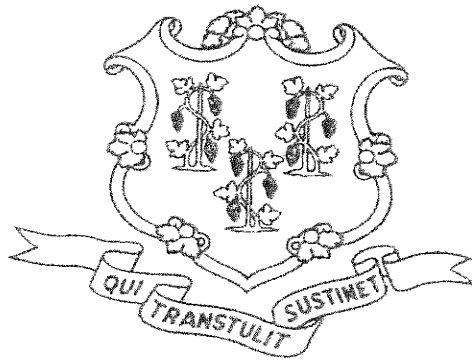


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2017

Name of Facility (as licensed) BRIDGEPORT HEALTH CARE CENTER INC	
Address (No. & Street, City, State, Zip Code) 600 Bond Street Bridgeport CT	
Type of Facility <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH 2061C	RHNS	(Specify)	Medicare Provider
------------------	---------------	------	-----------	-------------------

Medicaid Provider Numbers:	CCNH 200679	RHNS	ICF-IID
----------------------------	----------------	------	---------

For Department Use Only

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

Table of Contents

General Information - Administrator's/Owner's Certification	1
General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
General Information and Questionnaire - Type of Facility - Organization Structure	2
General Information and Questionnaire - Partners/Members	3
General Information and Questionnaire - Corporate Owners	3A
General Information and Questionnaire - Individual Proprietorship	3B
General Information and Questionnaire - Related Parties	4
General Information and Questionnaire - Basis for Allocation of Costs	5
General Information and Questionnaire - Leases	6
General Information and Questionnaire - Accounting Basis	7
Schedule of Resident Statistics	8
Schedule of Resident Statistics (Cont'd)	9
A. Report of Expenditures - Salaries & Wages	10
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B. Report of Expenditures - Professional Fees	13
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C. Expenditures Other than Salaries - Administrative and General	15
C. Expenditures Other than Salaries (Cont'd) - Administrative and General	16
Schedule C-1 - Management Services	17
C. Expenditures Other than Salaries (Cont'd) - Dietary	18
C. Expenditures Other than Salaries (Cont'd) - Laundry	19
C. Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
Depreciation Schedule	23
Amortization Schedule	24
C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C. Expenditures Other than Salaries (Cont'd) - Interest	26
C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D. Adjustments to Statement of Expenditures	28
D. Adjustments to Statement of Expenditures (Cont'd)	29
F. Statement of Revenue	30
G. Balance Sheet	31
G. Balance Sheet (Cont'd)	32
G. Balance Sheet (Cont'd)	33
G. Balance Sheet (Cont'd)	34
G. Balance Sheet (Cont'd) - Reserves and Net Worth	35
H. Changes in Total Net Worth	36
I. Preparer's/Reviewer's Certification	37

General Information

Name of Facility (as licensed) BRIDGEPORT HEALTH CARE CENTER INC	License No. 2061C	Report for Year Ended 9/30/2017	Page 1	of 37
---	----------------------	------------------------------------	-----------	----------

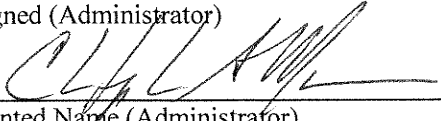
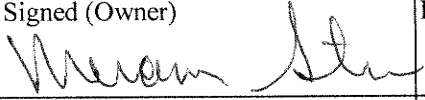
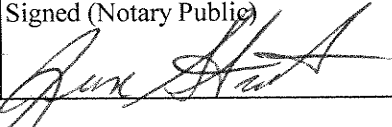
Administrator's/Owner's Certification

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, 2016 and ending September 30, 2017, 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 2-14-18	Signed (Owner) 		Date 2-14-18
Printed Name (Administrator) Christopher Massaro			Printed Name (Owner) Miriam Stern		
Subscribed and Sworn to before me:	State of CT	Date 2-14-18	Signed (Notary Public) 		Comm. Expires 4/30/22
Address of Notary Public 600 Broad Street Bpt Ct 06610					

(Notary Seal)

JUNE STURTEVANT
 NOTARY PUBLIC
 State of Connecticut
 My Commission Expires
 April 30, 2022

General Information

Name of Facility (as licensed) BRIDGEPORT HEALTH CARE CENTER INC	License No. 2061C	Report for Year Ended 9/30/2017	Page 1	of 37
---	----------------------	------------------------------------	-----------	----------

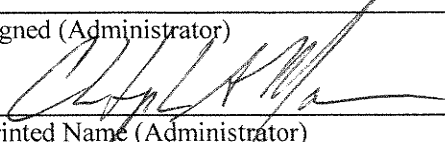
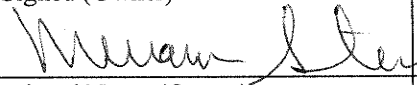
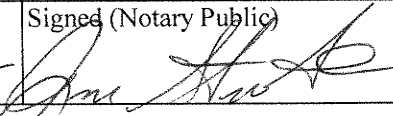
Administrator's/Owner's Certification

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, 2016 and ending September 30, 2017, 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 2-14-18	Signed (Owner) 		Date 2-14-18
Printed Name (Administrator) Christopher Massaro			Printed Name (Owner) Miriam Stern		
Subscribed and Sworn to before me:	State of CT	Date 2-14-18	Signed (Notary Public) 	Comm. Expires 4/30/22	
Address of Notary Public 600 Bond Street Bpt Ct 06610					

(Notary Seal)

JUNE STURTEVANT
 NOTARY PUBLIC
 State of Connecticut
 My Commission Expires
 April 30, 2022

General Information

Name of Facility (as licensed) BRIDGEPORT HEALTH CARE CENTER INC	License No. 2061C	Report for Year Ended 9/30/2017	Page 1	of 37
---	----------------------	------------------------------------	-----------	----------


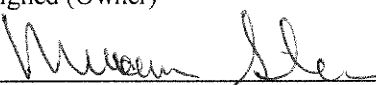
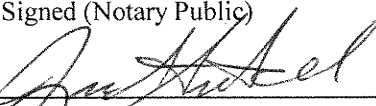
Administrator's/Owner's Certification

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, 2016 and ending September 30, 2017, 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 2-14-18	Signed (Owner) 		Date 2-14-18
Printed Name (Administrator) Christopher Massaro			Printed Name (Owner) Miriam Stern		
Subscribed and Sworn to before me:	State of CT	Date 2-14-18	Signed (Notary Public) 		Comm. Expires 4/30/22
Address of Notary Public 400 Broad Street Bt Ct 06610					

(Notary Seal)

JUNE STURTEVANT
 NOTARY PUBLIC
 State of Connecticut
 My Commission Expires
 April 30, 2022

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 10/1/2016	To 9/30/2017	
Address of Facility 600 Bond Street Bridgeport CT				
Report Prepared By Burg & Weingarten CPA PC	Phone Number 718-845-6141	Date 2/13/2018		
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 9/30/2017	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		
License Numbers:	CCNH 2061C	RHNS	(Specify)	Medicare Provider No.
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 checked="" 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				

General Information and Questionnaire Corporate Owners

Name of Facility BRIDGEPORT HEALTH CARE CENTER I	License No. 2061C	Report for Year Ended 9/30/2017	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 Individual Proprietorship

Name of Facility BRIDGEPORT HEALTH CARE CENTER INC	License No. 2061C	Report for Year Ended 9/30/2017	Page 3B	of 37
---	----------------------	------------------------------------	------------	----------

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

N/A

General Information and Questionnaire Related Parties*

Name of Facility BRIDGEPORT HEALTH CARE CENTER INC		License No. 2061C	Report for Year Ended 9/30/2017	Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input checked="" type="radio"/> Yes <input type="radio"/> 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? <input checked="" type="radio"/> Yes <input type="radio"/> 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	359,560
Rachel Blass		<input type="radio"/>	<input checked="" type="radio"/>	Shareholder	P15/1A5	10,485	
Norma Loren		<input type="radio"/>	<input checked="" type="radio"/>	Shareholder	P15/1A5	8,940	
Chaim Stern		<input type="radio"/>	<input checked="" type="radio"/>	Asst Admin	P 10 A3	145,239	
Joseph Stern		<input type="radio"/>	<input checked="" type="radio"/>	Asst Admin	P 10 A3	76,939	
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	487,411	
The Rosegarden Health & Rehabilitation Center LLC	3845 E Main St Waterbury CT	<input checked="" type="radio"/>	<input type="radio"/>	100% Loans, Allocation of cost			
		<input type="radio"/>	<input type="radio"/>				

* 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 BRIDGEPORT HEALTH CARE CENTER INC	License No. 2061C	Report for Year Ended 9/30/2017	Page 5	of 37
---	----------------------	------------------------------------	-----------	----------

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

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

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

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

2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.
 Bridgeport Health Care Center Inc owns and operates Bridgeport Health Care Center and Bridgeport Manor. One set of corporate books exists and is allocated to each facility using various methods - some direct, some using patient days, and some using square footage.

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

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

**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 BRIDGEPORT HEALTH CARE CENTER INC		License No. 2061C	Report for Year Ended 9/30/2017		Page 6	of 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	05/08/12	60 months	5,360	559
Great American Leasing PO BOX 606 Cedar Rapids IA 52406	<input type="radio"/>	<input checked="" type="radio"/>	Fax Machines	06/06/12	60 months	1,121	632
Accelerated Care Plus 9855 DOUBLE R BLVD Reno NV 89521	<input type="radio"/>	<input checked="" type="radio"/>	Therapy Equipment	05/01/17	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	5,989
De Lage Landen	<input type="radio"/>	<input checked="" type="radio"/>	Fax Machines	05/17/17	60 months	334	188
De Lage Landen	<input type="radio"/>	<input checked="" type="radio"/>	Fax Machines	08/27/17	60 months	96	54
Pitney Bowes POB 856179 Louisville, KY 40285	<input type="radio"/>	<input checked="" type="radio"/>	Mail Machine Equipment	09/28/16	12 months	6,285	3,542
	<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 ***	22,459

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 C	License No. 2061C	Report for Year Ended 9/30/2017	Page 7	of 37
--	----------------------	------------------------------------	-----------	----------

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

Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 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 Madison Street Capital	105 W Madison St Suite 1200 Chicago IL 60602
4	

Services Provided by This Firm (*describe fully*)

1 General Accounting, Balance Sheet, Trial Balance, Cost Report	\$ 55,842
2 Medicare Cost Report	\$ 7,185
3 Financial Consulting	\$ 1,099
4	\$
Charge for Services Provided	
	\$ 64,126

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 See attached sheet	
2	
3	
4	
5	

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

1

2

3

4

5

Services Provided by This Firm (*describe fully*)

1 See attached sheet	\$ 92,022
2	\$
3	\$
4	\$
5	\$
Charge for Services Provided	
	\$ 92,022

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

Legal

- | | |
|-----------------------------------|--------------|
| 1. Berchem, Moses 7 Devlin | 203-783-1200 |
| 2. Murtha Cullina, LLP | 860-240-6000 |
| 3. James Stedronsky, | 860-567-9111 |
| 4. Green & Sklarz, LLC | 203-285-8545 |
| 5. Michael P. Devlin, | 203-530-8375 |
| 6. Novack, Burnbaum, Crystal, LLP | 646-912-7549 |
| 7. White & Williams, LLP | 215-864-7000 |
| 8. J. Wright Leonard, BCFE, CDE | 215-735-4000 |

Address

1. 75 Broad Street, Milford, Ct 06460
2. 185 Asylum Street. Hartford, CT 06103
3. 62 West Street, Litchfield, CT 06759

4. 700 state Street Suite 100, New Haven, CT 06511
5. 31 Cherry Street Suite 1000, Milford, Ct 06460
6. 675 Third Avenue, New York, NY 10017
7. 1650 Market Street, One Liberty Place Suite 1800, Philadelphia, PA 19103

8. 1500 Walnut street# m12, Philadelphia, PA 19102

Services Provided		BHCC	BM	
1. All labor matters	\$118,077	66536	51541	
2. State legal matters, protection nursing home info	3,121	1759	1362	
3. IRS Tax Appeals	8,255	4652	3603	
4. Legal Fees (Pension}	1,751	987	764	
5. Legal Fees general labor matters	7,350	4142	3208	
6. Partnership issues	1,150	648	502	Disallowed
7. Legal fees (Ram Case} Working Capital Loans	21,800	12284	9516	
8. Legal services (Ram Case} Working Capital Loans	1,800	1014	786	
	\$163,304	92022	71282	

Schedule of Resident Statistics

Name of Facility BRIDGEPORT HEALTH CARE CENTER INC	License No. 2061C		Report for Year Ended 9/30/2017				Page 8	of 37
	Total All Levels	Total CCNH Level	Total RHNS Level	Period 10/1 Thru 6/30		Period 7/1 Thru 9/30		
				Total	CCNH	RHNS	(Specify)	Total
1. Certified Bed Capacity								
A. On last day of PREVIOUS report period	300	300		300		300	300	
B. On last day of THIS report period	300	300		300		300	300	
2. Number of Residents								
A. As of midnight of PREVIOUS report period	194	194		194		196	196	
B. As of midnight of THIS report period	193	193		196		193	193	
3. Total Number of Days Care Provided During Period								
A. Medicare	3,719	3,719		2,838		881	881	
B. Medicaid (Conn.)	65,662	65,662		49,311		16,351	16,351	
C. Medicaid (other states)								
D. Private Pay	2,201	2,201		1,741		460	460	
E. State SSI for RCH								
F. Other (Specify)								
G. Total Care Days During Period (3A thru F)	71,582	71,582		53,890		17,692	17,692	
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds								
A. Medicaid Bed Reserve Days	17	17		10		7	7	
B. Other Bed Reserve Days	37	37		37				
5. Total Resident Days (3G + 4A + 4B)	71,636	71,636		53,937		17,699	17,699	

Schedule of Resident Statistics (Cont'd)

Name of Facility BRIDGEPORT HEALTH CARE CENTER			License No. 2061C			Report for Year Ended 9/30/2017			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		181		5								
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								3,902	3,902				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								2,867	2,867				
C. Other								724	724				
D. Total Physical Therapy Treatments								7,493	7,493				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								289	289				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								409	409				
C. Other								89	89				
D. Total Speech Therapy Treatments								787	787				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								2,548	2,548				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								1,990	1,990				
C. Other								751	751				
D. Total Occupational Therapy Treatments								5,289	5,289				

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
BRIDGEPORT HEALTH CARE CENTER INC	2061C	9/30/2017	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	136,488	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	222,178	2,807				
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	333,031	20,565				
5. Dietary Service						
a. Head Dietitian	40,017	2,080				
b. Food Service Supervisor	151,375	7,215				
c. Dietary Workers	502,197	42,715				
6. Housekeeping Service						
a. Head Housekeeper	87,843	4,064				
b. Other Housekeeping Workers	557,260	54,625				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	57,341	2,733				
b. Other Maintenance Workers	113,938	6,577				
8. Laundry Service						
a. Supervisor	30,229	1,535				
b. Other Laundry Workers	80,571	7,499				
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	204,760	4,160				
b. RN						
1. Direct Care	1,140,745	32,994				
2. Administrative**						
c. LPN						
1. Direct Care	2,037,780	83,805				
2. Administrative**						
d. Aides and Attendants	3,438,852	247,287				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	152,762	9,057				
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	86,483	4,144				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	9,373,850	535,942				

* 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 BRIDGEPORT HEALTH CARE CENTER INC			License No. 2061C	Report for Year Ended 9/30/2017		Page 11	of 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 8,940				Bridgeport Manor		
Rachel Blass			Health Ins 10,484				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) BRIDGEPORT HEALTH CARE CENTER INC	License No. 2061C		Report for Year Ended 9/30/2017		Page 12	of 37				
	CCNH	RHNS (Specify)	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
Section III - Administrators***										
Christopher Massaro	136,488				2,080	A.2				
Section IV - Assistant Administrators										
Chaim Stern	145,239			Asst Administrator	1,404	A.3	Rosegarden, Bridgeport Manor	1,087	112,505	
Joseph Stern	76,939			Asst Administrator	1,403	A.3	Bridgeport Manor, Carlton, Rosegarden	1,087	59,599	

*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	License No.	Report for Year Ended	Page	of		
BRIDGEPORT HEALTH CARE CENTER INC	2061C	9/30/2017	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	105,284	2,201				
2. Dentist	12,000	180				
3. Pharmacist	32,976	824				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	253,171	4,132				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	36,000	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	21,909	481				
b. Other						
10. Occupational Therapist						
a. Resident Care	213,128	4,411				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	4,455	74				
2. Administrative***						
b. LPN						
1. Direct Care	822	27				
2. Administrative***						
c. Aides	566,637	25,353				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	1,246,382	38,043				

* 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 9/30/2017	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"/>	Children of Shareholder		
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"/>			
St Vincents Medical Center 2800 Main Street Bridgeport CT 06001	Speech Therapy	<input type="radio"/>	<input checked="" type="radio"/>			
BPT Hospital 267 Grant St Bridgeport CT 06610	Speech Therapy	<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"/>			
LTC Management 174 Scott Rd Prospect CT 06712	Dentist	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input 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	9/30/2017	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 609,729	609,729		
2. Disability Insurance	\$ 62,806	62,806		
3. Unemployment Insurance	\$ 117,182	117,182		
4. Social Security (F.I.C.A.)	\$ 708,285	708,285		
5. Health Insurance	\$ 2,815,283	2,815,283		
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 11,233	11,233		
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 369,434	369,434		
8. Uniform Allowance	\$ 17,837	17,837		
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*	\$			
d. Accounting and Auditing	\$ 64,126	64,126		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 92,022	92,022		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 39,439	39,439		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 17,479	17,479		
2. Cellular Phones	\$ 10,891	10,891		
i. Appraisal (<i>Specify purpose and attach copy</i>)* Working Capital	\$ 9,861	9,861		
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 141	141		
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	\$ 1,095,291	1,095,291		
Subtotal	\$ 6,041,039	6,041,039		

* 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	9/30/2017	16	37
Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	6,041,039	6,041,039		
l. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$			
3. Gifts to Staff and Residents	\$ 5,193	5,193		
4. Employee Travel	\$ 4,317	4,317		
5. Education Expenses Related to Seminars and Conventions	\$ 4,269	4,269		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 22,146	22,146		
7. Other (<i>Specify</i>) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 2,418	2,418		
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	\$ 2,550	2,550		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 1,113	1,113		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$			
10. Contributions*** See Attached Schedule	\$ 2,958	2,958		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 106,360	106,360		
12. Administrative Management Services**	\$			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 936,602	936,602		
C-14 Total Administrative & General Expenditures	\$ 7,128,965	7,128,965		

* 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)
Secretary Of State	\$ 56		
Costco	\$ 101		
CT Assoc Health Care Facilities	\$ 451		
Dept of Consumer Protection	\$ 23		
Credit Cards	\$ 420		
Amazon	\$ 62		
Total Dues	\$ 1,113	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Kars 4 Kids	\$ 592		
Yeshiva Tzemach Tzedek	\$ 2,029		
Yeshiva Bais Binyomin 56 Talmudic Institute Of Connecticut 281	\$ 337		
Total Contributions	\$ 2,958	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Charges	\$ 266,644		
Licenses	\$ 1,898		
Non Reimbursable	\$ 668,060		
Total Other Administrative and General	\$ 936,602	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility BRIDGEPORT HEALTH CARE CENTE	License No. 2061C	Report for Year Ended 9/30/2017	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		License No.	Report for Year Ended	Page	of
BRIDGEPORT HEALTH CARE CENTER INC		2061C	9/30/2017	18	37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$	602,979	602,979		
2. Non-Food Supplies	\$	205,457	205,457		
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)		\$	808,436	808,436	
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals:	Total no. of meals served per day:*	3	3		
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 BRIDGEPORT HEALTH CARE CENTER INC		License No. 2061C	Report for Year Ended 9/30/2017	Page 19	of 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. \$	258,586	258,586		
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 (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$				
c. Management Services**	\$				
d. Other (<i>Specify</i>)	\$				
3E. Total Laundry Expenditures (3a + b + c + d)	\$	258,586	258,586		
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	9/30/2017		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. \$	284,773	284,773		
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)		\$ 284,773	284,773		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy		\$			
	2. Purchased from		\$ 168,602	168,602		
b.	Medicine Cabinet Drugs		\$ 25,570	25,570		
c.	Medical and Therapeutic Supplies		\$ 513,456	513,456		
d.	Ambulance/Limousine***		\$			
e.	Oxygen					
	1. For Emergency Use		\$			
	2. Other***		\$ 32,795	32,795		
f.	X-rays and Related Radiological Procedures***		\$ 8,996	8,996		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)		\$			
h.	Laboratory***		\$ 9,876	9,876		
i.	Recreation		\$ 44,385	44,385		
j.	Other (Specify)**** See Attached Schedule		\$ 24,421	24,421		
5K.	Total Resident Care Expenditures (5a - 5j)		\$ 828,101	828,101		

* 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	\$ 213		
IV Supplies	\$ 14,865		
EKG	\$ 561		
Wound Care	\$ 8,782		
Total Other Resident Care	\$ 24,421	\$ -	\$ -

**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 9/30/2017	Page of 21 37						
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	(Specify)	Pg	Line
		Yes	No							
ADL Data System	9 Skyline Dr Hawthorne NY 10532	<input type="radio"/>	<input checked="" type="radio"/>		Computer Software Maintenance	40,118			16	11
Smartlinx Solutions	7271-A Investment Dr N Charleston SC 29418	<input type="radio"/>	<input checked="" type="radio"/>		Payroll and Time Clock Maintenance	24,840			16	11
Kone Elevator	16 Old Forge Road Rocky Hill CT 06067	<input type="radio"/>	<input checked="" type="radio"/>		Elevator Maintenance	37,831			22	6.f
Fire Protection	1701 Highland Ave Cheshire CT 06410	<input type="radio"/>	<input checked="" type="radio"/>		Fire System	11,425			22	6.f
Interstate Fire & Safety	PO Box 502 Harrison NY 10528	<input type="radio"/>	<input checked="" type="radio"/>		Fire Safety	8,473			22	6.f
Winter Bros	307 White St Danbury CT 06810	<input type="radio"/>	<input checked="" type="radio"/>		Trash Removal	38,657			22	6.f
Securitas	1 New Haven Ave Milford CT 06460	<input type="radio"/>	<input checked="" type="radio"/>		Security	73,677			22	6.f
Ilkes Exterminating	104 Norben Road Monsey NY 10952	<input type="radio"/>	<input checked="" type="radio"/>		Pest Control	8,749			22	3.b
Accountemps	2 Corporate Dr Ste 750, Shelton, CT 06484	<input type="radio"/>	<input checked="" type="radio"/>		Employee Service	15,504			16	11
James Rindfleisch	2952 Seneca St West Seneca NY 14224	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Service	9,016			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 II	2061C	9/30/2017			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 150,349	150,349				
b. Heat	\$ 185,464	185,464				
c. Light & Power	\$ 293,713	293,713				
d. Water	\$ 136,225	136,225				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 22,459	22,459				
f. Other (<i>itemize</i>)	\$ 197,050	197,050				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 985,260	985,260				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 147,322	147,322				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 147,322	147,322				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 173,150	173,150				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 173,150	173,150				
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	\$ 374,425	374,425				
c. Personal property taxes	\$ 44,578	44,578				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,406,141	1,406,141				

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

Depreciation Schedule

Name of Facility BRIDGEPORT HEALTH CARE CENTER INC		License No. 2061C	Report for Year Ended 9/30/2017				Page 23	of 37	
Property Item		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. Land Improvements									
1. Acquired prior to this report period		594,289							
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
A-4. Subtotal									
B. Building and Building Improvements									
1. Acquired prior to this report period		6,834,318							
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
B-4. Subtotal									
C. Non-Movable Equipment									
1. Acquired prior to this report period		215,445		215,445	215,445				
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Movable Equipment									
1. Motor Vehicles (Specify name, model and year of each vehicle)									
a. Schedule Attached									
b. Chevrolet Silverado		88,670		88,670	65,431	SL	5 yrs	5,496	
c. Ford E350		13,679		13,679	13,679	SL	5 yrs		
d. Laundry Truck		14,117		14,117	12,941	SL	5 yrs	1,177	
2. Movable Equipment		5,517		5,517	4,321	SL	5 yrs	1,104	
a. Acquired prior to this report period		2,608,929		2,608,929	1,899,623	S/L	Various	136,732	
b. Disposals (attach schedule)									
c. Acquired during this report period (attach schedule)				93,595		S/L	Various	2,813	
D-3. Subtotal									147,322
E. Total Depreciation									147,322

BRIDGEPORT HEALTH CARE CENTER INC
9/30/2017

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:				
12/31/2016	Water Fountain	\$ 1,558	5	\$ 234
1/31/2017	Furniture	\$ 44,757	15	\$ 1,989
5/31/2017	Air Conditioning	12154	10	405
5/31/2017	Ice Machine	2769	5	185
9/30/2017	Beds	32357	10	
Total additions for Movable Equipment		\$ 93,595		\$ 2,813 *
Deletions:				
Total deletions for Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/10/2016	Boiler	\$ 53,365	20	\$ 2,668
12/31/2016	Alarm Panel	\$ 4,392	10	\$ 329
1/31/2017	Renovations	12720	15	565
3/31/2017	Air Conditioning	72751	15	2425
7/31/2017	Sprinklers	13600	15	151
Total additions for Leasehold Improvement		\$ 156,828		\$ 6,138 *
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
8/27/2002	Infinity	54058	5yrs	0
1/10/2003	Toyota Avalon	33036	5yrs	0
7/21/2005	Toyota Avalon Disposed	0	5yrs	1675
1/30/2009	Cadillac	43666	5yrs	0
12/30/2012	Lexus	46580	5yrs	9316
Total		177340		10991
50.00% Bridgeport Health Care		88670		5496
50.00% Bridgeport Manor		88670		5496
Total		177340		10991

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

Name of Facility BRIDGEPORT HEALTH CARE CEN	License No. 2061C	Report for Year Ended 9/30/2017	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	300				
6. Square Footage	169,208				
7. Acquisition Cost					
a. Land					
b. Building					
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)	Variable				
b. Date Mortgage Obtained	08/28/07				
c. Interest Rate for the Cost Year	8.78%				
d. Term of Mortgage (number of years)	15				
e. Amount of Principal Borrowed	5.5m				
f. Principal balance outstanding as of	2,111,268				
Complete if Mortgage was Refinanced During Current Cost Year					
g. Type of Financing (e.g., fixed, variable)					
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
l. Principal Outstanding on Note Paid-Off					
Part C - Arms-Length Leases for Real Property Improvements Only					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
BRIDGEPORT HEALTH CARE CEN		2061C	9/30/2017		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 BRIDGEPORT HEALTH CARE C		License No. 2061C		Report for Year Ended 9/30/2017		Page 27	of 37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$ 82	82		
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$ 82	82		
12. D. Other Interest Expense (Specify) Insurance, Credit Lines, Late Fees, Working Capital				\$ 691,649	691,649		
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$ 691,731	691,731		
14. Insurance							
a. Insurance on Property (buildings only)				\$ 30,100	30,100		
b. Insurance on Automobiles				\$ 16,531	16,531		
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$ 59,190	59,190		
2. Fire and Extended Coverage				\$			
3. Other (Specify) Package, Pension, EPLI, Patient Fund				\$ 128,282	128,282		
14d. Total Insurance Expenditures (14a + b + c)				\$ 234,103	234,103		
15. Total All Expenditures (A-13 thru C-14)				\$ 23,246,328	23,246,328		

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
BRIDGEPORT HEALTH CARE CENTER INC				2061C	9/30/2017	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.			Bad Debts	\$			
10.	15	1d &	Accounting & Legal	\$ 1,747	1,747		
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	1j	Income Tax / Corporate Business Tax	\$ 141	141		
20.	16	m 10	Fund Raising / Contributions	\$ 2,958	2,958		
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 677,570	677,570		
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)				\$ 682,416	682,416		

* 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	\$ 668,060		
16	12	Travel	\$ 4,317		
16	13	Patient Expense	\$ 387		
16	13	Other Employee Service	4806		
Total Other A&G Adjustments			\$ 677,570	\$ -	\$ -

Annual Report of Long-Term Care Facility

CSP-29 Rev. 10/2006

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	9/30/2017	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 682,416	682,416		
Page 20 - Resident Care Supplies ***							
27.	20	5 a 2	Prescription Drugs	\$ 168,602	168,602		
28.			Ambulance/Limousine	\$			
29.	20	5 f	X-rays, etc	\$ 8,996	8,996		
30.	20	5 h	Laboratory	\$ 9,876	9,876		
31.	20	5 e 2	Medical Supplies	\$ 1,349	1,349		
32.			Oxygen (non emergency)	\$ 32,795	32,795		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 49,991	49,991		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.	22	7 d	Depreciation on Unallowable Motor Vehicles	\$ 5,496	5,496		
37.	22	10 c	Unallowable Property and Real Estate Taxes	\$ 1,381	1,381		
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 27,358	27,358		
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)			\$ 988,260	988,260		

*** 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.

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	9/30/2017	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 681,768	681,768		
Page 20 - Resident Care Supplies***							
27.	20	5 a 2	Prescription Drugs	\$ 168,602	168,602		
28.			Ambulance/Limousine	\$			
29.	20	5 f	X-rays, etc	\$ 8,996	8,996		
30.	20	5 h	Laboratory	\$ 9,876	9,876		
31.	20	5 e 2	Medical Supplies	\$ 1,349	1,349		
32.			Oxygen (non emergency)	\$ 32,795	32,795		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 49,991	49,991		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.	22	7 d	Depreciation on Unallowable Motor Vehicles	\$ 5,496	5,496		
37.	22	10 c	Unallowable Property and Real Estate Taxes	\$ 1,381	1,381		
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 27,358	27,358		
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)			\$ 987,612	987,612		

*** 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
9/30/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5 j	PT Supplies	\$ 213		
20	5 j	IV Supplies	\$ 14,865		
20	5 j	EKG	\$ 561		
20	5 j	Wound Care	\$ 8,782		
20	5 b	Emergency Replacement Box	\$ 25,570		
Total Other Ancillary Costs			\$ 49,991	\$ -	\$ -

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 Insurance	\$ 10,181		
16	1 6	Auto Expense	\$ 17,177		
Total Other Property Adjustments			\$ 27,358	\$ -	\$ -

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 CENTE	2061C	9/30/2017		30	37
Item	Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 18,920,210	18,920,210			
b. Medicaid Room and Board Contractual Allowance **	\$ (2,966,906)	(2,966,906)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,365,279	1,365,279			
b. Medicare Room and Board Contractual Allowance **	\$				
4. a. Private-Pay Residents and Other	\$ 763,484	763,484			
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	\$ 370,174	370,174			
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$ 30,145	30,145			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$ 26,711	26,711			
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$ 1,135	1,135			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 356,597	356,597			
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$ 33,065	33,065			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other (<i>Specify</i>) - Medicare	\$ (42,107)	(42,107)			
b. Other (<i>Specify</i>) - Non-Medicare	\$ 23,367	23,367			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 18,881,154	18,881,154			
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>)	\$ (11,937)	(11,937)			
V. Total Other Revenue (1 thru 8)	\$ (11,937)	(11,937)			
VI. Total All Revenue (III +V)	\$ 18,869,217	18,869,217			

* 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)
	Part B Contractual Allowance	\$ (42,107)		
Total Other Resident Revenue - Medicare		\$ (42,107)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
20 5h	Insurance-Lab	\$ 23,367		
Total Other Resident Revenue		\$ 23,367	\$ -	\$ -

Interest Income

Account

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

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
31 B7	Loss on auto	\$ (4,841)		
	Other income Non Reimbursable	\$ (7,096)		
Total Other Revenue		\$ (11,937)	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
BRIDGEPORT HEALTH CARE CEN	2061C	9/30/2017	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	7,464
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,932,036
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	139,524
a. Prepaid Insurance	44,814			
b. Prepaid Taxes	93,526			
c. Prepaid Auto Expense	1,184			
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)			\$	2,079,024
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>6,936,102</u>		\$	3,197,232
	Accum. Depreciation <u>3,738,870</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>2,702,524</u>		\$	663,356
	Accum. Depreciation <u>2,039,168</u>	Net		
7. Motor Vehicles	*Historical Cost <u>121,983</u>		\$	17,834
	Accum. Depreciation <u>104,149</u>	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

B-10. Total Fixed Assets (Lines B1 thru 9)			\$	3,878,422

* 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 CEN	2061C	9/30/2017	32	37
Account			Amount	
Total Brought Forward:			\$	5,957,446
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			
	Accum. Depreciation		Net	\$
5. Movable Equipment				
	*Historical Cost			
	Accum. Depreciation		Net	\$
6. Motor Vehicles				
	*Historical Cost			
	Accum. Depreciation		Net	\$
7. Minor Equipment-Not Depreciable				
				\$
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	7,428,607
D. Investment and Other Assets				
1. Deferred Deposits				
				\$
2. Escrow Deposits				
				\$
3. Organization Expense				
	*Historical Cost			
	Accum. Depreciation		Net	\$
4. Goodwill (Purchased Only)				
				\$
5. Investments Related to Resident Care (<i>itemize</i>)				
				\$
6. Loans to Owners or Related Parties (<i>itemize</i>)				
				\$ 526,375
Name and Address		Amount	Loan Date	
Rosegarden Health Care		526,375		
7. Other Assets (<i>itemize</i>)				
				\$ 82,155
Security Deposits			443	
			81,712	
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	608,530
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	13,994,583

* 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 IN		2061C	9/30/2017	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	6,608,135
2. Notes Payable (<i>itemize</i>)				\$	639,314
Citibank					7,500
Omicare					173,951
Yale New Haven					201,794
Working Capital					256,069
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	1,218
Name of Lender		Purpose	Amount	Date Due	
Lexus Auto Finance		Auto Loan	1,218		
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	870,756
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	2,227,783
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>)				\$	592,234
Accrued Water					10,307
Accrued Audit					8,750
Accrued Audit					572,422
Patient Funds					755
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	10,939,440

* 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		License No. 2061C	Report for Year Ended 9/30/2017	Page 34	of 37
Account				Amount	
Total Brought Forward:				10,939,440	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					
				\$	1,167,305
Name of Lender	Purpose	Amount	Date Due		
Peoples Bank	Sprinkler/Working Capital	1,167,305			
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$	2,668,025
Name and Address of Lender	Amount	Loan Date			
Bridgeport Realty	2,163,382				
	504,643				
4. Other Long-Term Liabilities (<i>itemize</i>)				\$	966,888
Citibank		28,893			
Towne Nursing		937,995			
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$	4,802,218
C. Total All Liabilities (Lines A-13 + B-5)				\$	15,741,658

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

Name of Facility	License No.	Report for Year Ended	Page	of
BRIDGEPORT HEALTH CARE CEN	2061C	9/30/2017	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			\$	(5,183,481)
6. Gain or Loss for Period				
	10/1/2016	thru	9/30/2017	
			\$	(4,377,111)
7. Total Net Worth			\$	(9,175,682)
C. Total Reserves and Net Worth			\$	(1,747,075)
D. Total Liabilities, Reserves, and Net Worth			\$	13,994,583

H. Changes in Total Net Worth

Name of Facility BRIDGEPORT HEALTH CARE CENT	License No. 2061C	Report for Year Ended 9/30/2017	Page 36	of 37	
Account			Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2016			\$	(4,954,144)	
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	18,869,217	
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	23,246,328	
D. Net Income or Deficit			\$	(4,377,111)	
E. Balance			\$	(9,331,255)	
F. Additions					
1. Additional Capital Contributed (<i>itemize</i>)					
Balance Adjustment	155,573				
2. Other (<i>itemize</i>)					
F-3. Total Additions					\$
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			\$	(9,175,682)	

I. Preparer's/Reviewer's Certification

Name of Facility BRIDGEPORT HEALTH CARE		License No. 2061C	Report for Year Ended 9/30/2017	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 <i>Asst</i>		Date Signed <i>2/15/18</i>	
Printed Name of Preparer Burg & Weingarten CPA PC					
Address 149-12 83rd Street Howard Beach NY 11414				Phone Number 718-845-6141	