State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2021

Name of Facility (as licensed) Bickford Health Care Center	
Address (No. & Street, City, State, Zip Code) 14 Main Street, Windsor Locks, CT 06096	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)	
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2021	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 Bickford Health Care Center [facility name], for the cost report period beginning October 1, 2020 and ending September 30, 2021, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

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

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Bickford Health Care Center	Period Covered:		From 10/1/2020	To 9/30/2021
Address of Facility 14 Main Street, Windsor Locks, CT 06096				
Report Prepared By Laydon and Company, LLC	Phone Number 203-799-1040		Date	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
(860) 623-4351	9/30/2021	2	37

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

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

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Elaine Thompson Madden	1134

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

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

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

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

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

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Paul Bobbitt	14 Main St. Windsor Locks, CT 06096	President	None
Louis Galli	14 Main St. Windsor Locks, CT 06096	President/Treas	None
Robert Sproat	14 Main St. Windsor Locks, CT 06096	Directors	None
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

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

Owner(s) of Facility
n/a

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General Information and Questionnaire
Related Parties*

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Somerset Health Care Management Group, LLC	PO Box 238 Granby, CT 06035	⊙	○		Provides Mgt Services, Administrator is rela	P 16 L m12	148,200	148,200
Somerset Health Care Management Group, LLC	PO Box 238 Granby, CT 06035	⊙	○		Group Purchasing of Liab/Prof Ins	P 27 L 14a	84,944	84,944
Somerset Health Care Management Group, LLC	PO Box 238 Granby, CT 06035	⊙	○		Group Purchasing of D&O Insurance	P 27 L 14c3	12,991	12,991
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.
** Provide the percentage amount of revenue received from non-related parties.

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General Information and Questionnaire
Basis for Allocation of Costs

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

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

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

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

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

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

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

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

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

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General Information and Questionnaire
Accounting Basis

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Laydon and Company, LLC	PO Box 945, Orange, CT 06477
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Monthly Accounting, Cost Reports, Annual Reviewed Financial Statements and Tax return, COVID funding reporting	$ 63,455
2		$
3		$
4		$
		Charge for Services Provided $ 63,455

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 Feldman, Perlstein & Greene, LLC	(203) 677-0551
2 Cicheiell & Cichiello, LLP	(860) 296-3457
3 Skoler, Abbott * Presser, PC	(413) 737-4753
4 Joseph A. Vatalie at Law	(203) 439-0602
5 Updike, Kelley & Spellacy, PC	(860)548-2600

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

1 10 Waterside Drive, Suite 303, Farmington, CT 06032
2 364 Franklin Avenue, Hartford, CT 06114
3 One Monarch Place, Suite 2000, Springfeild, MA 01144
4 575 Highland Avenue, Cheshire CT 06410
5 100 Peart St, PO Box 231277, Hartford, CT 06123-1277

Services Provided by This Firm (*describe fully*)

1		$
2		$
3		$
4		$
5		$
		Charge for Services Provided $

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

⊙ Yes ○ No Page 15 Line 1e

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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					Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	48	48			48	48						
B. On last day of THIS report period	48	48							48	48		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	26	26			26	26						
B. As of midnight of THIS report period	29	29							29	29		
3. Total Number of Days Care Provided During Period												
A. Medicare	984	984			891	891			93	93		
B. Medicaid (Conn.)	6,931	6,931			5,085	5,085			1,846	1,846		
C. Medicaid (other states)												
D. Private Pay	2,099	2,099			1,417	1,417			682	682		
E. State SSI for RCH												
F. Other (Specify) Hospice	568	568			454	454			114	114		
G. Total Care Days During Period (3A thru F)	10,582	10,582			7,847	7,847			2,735	2,735		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	10,582	10,582			7,847	7,847			2,735	2,735		

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Schedule of Resident Statistics (Cont'd)

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

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	3	21		5				
Per Diem Rate								
a. One bed rm.				356.00				
b. Two bed rms.	621.00	226.00		343.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	707	707		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	1,458	1,458		
D. ***Total Physical Therapy Treatments***	2,165	2,165		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	54	54		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	65	65		
D. ***Total Speech Therapy Treatments***	119	119		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	289	289		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	1,265	1,265		
D. ***Total Occupational Therapy Treatments***	1,554	1,554		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2021	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. of Schedule A1)						
2. Administrator(s) (Complete also Sec. II of Schedule A1)	96,742	2,157				
3. Assistant Administrator (Complete also Sec. I of Schedule A1)						
4. Other Administrative Salaries (telephon operator, clerks, receptionists, etc.	149,343	6,829				
5. Dietary Service						
a. Head Dietitian	9,182	204				
b. Food Service Supervisor	44,742	2,067				
c. Dietary Workers	144,647	10,984				
6. Housekeeping Service						
a. Head Housekeeper	33,338	2,353				
b. Other Housekeeping Workers	10,520	836				
7. Repairs & Maintenance Service						
a. Engineer or Chief of Maintenanc						
b. Other Maintenance Workers	58,481	3,220				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	27,406	2,185				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Resident						
a. Directors and Assistant Director of Nurses	125,495	2,871				
b. RN						
1. Direct Care	231,806	7,159				
2. Administrative**	62,979	2,101				
c. LPN						
1. Direct Care	169,176	6,902				
2. Administrative**						
d. Aides and Attendants	379,644	25,180				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	59,659	3,474				
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	40,003	1,519				
n. Marketing						
o. Other (Specify)						
See Attached Schedule						
A-13. Total Salary Expenditures	1,643,163	80,041				

* 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 ba

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2021	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Sarah H Thiede	96,742			Vacation & sick time	Responsible for daily operations	2,157	A2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2021	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist	2,688					
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	53,894					
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	11,934					
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	14,447					
b. Other						
10. Occupational Therapist						
a. Resident Care	40,749					
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	144,370					
2. Administrative***						
b. LPN						
1. Direct Care	91,841					
2. Administrative***						
c. Aides	869					
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	360,792					

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2021	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Prime Healthcare PC, 30 Jordan Lane, Wethersfield, CT 06109	Medical Director	○	⊙	
George Donahue MD, 150 Hazard Ave, Enfield, CT 06082	Medical Director	○	⊙	
Preferred Pharmacy Solutions 35 Arco Rd, Haverhill, MA 01835	Pharmacy Consultant	○	⊙	
WoodMark Pharmacy, 1142 Wehrle Drive, Williamsville, NY 14221	Pharmacy Consultant	○	⊙	
Fusion Rehab Services, LLC, 2389 Main St, Glastonbury, CT 06033	Therapy Services	○	⊙	
Encore Rehabilitaion Services, P.O. Box 933195, Cleveland, OH 44193	Therapy Services	○	⊙	
Caring Nurses, LLC, 107 Old Windsor Road, 2nd Floor, Bloomfield, CT 06002	Nursing Pool - RN & LPN	○	⊙	
IntelyCare, Inc, PO Box 200413, Pittsburgh, PA 15251-0413	Nursing Pool - RN & LPN	○	⊙	
Medical Solutions, LLC, PO Box 310737, Des Moines, IA 50331	Nursing Pool - RN	○	⊙	
Norton and Associaties, Inc , 97 Elm Street, Cohasset, MA 02025	Nursing Pool - RN , LPN & CNA	○	⊙	
Professional Nursing Services, 27 Siemon Company Drive, Suite 228 W, Watertown, CT	Nursing Pool - RN & LPN	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2021	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	48,086	48,086		
2. Disability Insurance	$				
3. Unemployment Insurance	$	20,706	20,706		
4. Social Security (F.I.C.A.)	$	124,291	124,291		
5. Health Insurance	$	16,742	16,742		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$				
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	294	294		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	33,051	33,051		
d. Accounting and Auditing	$	63,455	63,455		
e. Legal (*Services should be fully described on Page 7)*	$	28,100	28,100		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	4,947	4,947		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	3,124	3,124		
2. Cellular Phones	$	89	89		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	202,023	202,023		
Subtotal	$	544,908	544,908		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Misc. Employee Benefit	$ 69		
Employee Covid Testing	$ 225		
Total	$ 294	$ -	$ -

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2021	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		544,908	544,908		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	3,439	3,439		
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	266	266		
5. Education Expenses Related to Seminars and Conventions	$	485	485		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	81	81		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	235	235		
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	$	1,385	1,385		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$				
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions***	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	37,893	37,893		
12. Administrative Management Services**	$	148,200	148,200		
13. Other (*Specify*)	$	68,260	68,260		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	805,152	805,152		

* 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)
Supp & Exp - Marketing	$ 235		
Total Other Advertising	$ 235	$ -	$ -

Schedule of Dues

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

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Admin - Purchased Service	$ 29,719		
Bank Charges	$ 3,819		
Late Charges	$ 1,124		
Fines & Penalties	$ 29,250		
Misc. Expense	$ 50		
Lic & Dues - Pt Related	$ 680		
Lic & Dues - Non Pt Related	$ 691		
Rental House Expense	$ 2,927		
Total Other Administrative and General	$ 68,260	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Bickford Health Care Center	License No. 2178-C	Report for Year Ended 9/30/2021	Page 17 | of 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Somerset Health Care Management Group	148,200	Manage Facility including contract negotiations, plant, financial oversight and group purchasing of insurance	Page 16 Line m12

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Bickford Health Care Center	2178-C	9/30/2021	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	59,879	59,879		
2. Non-Food Supplies	$	10,704	10,704		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	70,583	70,583		

2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F. Resident Meals:	Total no. of meals served per day:*	87	87		

G.	Is cost of employee meals included in 2D?	⦿ Yes	○ No		
H.	Did you receive revenue from employees?	⦿ Yes	○ No	If yes, specify amt.	$2,289
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				P 18 L2a1
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	○ Yes	⦿ No	If yes, specify cost.	
K.	Is any revenue collected from these people?	○ Yes	⦿ No	If yes, specify amt.	
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	○ Yes	⦿ No	If yes, specify cost.	
N.	Is any revenue collected from employees?	○ Yes	⦿ No	If yes, specify amt.	
O.	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.

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

Name of Facility	License No.	Report for Year Ended	Page of
Bickford Health Care Center	2178-C	9/30/2021	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	4,274	4,274		
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $	1,192	1,192		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)	$				
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	5,466	5,466		

3E.	Laundry Questionnaire			
F.	Is cost of employee laundry included in 3D?	○ Yes	⊙ No	If yes, specify cost.
G.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
H.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	
I.	Is Cost of laundry provided to persons other than employees or residents included in 3D?	○ Yes	⊙ No	If yes, specify cost.
J.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
K.	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 3D.

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2021	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	24,103	24,103		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	24,103	24,103		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Outside Pharmacy		$	39,288	39,288		
b. Medicine Cabinet Drugs		$	2,241	2,241		
c. Medical and Therapeutic Supplies		$	69,815	69,815		
d. Ambulance/Limousine***		$	2,152	2,152		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	8,487	8,487		
f. X-rays and Related Radiological Procedures***		$	3,101	3,101		
g. Dental (*Not dentists who should be included under salaries or fees)*		$	5,472	5,472		
h. Laboratory***		$	3,185	3,185		
i. Recreation		$	16,488	16,488		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	635	635		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	150,864	150,864		

* 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)
Outpatient Expenses	$ 635		
Total Other Resident Care	$ 635	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2021	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
LTC Billing Solutions	10 Maple Street, Westford, MA 01886	○	⊙		Billing Service	28,230		P16L1m13		
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Bickford Health Care Center	2178-C	9/30/2021	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	27,367	27,367		
b. Heat	$	20,391	20,391		
c. Light & Power	$	38,583	38,583		
d. Water	$	22,430	22,430		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	41,456	41,456		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	150,227	150,227		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	365	365		
b. Building & Building Improvements	$	144,751	144,751		
c. Non-Movable Equipment	$	4,700	4,700		
d. Movable Equipment	$	6,949	6,949		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	156,765	156,765		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	5,861	5,861		
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	5,861	5,861		
9. Rental payments on leased real property less real estate taxes included in item 10b	$				
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	162,626	162,626		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Maintenance Contract	$ 540		
Purch Serv - Plant	$ 24,817		
Grounds Maintenance	$ 12,071		
Sprinkler & Fire Alarm Systems	$ 4,028		
Total Other Repairs and Maintenance	$ 41,456	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2021	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	5,469		5,469	3,647			365	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								365
B. **Building and Building Improvements**								
1. Acquired prior to this report period	3,931,458		3,931,458	3,099,466			144,589	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	2,436						162	
B-4. Subtotal								144,751
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	81,328		81,328	56,954			4,625	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	8,950						75	
C-4. Subtotal								4,700

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					537,421		537,421	513,604			6,949	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)												
D-3. Subtotal												6,949
E. ***Total Depreciation***												156,765

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:					
11/25/2020	Nurses station door	$ 595	10	$ 55	
3/10/2021	Coil in air handler replacement	$ 1,841	10	$ 107	
Total additions for Building Improvements		$ 2,436		$ 162	*
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:					
9/16/2021	Replace/install two new ejector pumps	$ 8,950	10	$ 75	
Total additions for Non-Movable Equipment		$ 8,950		$ 75	*
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:					
Total additions for Movable Equipment		$ -		$ -	*
Deletions:					
Total deletions for Movable Equipment		$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report period

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

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2021	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1. Organization Expense	6	96		800,000	358,333				
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1. Refinancing (New)	6	2018		26,373	20,512			5,861	
2.									
3.									
B-4. Subtotal									5,861
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									5,861

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2021	25	37

11. Property Questionnaire

Part A

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

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

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

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

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	05/17/18			
c. Interest Rate for the Cost Year	6.61%			
d. Term of Mortgage (number of years)	3			
e. Amount of Principal Borrowed	2,179,191			
f. Principal balance outstanding as of 9/30/21	1,928,893			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Bickford Health Care Center	2178-C	9/30/2021	26 | 37

Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$	132288	132,288		
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)	$	132,288	132,288		

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Bickford Health Care Center	2178-C	9/30/2021	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	132,288	132,288		
12. C. Movable Equipment				
1. Automotive Equipment $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*) $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
B. Item / Rate / Amount				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $				
12. D. Other Interest Expense (*Specify*) $	4,943	4,943		
PPP Loan				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	137,231	137,231		
14. Insurance				
a. Insurance on Property (buildings only) $	84,944	84,944		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $				
2. Fire and Extended Coverage $				
3. Other (*Specify*) $	12,991	12,991		
D&O $12991				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	97,935	97,935		
15. ***Total All Expenditures (A-13 thru C-14)*** $	3,608,142	3,608,142		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Bickford Health Care Center	2178-C	9/30/2021	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $	4,313	4,313		
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $	40,749	40,749		
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $	33,051	33,051		
10.			Accounting $				
10a.			Legal $				
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.			Unallowable Advertising * $	235	235		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $	93,000	93,000		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	1,123	1,123		
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) $	172,471	172,471		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
P10	A4	10 Marketing Allocation	$ 4,313		
Total Other Salaries Adjustment			$ 4,313	$ -	$ -

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	lm13	Late charges	$ 1,123		
Total Other A&G Adjustments			$ 1,123	$ -	$ -

Management Fees

2010	44,894	Allowable
CPI	1.0206	
2011	45,819	Allowable
	45,819	
CPI	1.0277	
2012	47,088	Allowable
	47,088	
CPI	1.0097	
2013	47,545	Allowable
	47,545	
CPI	1.0133	
2014	48,177	Allowable
	48,177	
CPI	0.9933	
2015	47,854	Allowable
	47,854	
CPI	1.0146	
2016	48,553	Allowable
	48,553	
CPI	1.0223	
2017	49,636	Allowable
	49,636	
CPI	1.0228	
2018	50,767	Allowable
	50,767	
CPI	1.0249	
2019	52,032	Allowable
	52,032	
CPI	1.0300	
2020	53,592	Allowable
	53,592	
CPI	1.0300	
2021	55,200	Allowable
Per page 16	148,200	
Disallowable	93,000	Page 28 Line 21

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

Name of Facility	License No.	Report for Year Ended	Page of
Bickford Health Care Center	2178-C	9/30/2021	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	172,471	172,471		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $	30,013	30,013		
28.			Ambulance/Limousine $	2,153	2,153		
29.			X-rays, etc $	1,964	1,964		
30.			Laboratory $	2,797	2,797		
31.			Medical Supplies $				
32.			Oxygen (non emergency) $	8,486	8,486		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $				
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $	24	24		
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Other - Indirect $				
43.			Interest Income on Account Rec. $				
44.			Other - Miscellaneous Administrative $				
45.			Management Fees Direct $				
46.			Management Fees Indirect $				
47.			Other - Direct $				
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
49. ***Total Amount of Decrease (Items 1 - 48)***			$	217,908	217,908		

*** 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	(Specify)
Total Other Ancillary Costs			$ -	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	6/1/11 Dishwasher and Fridge for Rental House	$ 24		
Total Excess Movable Equipment Depreciation			$ 24	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

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

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2021	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	2,406,257	2,406,257		
b. Medicaid Room and Board Contractual Allowance **	$	(961,944)	(961,944)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	292,912	292,912		
b. Medicare Room and Board Contractual Allowance **	$	215,759	215,759		
4. a. Private-Pay Residents and Other	$	944,217	944,217		
b. Private-Pay Room and Board Contractual Allowance **	$	(64,525)	(64,525)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	21,327	21,327		
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$	7,395	7,395		
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	$	68,079	68,079		
b. Physical Therapy - Medicare Contractual Allowance **	$	(8,650)	(8,650)		
c. Physical Therapy - Non-Medicare	$	18,823	18,823		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	6,943	6,943		
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$	4,580	4,580		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	50,026	50,026		
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$	13,043	13,043		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	(96,625)	(96,625)		
b. Other *(Specify)* - Non-Medicare	$	(36,433)	(36,433)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	2,881,184	2,881,184		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$	14,610	14,610		
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	715	715		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	1,567,847	1,567,847		
V. Total Other Revenue (1 thru 8)	$	1,583,172	1,583,172		
VI. Total All Revenue (III +V)	$	4,464,356	4,464,356		

* *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)
	Laboratory - Part A	$ 1,196		
	Contractual Adj Part A Ancil	$ (85,157)		
	Contractual Adj Sco-Part A Ancil	$ (12,664)		
Total Other Resident Revenue - Medicare		$ (96,625)	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Laboratory -Comm Ins	$ 116		
	laboratory - HMO	$ 385		
	Contractual Adj Comm Ins Ancillary	$ (6,844)		
	Contractual Adj Caid Ancill	$ (294)		
	Contractual Adj HMO Ancillary	$ (29,796)		
Total Other Resident Revenue		$ (36,433)	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Savings (3140)	113,659	$ 654		
	CT Care		$ 61		
Total Interest Income			$ 715	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Miscellaneous Income	$ 4,927		
	Unrestricted Donations	$ 200		
	HHS Stimulus Payment	$ 97,610		
	Forgiveness of Debt - PPP Loan	$ 443,896		
	Employee Retention Credit	$ 1,021,214		
Total Other Revenue		$ 1,567,847	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2021	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 166,660
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 655,851
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 6,411
5. Prepaid Expenses				$ 67,221
a. Prepaid Insurance		20,186		
b. Prepaid Expenses, Other		47,035		
c.				
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 1,022,765
Utility Deposits		1,550		
Employee Retention Credit Receivable		1,021,215		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,918,908
B. Fixed Assets				
1. Land				$ 150,000
2. Land Improvements	*Historical Cost	5,469		$ 1,457
	Accum. Depreciation	4,012	Net	
3. Buildings	*Historical Cost	3,933,894		$ 689,677
	Accum. Depreciation	3,244,217	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	90,278		$ 28,624
	Accum. Depreciation	61,654	Net	
6. Movable Equipment	*Historical Cost	537,421		$ 16,868
	Accum. Depreciation	520,553	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 886,626

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			$ -

Schedule of Other Current Assets (itemized) Page 31 Line A8

Page Ref	Line Ref	Description	
Total Other Current Assets (Itemize)			$ -

Schedule of Other Fixed Assets (Itemize) Page 31 Line B9

Page Ref	Line Ref	Description	
Total Other Other Fixed Assets (Itemize)			$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

Schedule of Other Current Liabilities (Itemize) Page 33 Line A12

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

Schedule of Other Long-Term Liabilities (Itemize) Page 34 Line B4

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2021	32	37

Account				Amount
			Total Brought Forward:	$ 2,805,534
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost	800,000		
	Accum. Depreciation	358,333	Net	$ 441,667
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 441,667
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 3,247,201

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2021	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 551,787
2. Notes Payable (*itemize*)	$
See Schedule	
3. Loans Payable for Equipment (*Current portion*) (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)	$ 173,163
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$
7. Medicare Final Settlement Payable	$
8. Medicare Current Financing Payable	$
9. Mortgage Payable (*Current Portion*)	$ 95,976
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)	$ 10,625
11. Accrued Income Taxes*	$
12. Other Current Liabilities (*itemize*)	$ 141,666

Accrued Expenses	56,740	Security Deposits	2,625
Medicaid User Fee Payable	56,523	Accrued Property Tax	732
Credit Balance Liabilities	6,691		
Residents Deposits	18,355	See Schedule	

A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 973,217

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2021	34	37

Account	Amount
Total Brought Forward:	973,217
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$ 1,832,917
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$
See Schedule	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 1,832,917
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 2,806,134

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

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2021	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (415,148)
	6. Gain or Loss for Period 10/1/2020 thru 9/30/2021	$ 856,215
	7. Total Net Worth	$ 441,067
C.	***Total Reserves and Net Worth***	$ 441,067
D.	***Total Liabilities, Reserves, and Net Worth***	$ 3,247,201

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2021	36	37

Account	Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2020	$ (415,148)
B. Total Revenue (*From Statement of Revenue Page 30*)	$ 4,464,356
C. Total Expenditures (*From Statement of Expenditures Page 27*)	$ 3,608,142
D. Net Income or Deficit	$ 856,215
E. Balance	$ 441,067
F. Additions	
1. Additional Capital Contributed (*itemize*)	
2. Other (*itemize*)	
F-3. Total Additions	$
G. Deductions	
1. Drawings of Owners/Operators/Partners (*Specify*)	$

Name and Address (*No., City, State, Zip*)	Title	Amount

2. Other Withdrawings *(Specify)*	$

Purpose	Amount

3. Total Deductions		$
H. ***Balance at End of Period***	09/30/21	$ 441,067

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Bickford Health Care Center	2178-C	9/30/2021	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Laydon and Company, LLC

Addres Address	Phone Number
PO Box 945, Orange, CT 06477	203-799-1040

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Elmer A. Laydon, CPA	203-799-1040

Contact Email Address
elaydon@laydoncpa.com