1,887		\$ -
PERMITS & LICENSES	\$ 1,530		\$ -
VOLUNTEER EXPENSE	\$ -		\$ -
BANK FEES	\$ 11,036		\$ -
CMS REVISIT USER FEES	\$	3.7	\$ -
PENALTIES	\$ 5.55	1911 1931	\$ -
LATE FEES	\$ 2,456		\$ -
Rounding			
	3.5		
11 11 11 11	19.15	1	
Total Other Administrative and General	\$ 26,385	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No. 2148-C	Report for Year Ended 9/30/2015	Page of 17 37
Bidwell Care Center,LLC		713V14V13	Indicate Where Costs
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	are Included in Annual Report Page #/Line #
iCare Management, LLC/iCare Health Management, LLC	244,663	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	118,393	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	42,062	MANAGEMENT FEES- INDIRECT CARE	Pg 20 j

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

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

			ote o		<u> </u>	-	. C 37	D. 1. 1	Page	of
Name of Facility							Report for Year Ended			37
Bidwell Care Center,LLC				2148-C		9/30/2015			18	31
	Item				Γotal	C	CNH	RHNS	Nurse	Fac-Aids
2.	Dietary a. In-House Preparation & Service									
	1. Raw Food		\$		268,510		268,510			
-	2. Non-Food Supplies		\$		36,851		36,851			
<u> </u>	3. Other (<i>Specify</i>)		9		18,626		18,626			
	DIETARY SUPPLEMENTS									
	b. Purchased Services (by contract other		9	3	13,631		13,631	Town Adequate Americal A LEGISTER STREET, PARTICULAR PLANTS AND		
	than through Management Services) (Complete Schedule C-2 att. Page 21)							19 (1995) 9 (1925) 1 (1944) 1 (1945)		
	c. Management Services**		5	5						
—	d. Other (Specify)		(6	5,700		5,700			
	DIETARY MINOR EQUIPMENT									
2E.	Total Dietary Expenditures $(2a + b + c + d)$		(\$	343,319		343,319			
2F.	Dietary Questionnaire				Total	C	CNH	RHNS	Nurs	eFac-Aids
G.	Resident Meals: Total no. of meals served per	day	/ : *		360		360			
H.	Is cost of employee meals included in 2E?		Yes		0	No				
I.	Did you receive revenue from employees?	0	Yes		•	No		If yes, specify amt.		
J.	Where is the revenue received reported in the	Cos	st Repo	rt? (F	age/Line	Item))			
К.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	0	Yes		•	No		If yes, specify cost.		
L.	Is any revenue collected from these people?	0	Yes		•	No		If yes, specify amt.		
M.	Where is the revenue received reported in the	Co	st Repo	ort? (F	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?	0	Yes		•	No		If yes, specify amt.		
P.	Where is the revenue received reported in the	Со	st Repo	ort? (I	Page/Line	[tem])			
<u> </u>										

^{*} 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			eport for Yo	ear Ended	Page	of
Bidw	Bidwell Care Center,LLC			148-C	_	9/30/2015		19	37
	<u>Item</u>			Total		CCNH	RHNS	Nurs	eFac-Aids
	Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies,		Lbs.						
	gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$	445	5	445			
	2. Employee items including uniforms, gowns, etc. washed, ironed and/or		Lbs.					-	
	processed.***		Amt. \$						
	3. Personal clothing of residents		Lbs.		_				
	washed, ironed, and/or processed.***	_	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)		\$	361,968	8	361,968			43 JPS 70 Salata 2008
	c. Management Services**		\$		_				
	d. Other (Specify) LAUNDRY SUPPLIES		\$						
3E.	Total Laundry Expenditures $(3a+b+c+d)$		\$	362,413	3	362,413			
3F. G.	Laundry Questionnaire Is cost of employee laundry included in 3E?	0	Yes	•) N	No	If yes, specify cost.		
H.	Did you receive revenue from employees?	0	Yes	0)]	No	If yes, specify amt.		
I.	Where is the revenue received reported in the C	ost	Report	?		(Page/Line	Item)		
J.	In Cost of laundry provided to persons other		Yes		1 (No	If yes, specify cost.		
K.	Did you receive revenue from these people?	0	Yes	•	1 (If yes, specify amt.		
L.	Where is the revenue received reported in the C	ost	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)

1 '		License No.	Repo	ort for Year E	nded	Page	of
Bid	well Care Center,LLC	2148-C		9/30/2015		20	37
	Item			Total	CCNH	RHNS	NurseFac- Aids
4.	Housekeeping	Sq. Ft. Serviced					
' '	a. In-House Care	by Personnel					
	1. Supplies - Cleaning (Mops, pails, brooms, etc.)	Amt,	\$	28,131	28,131		
	b. Purchased Services (by contract other	Sq. Ft. Serviced					
	than through Management Services)	by Personnel					
Į.	(Complete Schedule C-2 att. Page 21)	Amt.	\$	410,329	410,329		
	c. Management Services*		\$				
	d. Other (Specify)		\$				
	HOUSEKEEPING MINOR EQUI	PMENT		114			
4E.	Total Housekeeping Expenditures (4a +	b+c+d)	\$	438,460	438,460		
5.	Resident Care (Supplies)**						100
	a. Prescription Drugs***						
	1. Own Pharmacy	\$					
	2. Purchased from		\$	171,494	171,494		
	OMNICARE PHARMACY						
	b. Medicine Cabinet Drugs		\$	15,136	15,136		
	c. Medical and Therapeutic Supplies		\$	62,319	62,319		
	d. Ambulance/Limousine***		\$	9,744	9,744		
	e. Oxygen						10000
	 For Emergency Use 		\$	8,405	8,405		
	2. Other***		\$		· .		
	f. X-rays and Related Radiological		\$	18,609	18,609		
	Procedures***						
	g. Dental (Not dentists who should be in	cluded under	\$				
	salaries or fees)						
	h. Laboratory***		\$	24,920	24,920		
	i. Recreation		\$		250005		
	j. Other (Specify)****		\$	350,985	350,985		
<u></u>	See Attached Schedule		Φ.	661.614	((1,(1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,		
5K	. Total Resident Care Expenditures (5a -	5])	\$	661,611	661,611	<u></u>	

^{*} 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	NurseFac- Aids
NURSING ADMIN SUPPLIES	\$ 416		\$ -
NURSING MINOR EQUIP	\$ 10,234		\$ -
MEDICAL RECORDS SUPPLIES	\$ 20		\$ -
MEDICAL RECORDS MINOR EQUIPMENT	\$		\$
MANAGEMENT ALLOCATIONS - DIRECT	\$ 118,393		\$
NON-COVERED PPS DR. VISITS	\$ 769		\$ -
RESIDENT CARE SUPPLIES	\$		\$ -
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 15,416		\$
PERSONAL CARE SUPPLIES	\$ 10,665		\$
INCONTINENCY SUPPLIES	\$ 35,628		\$
VACCINE RESIDENTS	\$ 1,983		\$
PATIENT SPECIAL NEEDS	\$ 664		\$ -
PHYSICAL THERAPY SUPPLIES	\$ 1,095	ENVENTE NEW YORK	\$ -
PHYSICAL THERAPY EQUIPMENT RENT	\$		\$
PHYSICAL THERAPY MINOR EQUIPMENT	\$		\$ -
OCCUPATIONAL THERAPY SUPPLIES	\$ 71		\$ -
OCCUPATIONAL THERAPY EQUIP RENTAL	\$ -		\$ -
OCCUPATIONAL THERAPY MINOR EQUIP	\$		\$ -
SPEECH THERAPY SUPPLIES	\$ -		\$ -
SPEECH THERAPY EQUIPMENT RENT	\$ -		\$ -
SPEECH THERAPY MINOR EQUIPMENT	\$ -		\$ -
RENTALS FOR NURSING EQUIPMENT NON BILLABLE	\$ 72,181		\$ -
EQUIPMENT RENTAL: AIDS UNIT	\$		\$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ 840		\$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$		\$ -
HI LOW BED RENTAL & MATTRESSES	\$ 2,909		\$
IV THERAPY SUPPLIES	\$ 28,570		\$ -
IV THERAPY CONTRACT SERVICE	\$ -		\$
MEDICAL WASTE CONTRACT SERVICE	\$ 3,350		\$
ACTIVITIES SUPPLIES	\$ 5,719		\$
ACTIVITIES MINOR EQUIPMENT	\$		\$
MANAGEMENT ALLOCATION - INDIRECT	\$ 42,062		\$ -
ADMISSIONS SUPPLIES	\$		\$
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$ -		\$ -
Total Other Resident Care	\$ 350,985	\$ -	\$ -

Annual Report of Long-Term Care Facility CSP-21 Rev. 10/2001 State of Connecticut

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

Name of Facility Bidwell Care Center LLC	•	7		License No. 2148-C	Report for Year Ended 9/30/2015				Page 21	of 37
	and the state of t	Related ** to Owners,	o Owners,							
		Operators, Officers	Officers				Total Cost	Total Cost/Page Ref. ***		
Name of Individual or Company	Address	Yes	S _o	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	NurseFac- Aids	Pg L	Line
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	0	0	VENDOR	Housekeeping Services	408,428			20 4	4b
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	0	0	VENDOR	Laundry Services	360,290			19 3	3b
Eagle Elevator		0	0	VENDOR	Elevator Contract	6,126	3		22 6	6F
Bioserve, Inc.		0	0	VENDOR	Medical Waste	3,350			22 6	6F
A-1 Snowplowing / Brickman landscaping/Twin Landscaping Inc		0	0	VENDOR	Snow Removal/Landscaping	24,579	1		22 6	6F
CWPM - Recycling	Box 415, Plainville, CT 06062	0	0	VENDOR	Trash removal	18,181			22 6	6F
American HealthTech	,	0	0	VENDOR	Software Maintenance Contract	17,835			16 N	M11
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	0	0	VENDOR	Payroll Services	41,979			16 1	MII
National Datacare Corp		0	0	VENDOR	Resident Trust Software	2,541			16 N	MII
Prime Care Technologuy services		0	0	VENDOR	Computer Consulting Services	34,229			16 1	M11
Priotiry Express		0	0	VENDOR	Courier Services	4,902	***************************************		16 N	M11
Point Right Inc		0	0	VENDOR	Nursing Software	4,290	9		. 16 N	M11
		0	0	VENDOR						
;		0	0	VENDOR						

^{*} List all contracted services over \$10,000. Use additional sheets if necessary. ** Refer to Page 4 for definition of related.

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

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

Name of Facility	License No.	Report for Ye	ar Ended		Page	of
Bidwell Care Center,LLC	2148-C	9/30/2015			22	37
Item		Total	CCNH	RHNS	NurseF	ac-Aids
6. Maintenance & Operation of Plant		31				
a. Repairs & Maintenance	9	\$ 30,761	30,761			
b. Heat	9	\$ 17,650	17,650			
c. Light & Power	5	\$ 112,050	112,050			
d. Water	(\$ 52,410	52,410			
e. Equipment Lease (Provide detail on p	age 6) S	\$ 36,733	36,733			
f. Other (itemize)		\$ 99,497	99,497	ann an thair		
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a -	6f) S	\$ 349,102	349,102			
7. Depreciation (complete schedule page 23						
a. Land Improvements		\$				
b. Building & Building Improvements		\$ 19,013	19,013			
c. Non-Movable Equipment		\$				
d. Movable Equipment		\$ 65,931	65,931			
*7e. Total Depreciation Costs $(7a + b + c + d)$)	\$ 84,943	84,943			
8. Amortization (Complete att. Schedule Pa	ge 24*)					
a. Organization Expense		\$ 				
b. Mortgage Expense		\$				
c. Leasehold Improvements		\$ 45,774	45,774			
d. Other (Specify)		\$ 				
*8e. Total Amortization Costs (8a + b + c + c	l)	\$ 45,774	45,774		ļ	
9. Rental payments on leased real property l	less				1	
real estate taxes included in item 10b		\$ 601,500	601,500			
10. Property Taxes						
a. Real estate taxes paid by owner		\$			1	
b. Real estate taxes paid by lessor		\$ 98,973	98,973			
c. Personal property taxes		\$ 13,118	13,118			
11. Total Property Expenses (7e + 8e + 9 +	10)	\$ 844,308	844,308			

^{*} 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	NurseFac-Aids
PLANT SUPPLIES	\$ 15,084		\$ -
PLANT CONTRACT SERVICE LABOR	\$ 5,446		\$ -
ELEVATOR CONTRACT SERVICE	\$ 2,290		\$ -
FIRE/SPRINKLER CONTRACT SERVICE	\$ 5,388		\$ -
LANDSCAPING CONTRACT SERVICE	\$ 11,410		\$ -
SNOW REMOVAL CONTRACT SERVICE	\$ 16,913		\$
TRASH REMOVAL CONTRACT SERVICE	\$ 18,181		\$ -
HVAC CONTRACT SERVICE	\$ -		\$
SECURITY CONTRACT SERVICE	\$ -		\$ -
PLANT CONTRACT SERVICE OTHER	\$ 9,810		\$ -
PLANT MINOR EQUIPMENT	\$ 12,426		\$ -
RENT AUTO	\$ -		- \$
RENT EQUIPMENT	\$ -		\$ -
RENT OTHER	\$ 2,550		\$
Total Other Repairs and Maintenance	\$ 99,497	\$ -	\$

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-23 Rev. 10/2006

•	
	10/2006
•	Rev.
	SP-23

Name of Facility Diducal Goas Contact 11 C			License No. 2148-C	Ç	ense No. 2148-C	Report for Year Ended 9/30/2015	nded		Page 23	of 37
Diamen Car Control, D.C.			Historical Cost	Less	out to Be	Accumulated Depreciation to	Method of	Useful	Depreciation	
Property Item			Exclusive of Land	Salvage Value	Depreciated	Year's Operations	-	Life	for This Year	Totals
A. Land Improvements									200 - 1 Comm	
Acquired prior to this report period Dienocals (attach schedule)										
3 Aconired during this report period (attach schedule)	schedule)									
A-4. Subtotal										
B. Building and Building Improvements					1	r T			10.012	
 Acquired prior to this report period 			190,125		190,125	7761			19,013	
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	schedule)									01001
B-4. Subtotal										19,013
C. Non-Movable Equipment										
1. Acquired prior to this report period										
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	schedule)									
C-4. Subtotal										
	Is a mileage		,			*				
	logbook maintained?	Date of Acquisition	Historical	Less		Accumulated Depreciation to	Method of			
1		1	Exclusive of	Salvage	Cost to Be	Beginning of	Computing		Depreciation	
	Yes No	Month Year	Land	Value	Depreciated	Year's Operations	_	Life	for This Year	Totals
D. Movable Equipment						The section of				
1. Motor Vehicles (Specify name, model										
		1 2010	000.5		\$ 300	5 300	8/7	48 Months		
	yes	4 2010	2,300		1 709			48 Months	285	
Trailer for laundry vehicle	yes	1107 C	1,/07		1,107		7			
d.										
2. Movable Equipment										
a. Acquired prior to this report period			927,289		927,289	741,010		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	65,070	
b. Disposals (attach schedule)	-	TO THE TAXABLE PARTY OF TAXABLE PAR	A STATE OF THE STA							
c. Acquired during this report period		-							763	
(attach schedule)		ACTION ANNUAL PROPERTY OF THE	8,919						9/6	100 37
D-3. Subtotal										65,951
Total Designation										77 77

Useful

Schedule of Land Improvements Acquired during this report period

Schedule of Pand 110	provements Acquired during this report period		Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
			403,633,535	
			No State of	
Total additions for I	and Improvements	\$ -		\$ -
Deletions:				
			111111111111111111111	
			1000	
		1.11	15.1	
			1 1 1 1 1 1 1 1 1	
	and Improvements	\$ -		\$ -

^{*}Ties to Page 23, Line A3

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				1000
THE STANKING STANKS				\$ -
Total additions for	Building Improvements	\$		\$ -
Deletions:				
Defetions:		V-100		
			3.4.30.0074.53.6	14114 (1911)
				The family
		1 1 1 1 1 1		TEAN SEA

	Building Improvements	\$ -		\$ -

^{*}Ties to Page 23, Line B3

Schedule of Non-Movable Equipment Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
			Albert Belling	
1, 1				1 1 1 1 1 1 1 1 1
Total additions for	Non-Moyable Equipment	\$		\$ -
Deletions:				
			1 - 11/1 11/1	
		18.15.2		44.64
Total deletions for	Non-Movable Equipment	\$		\$ -

^{*}Ties to Page 23, Line C3

^{**}Ties to Page 23, Line A2

^{**}Ties to Page 23, Line B2

^{**}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:			***	
1/23/2015	Box, Control for Acuator: Medline	\$ 1,868	60	\$ 249
5/1/2015	Bed - Medline	\$ 3,609	60	\$ 241
6/5/2015	Floor Lift: Direct Supply	\$ 3,442	120	\$ 86

Total additions for	Movable Equipment	\$ 8,919		\$ 576
Deletions:				
			1999	3 A.
		NAME OF A		
Total deletions for	Movable Equipment	\$ -	in the August States	\$ -

^{*}Ties to Page 23, Line D2c **Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

	•		Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
1/30/2015	Replaced Evaporator in Freezer: Proline	\$ 2,171	120	\$ 145
10/3/2014	Upgraded Freezer: Proline	\$ 4,328	120	\$ 397
5/29/2015	Replaced Valve on Water Heater: Saucier Mechanical Serv.	\$ 5,134	120	\$ 171
3/31/2015	Upgraded Kitchen Drain: Saucier Mechanical Serv.	\$ 3,167	300	\$ 63
6/12/2015	Installed Ice Machine: Proline	\$ 4,068	120	\$ 102
Total additions for	Leaschold Improvement	\$ 18,868		\$ 878
Deletions:				
Total deletions for	Leasehold Improvement	\$ -		\$ -

^{*}Ties to Page 24, Line C3
**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility CSP-24 Rev. 10/2006 State of Connecticut

Amortization Schedule*

Nome of Earlity		License No.		Report for Year Ended	r Ended		Page	fo
Bidwell Care Center LLC		2148-C		9/30/2015			24	37
				Accumulated				
	Date of			Amort. to				
	Acquisition			Beginning of	Basis for			
		Length of	Cost to Be	Year's	Computing	45	Amortization	- -
Item	Month Year	r Amortization	Amortized	Operations	Amortization**	%	for This Year	lotals
A. Organization Expense			,					
1. Organization Expense		5	3,410	3,410				
2.								
33.					A CONTRACTOR OF			
A-4. Subtotal								
B. Mortgage Expense								
1.								
2.								
3.				XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	A PARTY COMMENTAL STATE OF THE			
B-4. Subtotal								
C. Leasehold Improvements and Other								
1. Acquired prior to this report period	•		612,939	374,042			44,896	
2. Disposals (attach schedule)				ACTION AND AND AND AND AND AND AND AND AND AN				
3. Acquired during this report period				有多年 医线线				
(attach schedule)			18,868				8/8	1000
C-4. Subtotal								45,774
D. Total Amortization								42,7/4
* Straight-line method must be used								

* 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

	ne of Facility well Care Center,LLC	License No. 2148-C	Report for Year End 9/30/2015	ded		Page 25	of 37
	Property Questionnaire						
11.	Part A			*···	MAY T		
	Is the property either owned by the or leased from a Related Party?*	ne Facility 💿	Yes	0	No	If "Yes," complete If "No," complete	
	*If any owner or operator of this fa business association to any person a related party transaction.	cility is related by family, n or organization from whom	narriage, ownership, abil buildings are leased, the	ity to control or on it is considered			
	Description		Total				
	Date Land Purchased	-AMES	12/01/03				
	2. Date Structure Completed			442000		La Salata d	
	3. If NOT Original Owner, Dat	e of Purchase	12/01/03				
	4. Date of Initial Licensure		12/01/03				
	Total Licensed Bed Capacity		131				
	6. Square Footage						
	7. Acquisition Cost			2 E 5 2 5 7			
	a. Land						
	b. Building		1.3.5	0.114	2d Mentagas	4th Mortg	ra da
	Part B - Owner and Related Pa	arties	1st Mortgage	2nd Mortgage	3rd Morigage	411 1/10/15	gage
	1. Financing	~ 1 '11)	THID Could				
	a. Type of Financing (e.g., t	fixed, variable)	HUD fixed 05/30/13				
<u> </u>	b. Date Mortgage Obtained	V	335.00%				
	c. Interest Rate for the Cost		333.00%				
ļ	d. Term of Mortgage (number Amount of Principal Bor		3,259,200				****
	f. Principal balance outstan						
	Complete if Mortgage was		3,810,117				
	During Current Cost Y						
_	g. Type of Financing (e.g.,						
	h. Date of Refinancing						
	i. New Interest Rate						
-	i. Term of Mortgage (numb	per of years)					
	k. Amount of Principal Bor						
	 Principal Outstanding on 				<u> </u>		
	Part C - Arms-Length Lea	ses for Real Property	Improvements Onl	<u>y</u>			
	Name and Address of Less	or Pro	operty Leased	Date of Lease	Term of Leas	e Annual Amoun	t of Lease
		·					
_							
L							

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 Ye	ar Ended		Page	of
Bidwell Care Center,LLC	2148-C	^	9/30/2015			26	37
Item			Total	CCNH	RHNS	NurseFa	ac-Aids
12. Interest							
A. Building, Land Improve	ment & Non-Movabl	e					İ
Equipment		ф					
1. First Mortgage Name of Lender		Rate					
Name of Lender		Kalt			56		
Address of Lender			7.5				
			100,000				
2. Second Mortgage		\$					
Name of Lender		Rate					
Address of Lender			9 10 2 F2 5 F3				
Address of Lender				100			
3. Third Mortgage		\$			- 10-		
Name of Lender		Rate					
Address of Lender			120				
4. Fourth Mortgage							
Name of Lender		Rate					
TVAITE OF BEHAVI					100		
Address of Lender				0.000			
			- 4				
B. CHEFA Loan Informati	on						
1. Original Loan Amou	<u>nt</u>		8				
2. Loan Origination Da	te						
3. Interest Rate %					12.5		
4. Term							
5. CHEFA Interest Exp	ense						
12 B7. Total Building Interest Exp) :	8				
				ry Subtotals	forward to	nevt nage	`

(Carry Subtotals forward to next page)

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

Name of Facility	License No.		Report for Ye	ear Ended		Page of
Bidwell Care Center,LLC	2148-C		9/30/2015			27 37
lte			Total	CCNH	RHNS	NurseFac-Aid
	Subtotals Brou	ight Forward:				
12. C. Movable Equipment		Φ.				
1. Automotive Equipme	· · · · · · · · · · · · · · · · · · ·	\$				
A. Item	Rate	Amount				
Lender			#13_00F700			
Address of Lender						The Section of the Se
2. Other (Specify)		\$		<u> </u>		
A, Item	Rate	Amount			100	
71, 1011			9-18-21-19			
Lender						17.5
Address of Lender						400000
						100
B. Item	Rate	Amount				
			42.49			0.0000000000000000000000000000000000000
Lender						
Address of Lender						
12. C. 3. Total Movable Equip	oment Interest					
Expense (C1 + 2)		5				
12. D. Other Interest Expense	(Specify)	5	27,684	27,684		
INTEREST			50000000	1000000		
13. Total All Interest Expense	(12B7 + 12C3 + 12L)	D) \$	27,684	27,684		
14. Insurance			12.222	12 222		
a. Insurance on Property (13,332 1,483		
b. Insurance on Automobi			1,483	1,465		
c. Insurance other than Pr 1. Umbrella (Blanket C			38,531	38,531		1
2. Fire and Extended C			5 36,331	30,551		
3. Other (<i>Specify</i>)	overage		3,000	3,000		
5. Other (Specify)		,	5,000	5,000		
						100 mg
14d. Total Insurance Expenditu	res(14a+b+c)	100	56,346	56,346	The second secon	
15. Total All Expenditures (A-	13 thru C-14)		12,630,559	12,630,559		

D. Adjustments to Statement of Expenditures

Name	of Fa	acility	Lic	ense No.	Report for Ye	ar Ended	Page		of
		re Center,LLC		2148-C	9/30/2015		28		37
				Total					
Item	Page	Line		Amount of					
No.	_	i		Decrease	CCNH	RHNS	Nurse	Fac-	Aids
		Salaries and Wages		In the second					
1		Outpatient Service Costs	\$			Transfer and Francisco Fra			
2.		Salaries not related to Resident Care	\$						
3.		Occupational Therapy	\$						
4.		Other - See attached Schedule	\$						
	13 - 1	Professional Fees							
5.	1	Resident Care Physicians **	\$						
6,		Occupational Therapy	\$						
7.		Other - See attached Schedule	\$	86,035	86,035				
	s 15 d	2 16 - Administrative and General							
8.	1	Discriminatory Benefits	\$						
9.	 	Bad Debts	\$	134,424	134,424				
10.		Accounting & Legal	\$						
11.		Telephone	\$						
12.		Cellular Telephone	\$						
13.		Life insurance premiums on the life			HOLE STREET				
15,		of Owners, Partners, Operators	\$			- 1 3820 M September 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1			
14.	-	Gifts, flowers and coffee shops	\$						
15.		Education expenditures to colleges or							
10.		universities for tuition and related costs							
		for owners and employees	\$			\$1 \$200000000000000000000000000000000000	Qualificación (Companyo		
16.		Travel for purposes of attending							
101		conferences or seminars outside the			0.00				
		continental U.S. Other out-of-state			100000				
		travel in excess of one representative	\$		(1) 12 (1) 13 (1)				
17.	<u> </u>	Automobile Expense (e.g. personal use)	\$						
18.		Unallowable Advertising *	\$	34,032	34,032				
19.	+	Income Tax / Corporate Business Tax	\$						
20.		Fund Raising / Contributions	\$						
21.		Unallowable Management Fees	\$						
22.		Barber and Beauty	\$						
23.	_	Other - See attached Schedule	\$		2,456				
		Dietary Expenditures			100				
24		Meals to employees, guests and others		5 5 5 5 5 5					
2-1	1	who are not residents	\$	555-2015			School Services		angecus sources
Paga	0 19 -	Laundry Expenditures							
25		Laundry services to employees, guests							
23		and others who are not residents	\$			on and an exercise of the second seco	A STATE OF THE STA		
Pag	0 20	Housekeeping Expenditures							
26	1	Housekeeping services to employees, guests			The state of the s	4.0			7
۷0	'	and others who are not residents	\$						-10500000000000000000000000000000000000
		Subtotal (Items 1 - 26)			256,947				
		one "Help Wonfod"	4		Carry Subtotal		t naga	١	

* 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	NurseFac-Aids
11.11					
	-				
Total Othe	r Salaries	Adjustment	\$ -	\$	\$

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
14.4					
16		Management fee over cost	\$ -		\$ -
15		Provider User Fee Medicare days	\$ 86,035		
1.15					
Total Othe	r Fees Adi	ustments	\$ 86,035	\$ -	\$

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
16a		PENALTIES	\$		\$
16a		LATE FEES	\$ 2,456		\$
16a	Marie Control	PRIOR PERIOD EXPENSES			
		rounding	0		
				T 1888	
Total Othe	r A&G Ad	iustments	\$ 2,456	\$	\$ 35000 002 000

Annual Report of Long-Term Care Facility

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

Marie	e of Fa	01114-	D. Adjustments to Statemen		ense No.	Report for Y		Page	of
		-		LIC	2148-C	9/30/2015	cai Eliucu	29	37
Biaw	en Ca	re Cei	nter,LLC		· Total	9/30/2013		29	<u> </u>
T.	D	т			Amount of	İ			
	Page		Item Description		Decrease	CCNH	RHNS	Murce	Fac-Aids
No.	No.	No.	Subtotals Brought Forward	\$	256,947	256,947	KIIIVS	Muisc	1.40-711d3
D	20 7			Ф	230,947	230,947			
	20 - F	cestae	nt Care Supplies***	\$					
27.			Prescription Drugs Ambulance/Limousine	\$	9,744	9,744			
28.				<u>э</u> \$	18,609	18,609			
29.			X-rays, etc	\$	24,920	24,920	*****		
30.		-	Laboratory	<u> </u> \$	24,920	24,920			
. 31.			Medical Supplies	<u>\$</u>					
32.			Oxygen (non emergency)	\$				<u> </u>	
33,			Occupational Therapy	<u>\$</u>	2,183	2,183		<u> </u>	
34.	22.7	.	Other - See Attached Schedule	Ф	2,183	2,163			
	! <i>ZZ = 1</i> !	<u>naini</u>	enance and Property						
35.			Excess Movable Equipment Depreciation	σ					
	<u> </u>		See Attached Schedule	\$					
36.			Depreciation on Unallowable	ı.					
	ļ		Motor Vehicles	\$					
37.			Unallowable Property and Real	ф					
		ļ	Estate Taxes	\$					
38.	ļ	ļ	Rental of Building Space or Rooms	\$		<u> </u>		ļ	
39.	<u> </u>	<u> </u>	Other - See Attached Schedule	\$					
-	27 - 1	nsura		Φ.					
40.		<u> </u>	Mortgage Insurance	\$					
41.		<u> </u>	Property Insurance	\$					
	r - Mi	scella							
42.	1	ļ	Research or Experimental Activities	\$		ļ <u></u>		ļ	,
43.		<u> </u>	Radio and Television Revenue	\$				<u> </u>	
44.		ļ	Vending Machine Revenue	\$					
45.		ļ	Purchase Discounts and Allowances	\$				<u> </u>	
46,		<u> </u>	Duplications of functions or services	\$					
47.			Expenditures made for the protection,						
			enhancement or promotion of the	_					
		-	providers interest	\$					
48.		ļ	Interest Income on Accounts Rec	\$					
49.	-		Other (include personnel and other			100			
			costs unrelated to resident care) - See						
			Attached Schedule	\$	35	35			
		rofit l	Providers Only						
50			Building/Non Movable Eq. Depreciation			100			
			Unallowable Building Interest -						
	<u></u> _		See Attached Schedule	\$					
51	. Tota	l Amo	ount of Decrease (Items 1 - 50)	\$	312,438	312,438	<u> </u>		

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

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
20	5J	NON-COVERED PPS DR. VISITS	769.03		
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	1,291		
13	B9A	ST- Resident Care (for outpatent therapy - see schedule)		Allenn SAA	HERE HE ELLEN
. 13	B10A	OT-Resident Care (for outpatient therapy - see schedule)	123		
Total Other	er Ancillary	y Costs	\$ 2,183	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
I mgc Rei					
					Preserve programme
Total Exce	ss Movable	Equipment Depreciation	\$ -	\$ -	\$

Schedule of Other Property Adjustments

age Ref Line Ref Description	CCNH	RHNS	NurseFac-Aids
Page Ref Line Ref Description			
Fotal Other Property Adjustments	\$ -	\$ -	\$

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
20	4A1	Houskeeping Supplies (for Outpatient Therapy - see schedule)	2		
20	4B	Housekeeping purchased services (for Outpatient Therapy see schedule)	26		
22	6B	Heat (for outpatient Therapy see schedule)	2		
22	6C	Light and Power (for outpatient therapy see schedule)	2		
22	6D	water (for outpatient therapy see schedule)	2		
22	6A	Repair&Maint (for outpatient therapy see schedule)	2		
Total Othe	r Adjustm	ents	\$ 35	\$ 1111	

Schedule of Unallowable Building Interest

Page Ref	Line Ref Description	CCNH	RHNS	NurseFac-Aids
I lige Kez				
			I HANAY	
Total Unal	lowable Building Interest	\$ -	\$ -	\$ 555

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F. Statement of Revenue

Name of Facility	License No.		Report for Yo	ear Ended		Page	of
Bidwell Care Center,LLC	2148-C		9/30/2015			30	37
					5.55.00	3.Y T	4 * 1
	Item		Total	CCNH	RHNS	NurseFac	-Aids
I. Resident Room, Board & Routin							
1. a. Medicaid Residents (CT on		\$	9,514,355	9,514,355			
b. Medicaid Room and Board		\$					
2. a. Medicaid (All other states)		\$					
b. Other States Room and Bo		\$					
3. a. Medicare Residents (all inc		\$	2,045,216	2,045,216			
b. Medicare Room and Board		\$					
4. a. Private-Pay Residents and		\$	391,683	391,683			
b. Private-Pay Room and Boa	rd Contractual Allowance **	\$					
II. Other Resident Revenue							
1. a. Prescription Drugs - Medic	care	\$	147,638	147,638			
b. Prescription Drugs - Medic	care Contractual Allowance **	\$	(147,638)	(147,638)			
c. Prescription Drugs - Non-N	Medicare	\$	25,559	25,559			
d. Prescription Drugs - Non-N	Medicare Contractual Allowance **	\$	(25,559)	(25,559)			
2. a. Medical Supplies - Medica	re	\$					
b. Medical Supplies - Medica	re Contractual Allowance **	\$					
c. Medical Supplies - Non-M	edicare	\$					
	edicare Contractual Allowance **	\$			w		
3. a. Physical Therapy - Medica		\$	344,574	344,574			
b. Physical Therapy - Medica		\$	(291,113)	(291,113)			
c. Physical Therapy - Non-M		\$	98,734	98,734			
	edicare Contractual Allowance **	\$	(98,734)	(98,734)			
4. a. Speech Therapy - Medicar		\$	72,350	72,350			
b. Speech Therapy - Medicar		\$	(58,346)	(58,346)		<u> </u>	
c. Speech Therapy - Non-Me		\$	39,375	39,375			
d. Speech Therapy - Non-Me	dicare Contractual Allowance **	\$	(39,375)	(39,375)	ļ		
5. a. Occupational Therapy - M		\$	374,220	374,220			
	fedicare Contractual Allowance **	\$	(295,831)	(295,831)			
c. Occupational Therapy - N	on-Medicare	\$	100,065	100,065	*********		
	Ion-Medicare Contractual Allowance **	\$	(99,806)	(99,806)			
6. a. Other (Specify) - Medicare		\$	69,298	69,298			
b. Other (Specify) - Non-Me		\$	28,367	28,367			
III. Total Resident Revenue (Secti	,	\$	12,195,032	12,195,032			
IV. Other Revenue*							
Meals sold to guests, employer	ees & others	\$		S ACCUSATION OF THE PROPERTY AND ACCUSATION OF	(1) (4) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1	The state of the s	y
2. Rental of rooms to non-reside		\$					
	2110	\$		1			
Telephone Rental of Television and Cab	le Services	\$.	<u> </u>		1	
5. Interest Income (Specify)	10 501, 1005	 \$		12			
6. Private Duty Nurses' Fees		\$					
7. Barber, Coffee, Beauty and C	rift shons	<u> </u>				<u> </u>	
8. Other (Specify)	nie oropo	<u></u> \$	-				
V. Total Other Revenue (1 thru 8)		\$		12			
			,	-		1	
VI. Total All Revenue (III +V)		4	12,195,043	12,195,043	<u> </u>		

^{*} 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

Ref Description					CCNH	RHNS	NurseFac-Aid:
Lab Medicare	5.75	:		\$	107,323		1.5
Lab Medicare CA			1.1	\$	(107,323)	V 2	11,144.00
Oxygen Medicare				\$	245		
Oxygen Medicare CA		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		\$	(215)		
Equipment rental	4. 11		14	S	4,338	4 1	
Equipment rental CA		7.71.31		\$	(4,338)		
Pen Therapy	1919		200	\$			
Pen Thempy CA			No. 1	\$			
Therapy Beds Medicar	e			S			
Therapy Beds Medicar				\$			
Radiology Medicare				5	15,618		1
Radiology Medicare C	Α :			5	(15,618)		
IV Therapy				\$	36,494		
IV Therapy CA		1000		S	(36,494)	1 1 1 1 1 1	1.0
Medical Transportatio	n	A. A. A. S. C. C.	41 (51) (51) (41)	S	15 6 2 2 2 2 2		3,53,53
Medical Transportatio		1997		ş		3.000	1 1 1 1 1 1 1 1
Glucose testing	1 1 1 1 1 1 1 1			\$	4.1	11111111111	
Glucose testing CA				\$		22/20/20/20	
Outpatient therapy	14.14.14			\$	69,298	444421 144	1 1000 1000
1444	1544 (155)			L.		As refreshed	4 14 14 14 14
Other Resident Revenue -	Medicare	4 - 4 - 4 - 4 - 4 - 5 - 5 - 5		8	69,298	\$	\$

Schedule of Other Non-Medicare Resident Revenue

Related Exp

f Description						C	CNH	RHNS	NurseFac-Aic
Lab	10.114	11.5	- 1				7,460.58		100
Lab CA	1 1 1 1 1 1 1 1 1 1 1				11.1	-	7,460.58)	1.1	4. 3. 4.
Oxygen	100000	100	Girt Variati	CARA CAR	1.0	s	715		\$ -
Oxygen CA	e se especial		ett sammer	t Herry		S	(715)	1 - 1	\$ -
Equipment rer	tal	14, 14	16.14.5	19414		\$	11,886	74.3.4	
Equipment rea						\$	(11,886)		
Pen Therapy			11			\$			
Pen Thorapy C	'A				``	\$	-		
Therapy Beds						s			
Therapy Beds	CA					\$			
Rudiology						\$	2,291		
Radiology CA						s	(2,291)		
Medical Trans	portation		·			2			
Medical Trans	portation CA					s	-		
Glucose Testi	ıg					\$			
Glucose Testin	ig CA					3	· <u>-</u>		_
IV therapy		7 1 1 1 1		·	·	5	3,708	1.0	\$ -
IV therapy C/						S	(3,708)		<u>s</u> -
Flu shot reven	uc					\$	2,432	44.	
		1.11				<u> </u>	1,111		
PRIOR YEAR	ADJ - ANCILL	ARY & OTHE	R ·		1 - 1	S	25,935		75.0
					4 1 1 1 1 1		<u> </u>		
rounding		1, 1		- 15 ₂ ,		\$	(1)		
	e tegysdetti	1.4.1.1.1			are Medice exp		State Trap to a	100	
.10			190 190 190		43,343,41,541,		21/22/2015/20	1500 1500	
Other Resident Re	venue	e tresper	1,000	and the state of the state		\$	28,367	\$	\$

Interest Income

Account

Page Ref Account	Balance	CCNH	RHNS	NurseFac-Aids
INTEREST INCOME		S 12		1
Total Interest Income	1	\$ 12	\$ -	

Schedule of Other Revenue

Page Ref	Description				CCNH	RHNS	NurseFac-Aid
r ngo zer	MEALS				\$	+ 1, 1	
	TELEVISION INCOME				s -		
	CONCESSIONS / VENDING IN	COME			\$ -		
	RESIDENT LATE FEE REVEN	Æ			\$ -		
	RESIDENT ATTORNEY FEE R		4.1	1.1.1	\$ -	1 1	
	TELEPHONE INCOME			4.11	\$		
	OTHER INCOME				s -		
		11.1					
		1 11 11 11 11		<u> </u>	1 1 1 1 1 1		
		1.00			14.57.11		
****							1
							-
Total Oth	er Revenue				\$ -	s -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year	Ended	Page	of
Bidwell Care Center,LLC	2148-C	9/30/2015		31	37
	Account			An	nount
Assets					
A. Current Assets					(40 4 5 5 0)
1. Cash (on hand and in				\$	(186,329)
	eceivable (Less Allowance			\$	819,690
Other Accounts Rece	ivable (Excluding Owners	or Related Parties)		\$	79,947
4 Inventories				\$	
Prepaid Expenses				\$	303,705
a. Prepaid Insurance		295,867			
b. Prepaid Property T	axes	3,094			
c. Prepaid Expenses	Other	4,744			
d.					
6. Interest Receivable				\$	
7. Medicare Final Settle	ment Receivable			\$	
8. Other Current Assets				\$	(517,816)
Due From (to) Related		(383,844)			
Other Owners reserve	3	(133,912)		275
A-9. Total Current Assets (L.	ines A1 thru 8)			\$	499,197
B. Fixed Assets					
1. Land				\$	
2. Land Improvements	*Historical Cost			\$	
•	Accum, Deprecia	ition	Net		
3. Buildings	*Historical Cost	190,125		\$	163,191
٥	Accum. Deprecia	ation 26,934	Net		
4. Leasehold Improvem		631,807		\$	211,991
•	Accum. Deprecia	ation 419,815	_ Net		
5. Non-Movable Equip	nent *Historical Cost			\$	
1 .	Accum. Deprecia	ation	Net		
6. Movable Equipment	*Historical Cost	936,208		\$	129,552
	Accum. Deprecia		_		
7. Motor Vehicles	*Historical Cost	7,009		\$	
,, 2,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Accum. Deprecia	ation 7,009	_ Net		
8. Minor Equipment-No				\$	
9. Other Fixed Assets (itemize)			\$	36,042
Construction in Pr	•	36,042			
B-10. Total Fixed Assets (Lines D1 thm; (1)			\$	540,777
B-10. Total Fixed Assets (rmes D1 mu 9)			Īφ	340,777

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

G. Balance Sheet (cont'd)

		Facility	License No.	Report for Year Ended		Page	of
Bidy	/ell	Care Center,LLC	2148-C	9/30/2015	<u>, </u>	32	37
			Account		4	Amo	
				Total Brought Forward:	\$		1,039,974
C,		asehold or like property record	ded for Equity Purpose	S.	Φ.		
		Land			\$		
	2.	Land Improvements	*Historical Cost	*	4		
			Accum. Depreciation	n Net	\$		
	3.	Buildings	*Historical Cost		φ.		
			Accum. Depreciation	n Net	\$		
	4.	Non-Movable Equipment	*Historical Cost	31	φ.		
			Accum. Depreciation	n Net	\$		
	5.	Movable Equipment	*Historical Cost	NT /	Φ		
			Accum. Depreciation	n Net	\$		
	6.	Motor Vehicles	*Historical Cost		ф		
			Accum. Depreciation	n Net	\$		
	7. Minor Equipment-Not Depreciable						
C-8		tal Leasehold or Like Proper	ties (C1 thru 7)		\$		
D.		vestment and Other Assets			Φ.		
		Deferred Deposits			\$		
		Escrow Deposits			\$		
	3.	Organization Expense	*Historical Cost	3,410	Φ.		
			Accum. Depreciation	n 3,410 Net	\$		
		Goodwill (Purchased Only)			\$		55.046
	5.	Investments Related to Resident	dent Care (itemize)		\$	7	55,246
		Patient Trust Funds		52,691			
		Long Term Deposit - prir	necare	2,555	.		
	6.	Loans to Owners or Related			\$		
		Name and Address	Amount	Loan Date			
		/			1		
	7.	Other Assets (itemize)			\$		
i					_		
					\$		
	D-8. Total Investments and Other Assets (Lines D1 thru 7)						55,246
D-9	Ta	otal All Assets (Lines A9 + B	10 + C8 + D8		\$		1,095,220

^{*} 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 Fac	me of Facility License No. Report for Year Ended		Page	of			
Bidwell Care	e Cen	ter,LLC	2148-C	9/30/2015		33	37
			Account	10.470		An	nount
Liabilities	······································	4.44					
A.	Cu	rrent Liabilities					
	1.	Trade Accounts Payable				\$	588,262
	2.	Notes Payable (itemize)			22	\$	822,999
		Working Capital Line of	Credit	822,999	9		
		-					
						<u> </u>	
	3.	Loans Payable for Equipr				\$	
		Name of Lender	Purpose	Amount	Date Due		
-							
							described.
	4.	Accrued Payroll (Exclusi	ve of Owners and/or	Stockholders only)	<u></u>	\$	353,997
	5.	Accrued Payroll (Owners				\$	
	6.	Accrued Payroll Taxes Pa				\$	
	7.	Medicare Final Settlemen				\$	
	8.	Medicare Current Financ				\$	
	9.	Mortgage Payable (Curre				\$	
		. Interest Payable (Exclusiv		Related Parties)		\$	
		. Accrued Income Taxes*				\$	
		. Other Current Liabilities	(itemize)			\$	1,800,945
		Related Party Payables	1,641	,465			
		Accrued Expenses	17	7,652			
		Accrued Resident User Fees		2,612			
		Accrued Workers Comp Expense),784)			
A-13	3. To	<i>tal Current Liabilities</i> (Li	nes A1 thru 12)			\$	3,566,203

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

G. Balance Sheet (cont'd)

ame of Facility License No. Report for Year Ended		Page	of		
Bidwell Care Center,LLC	2148-C	9/30/2015		34	37
	Account			Amo	ount
		Total Brougl	nt Forward:		3,566,203
Liabilities (cont'd)					
B. Long-Term Liabilities					
 Loans Payable-Equipmen 	t (itemize)		\$		
Name of Lender	Purpose	Amount	Date Due	100	
		,			
	1				
			\$		
2. Mortgages Payable	1.4.1 D4! (24	-)	\$		
3. Loans from Owners or Re	*****		2000	76 J. W.	
Name and Address of Lender	Amount	Loan D	rate		
				9.5	
4. Other Long-Term Liabili	ties (itemize)		\$		52,691
Patient Trust Funds		52,691			

B-5. Total Long-Term Liabilities	(Lines B1 thru 4)		\$		52,691
C. Total All Liabilities (Lines A	\-13 + B-5)		\$		3,618,894

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

	ne of Facility	License No.	Report for Ye 9/30/2015	ear Ended	Page 35	of 37
Bia	well Care Center,LLC	Account	J9/30/2013	THE COLUMN TO THE COLUMN TWO THE COL		mount
A.	Reserves	2 toodait				
	1. Reserve for value of lease	ed land			\$	
	Reserve for depreciation to be amortized	value of leased build	ings and appurter	nances	\$	
	3. Reserve for depreciation	value of leased perso	nal property (Equ	uity)	\$	
	4. Reserve for leasehold rea	l properties on which	n fair rental value	is based	\$	
	5. Reserve for funds set asic	le as donor restricted			\$	
	6. Total Reserves				\$	
B.	Net Worth 1. Owner's Capital				\$	25,000
	2. Capital Stock				\$	
	3. Paid-in Surplus				\$	
	4. Treasury Stock				\$	
	5. Cumulated Earnings				\$	(2,113,158)
	6. Gain or Loss for Period	10/1/20	014 thru	9/30/2015	\$	(435,516)
	7. Total Net Worth				\$	(2,523,674)
C.	Total Reserves and Net Wor	th			\$	(2,523,674)
D.	Total Liabilities, Reserves, a	ind Net Worth			\$	1,095,220

H. Changes in Total Net Worth

Name of Facility License No. Report for Year Ended Page	of
Bidwell Care Center, LLC 2148-C 9/30/2015 36	37
	Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2014 \$	
B. Total Revenue (From Statement of Revenue Page 30) \$	12,195,043
C. Total Expenditures (From Statement of Expenditures Page 27) \$	12,630,559
D. Net Income or Deficit \$	(435,516)
E. Balance \$	(435,516)
F. Additions	
1. Additional Capital Contributed (<i>itemize</i>)	
	1 form 1 (1) (1)
	4.00
2. Other (itemize)	
	A Complete S
	200 PM
F-3. Total Additions	
G. Deductions	
1. Drawings of Owners/Operators/Partners (Specify)	
Name and Address (No., City, State, Zip) Title Amount	
	and the same of th
2. Other Withdrawings (Specify) \$	
Purpose Amount	
	Committee of
3. Total Deductions \$	
H. Balance at End of Period 09/30/15 \$	(435,516)

I. Preparer's/Reviewer's Certification

Name of Facility Bidwell Care Center,LLC		License N	lo.	Report for Year Ended		of		
		<u></u>	2148-C	9/30/2015		37		
Check appropriate category								
Ø	Chronic and Convalescent Nursing Home only (CCNH)		ne with Nursing on only (RHNS)	☑ NurseFac-Aids				
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	Date Signed			
H		VP	Finance	2-10-16				
Printe	d Name of Preparer							
3.00	e MacKinnon	***************************************	1 4700	Phone Number		o.		
Audit	z Augicaa							
341 Bidwell Street, Manchester, CT 06040				860-570-2140 ext 15				