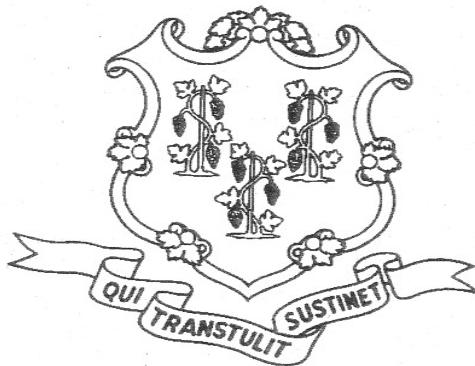


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2022

Name of Facility (as licensed) Farmington Rehab Center, LLC d/b/a Amberwoods of Farmington					
Address (No. & Street, City, State, Zip Code) 416 Colt Highway, Farmington, CT 06032					
Type of Facility					
Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)		Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS)		<input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2021		Report for Year Ending 9/30/2022			

License Numbers:	CCNH 2332	RHNS	(Specify)	Medicare Provider 07-5419
------------------	--------------	------	-----------	------------------------------

Medicaid Provider Numbers:	CCNH 9241	RHNS	ICF-IID
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### For Department Use Only

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

**General Information**

Name of Facility (as licensed) Farmington Rehab Center, LLC d/b/a Amberwoods of	License No. 2332	Report for Year Ended 9/30/2022	Page 1	of 37
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**Administrator's/Owner's Certification**

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Farmington Rehab Center, LLC d/b/a Amberwoods of Farmington [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, 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.

\*\*Subject to Desk Review audit

Signed (Administrator)	Date	Signed (Owner)	Date	
Printed Name (Administrator) Renata Cocoza		Printed Name (Owner) Moshe Bernstein		
Subscribed and Sworn to before me:	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public				

(Notary Seal)

# 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
<b>A. Report of Expenditures - Salaries &amp; Wages</b>	<b>10</b>
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>B. Report of Expenditures - Professional Fees</b>	<b>13</b>
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
<b>C. Expenditures Other than Salaries - Administrative and General</b>	<b>15</b>
<b>C. Expenditures Other than Salaries (Cont'd) - Administrative and General</b>	<b>16</b>
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
<b>D. Adjustments to Statement of Expenditures</b>	<b>28</b>
<b>D. Adjustments to Statement of Expenditures (Cont'd)</b>	<b>29</b>
<b>F. Statement of Revenue</b>	<b>30</b>
<b>G. Balance Sheet</b>	<b>31</b>
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
<b>H. Changes in Total Net Worth</b>	<b>36</b>
<b>I. Preparer's/Reviewer's Certification</b>	<b>37</b>

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Farmington Rehab Center, LLC d/b/a Amberwoods of Farmington	Period Covered:		From 10/1/2021	To 9/30/2022
Address of Facility 416 Colt Highway, Farmington, CT 06032				
Report Prepared By Zella Healthcare Consulting, LLC	Phone Number 203-808-8197	Date 1/24/2022		
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	\$			
<b>6. Total Wages Paid</b>	<b>\$</b>			
7. Total salaries paid	\$			
<b>8. Total Wages and Salaries Paid (As per page 10 of Report)</b>	<b>\$</b>			

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	Report for Year Ended	Page	of
860-677-1671	9/30/2022	2	37

Name of Facility (as shown on license)		Address (No. & Street, City, State, Zip)		
Farmington Rehab Center, LLC d/b/a Amberwoods of Farming		416 Colt Highway, Farmington, CT 06032		
License Numbers:	CCNH 2332	RHNS	(Specify)	Medicare Provider No. 07-5419
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No      If "Yes," explain fully.				

<b>Administrator</b>		
Name of Administrator Renata Cocozza		Nursing Home Administrator's License No.: 1533
Other Operators/Owners who are assistant administrators (full or part time) of this facility.		
Name		License No.:

## **General Information and Questionnaire Partners/Members**

State of Connecticut

**Annual Report of Long-Term Care Facility**

CSP-3A Rev. 10/2005

**General Information and Questionnaire**  
**Corporate Owners**

Name of Facility Farmington Rehab Center, LLC d/b/a Amber	License No. 2332	Report for Year Ended 9/30/2022	Page of 3A   37
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation N/A	Business Address	State(s) in Which Incorporated	
Name of Directors, Officers N/A	Business Address	Title	No. Shares Held by Each
Names of Stockholders Owning at Least 10% of Shares N/A			

**General Information and Questionnaire  
Individual Proprietorship**

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a Amberwoods	2332	9/30/2022	3B	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 Farmington Rehab Center, LLC d/b/a Amberwoods of	License No. 2332	Report for Year Ended 9/30/2022	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?	<input type="radio"/> Yes	<input checked="" 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	%**				
Realty of Farmington LLC	2600 Nostrund Avenue, Brooklyn, NY 11210	<input type="radio"/>	<input checked="" type="radio"/>		Rent Expense	Page 22 Line 9	657,810	657,810
Realty of Farmington LLC	2600 Nostrund Avenue, Brooklyn, NY 11210	<input type="radio"/>	<input checked="" type="radio"/>		Property Taxes	Page 22 Line 10a	142,419	142,419
Realty of Farmington LLC	2600 Nostrund Avenue, Brooklyn, NY 11210	<input type="radio"/>	<input checked="" type="radio"/>		Property Insurance	Page 27 Line 14a	26,586	26,586
Realty of Farmington LLC	2600 Nostrund Avenue, Brooklyn, NY 11210	<input type="radio"/>	<input checked="" type="radio"/>		General & Business Liability Insurance	Page 27 Line 14c3	73,185	73,185
Realty of Farmington LLC	2600 Nostrund Avenue, Brooklyn, NY 11210	<input type="radio"/>	<input checked="" type="radio"/>		Umbrella Insurance	Page 27 Line 14c1	10,435	10,435
		<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 checked="" 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 Farmington Rehab Center, LLC d/b/a Amberwood	License No. 2332	Report for Year Ended 9/30/2022	Page 5	of 37
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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 ( <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.

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.

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

⊕ No

Total \*\*\*

16,990

\* 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 Farmington Rehab Center, LLC d/b/a	License No. 2332	Report for Year Ended 9/30/2022	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

⊕ Accrual      ○ Cash      ○ Modified Cash

Is the accounting basis for this

period the same as for the previous period?  Yes  No

If "No," explain.

## Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Nesso Accounting	409 Canal Street, Milldale, CT 06467
2 Whittlesey, PC	280 Trumbull St., Hartford, CT 06103
3 SY Consultant	1138 E. 12th Street, Brooklyn, NY 11230
4	

Services Provided by This Firm (*describe fully*)

1	Accounting Services	\$	19,380
2	401K Audit	\$	11,500
3	Consulting	\$	15,000
4		\$	
		Charge for Services Provided	
		\$	45,880

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

Yes  No | Page 15 Line 1d

## **Legal Services Information**

Name of Legal Firm or Independent Attorney	Telephone Number
1 Robinson and Cole	860-275-8200
2 American Arbitration Association	917-438-1660
3 Various	Various
4	
5	

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

1 280 Trumbull St., Hartford, CT 06103  
2 120 Broadway, Floor 21, New York, NY 10271  
3 Various  
4  
5

Services Provided by This Firm (*describe fully*)

1	General Legal Counsel	\$	120,971
2	Arbitration Hearing	\$	650
3	Conservator (Disallowed)	\$	828
4		\$	
5		\$	
		Charge for Services Provided	
		\$	122,449

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

Page 15 Line 1e

## Schedule of Resident Statistics

Name of Facility Farmington Rehab Center, LLC d/b/a Amberwoods of Farmington			License No. 2332			Report for Year Ended 9/30/2022				Page 8 of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity					130	130						
A. On last day of PREVIOUS report period	130	130										
B. On last day of THIS report period	130	130							130	130		
2. Number of Residents					88	88						
A. As of midnight of PREVIOUS report period	88	88										
B. As of midnight of THIS report period	107	107							107	107		
3. Total Number of Days Care Provided During Period					1,402	1,402				516	516	
A. Medicare	1,918	1,918										
B. Medicaid (Conn.)	18,715	18,715			13,302	13,302				5,413	5,413	
C. Medicaid (other states)												
D. Private Pay	2,217	2,217			1,458	1,458				759	759	
E. State SSI for RCH												
F. Other (Specify) Insurance, VA, Managed Care	11,556	11,556			8,668	8,668				2,888	2,888	
G. Total Care Days During Period (3A thru F)	34,406	34,406			24,830	24,830				9,576	9,576	
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	365	365			263	263				102	102	
<b>5. Total Resident Days (3G + 4A + 4B)</b>	<b>34,771</b>	<b>34,771</b>			<b>25,093</b>	<b>25,093</b>				<b>9,678</b>	<b>9,678</b>	

## Schedule of Resident Statistics (Cont'd)

Name of Facility Farmington Rehab Center, LLC d/b/a Amberry	License No. 2332	Report for Year Ended 9/30/2022	Page 9	of 37
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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			CCNH	RHNS	(Specify)		
				(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.

1st change	Change in Resident Days			CCNH	RHNS	(Specify)
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		58		49				
Per Diem Rate								
a. One bed rm.	Various	274.12		470.00				
b. Two bed rms.	Various	274.12		440.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B	445	445	(Specify)
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments	260	260	
C. Other	10,459	10,459	
<b>D. Total Physical Therapy Treatments</b>	<b>11,164</b>	<b>11,164</b>	

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	99	99	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments	66	66	
C. Other	1,386	1,386	
<b>D. Total Speech Therapy Treatments</b>	<b>1,551</b>	<b>1,551</b>	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	779	779	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments	266	266	
C. Other	10,459	10,459	
<b>D. Total Occupational Therapy Treatments</b>	<b>11,504</b>	<b>11,504</b>	

## Report of Expenditures - Salaries &amp; Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2022		10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes <input type="radio"/> No			
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)	193,566	2,080			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	102,169	3,156			
5. Dietary Service					
a. Head Dietitian	24,568	629			
b. Food Service Supervisor	72,565	2,465			
c. Dietary Workers	343,649	18,445			
6. Housekeeping Service					
a. Head Housekeeper	38,256	2,129			
b. Other Housekeeping Workers	183,453	10,131			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	54,275	2,080			
b. Other Maintenance Workers	53,911	2,411			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers					
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	250,890	4,764			
b. RN					
1. Direct Care	410,295	9,152			
2. Administrative**	768,682	21,566			
c. LPN					
1. Direct Care	1,090,218	30,311			
2. Administrative**					
d. Aides and Attendants	1,990,961	86,347			
e. Physical Therapists					
f. Speech Therapists					
g. Occupational Therapists					
h. Recreation Workers	176,059	8,466			
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	190,606	5,356			
n. Marketing					
o. Other (Specify)					
See Attached Schedule					
A-13. Total Salary Expenditures	5,944,123	209,488			

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

\*\* Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and

Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

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

**Schedule of Other Salaries and Wages (Page 10)**

**Schedule of Other Fees (Page 13)**

State of Connecticut

**Annual Report of Long-Term Care Facility**

CSP-11 Rev. 10/2005

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

Name of Facility Farmington Rehab Center, LLC d/b/a Amberwoods of Farmington				License No. 2332		Report for Year Ended 9/30/2022			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)							
<b>Section I - Operators/Owners</b>										
<b>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).</b>										

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

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

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
Farmington Rehab Center, LLC d/b/a Amberwoods of Farmington				2332		9/30/2022			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)							
<b>Section III - Administrators***</b>										
Renata Coccozza	193,566			Non Discriminatory	Administrator	2,080	A2			
<b>Section IV - Assistant Administrators</b>										

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

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

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

**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended		Page	of
	2332	9/30/2022		13	37
	Total Cost and Hours				
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary</b> (For all such services complete Schedule B1)					
1. Dietitian					
2. Dentist					
3. Pharmacist					
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	294,338	2,974			
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	35,750	300			
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) Other Resident Care (Disallowed)	15,283	N/A			
9. Speech Therapist					
a. Resident Care	36,640	567			
b. Other					
10. Occupational Therapist					
a. Resident Care	170,033	3,192			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	16,800	168			
2. Administrative***					
b. LPN					
1. Direct Care	180,619	3,612			
2. Administrative***					
c. Aides	463,467	15,449			
d. Other					
12. Other (Specify) See Attached Schedule	43,202	710			
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	1,256,132	26,972			

\* 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\***

\* 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
		9/30/2022		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 306,638	306,638			
2. Disability Insurance	\$ 7,234	7,234			
3. Unemployment Insurance	\$ 57,530	57,530			
4. Social Security (F.I.C.A.)	\$ 465,175	465,175			
5. Health Insurance	\$ 993,541	993,541			
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 4,513	4,513			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 170,396	170,396			
8. Uniform Allowance	\$				
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 11,132	11,132			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$				
d. Accounting and Auditing	\$ 45,880	45,880			
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 122,449	122,449			
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$				
g. Office Supplies	\$ 22,268	22,268			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 11,880	11,880			
2. Cellular Phones	\$ 5,640	5,640			
i. Appraisal ( <i>Specify purpose and attach copy</i> )*	\$				
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$				
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	\$ 631,440	631,440			
<b>Subtotal</b>	\$ 2,855,716	2,855,716			

\* 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**

Attachment Page 15

## **Schedule of Other Employee Benefits**

## Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
	\$ -		
<b>Total</b>	\$ -	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a Amberwoods of	2332	9/30/2022	16	37
Item	Total	CCNH	RHNS	(Specify)
<b><i>Subtotals Brought Forward:</i></b>	2,855,716	2,855,716		
I. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$			
3. Gifts to Staff and Residents	\$	4,276	4,276	
4. Employee Travel	\$	778	778	
5. Education Expenses Related to Seminars and Conventions	\$	19,814	19,814	
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$			
7. Other ( <i>Specify</i> ) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$	14,619	14,619	
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$			
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	1,438	1,438	
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	\$	3,009	3,009	
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	445	445	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$			
10. Contributions*** See Attached Schedule	\$			
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$	175,812	175,812	
12. Administrative Management Services**	\$			
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	17,183	17,183	
<b><i>C-14 Total Administrative &amp; General Expenditures</i></b>	\$	3,093,090	3,093,090	

\* 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)
	\$ -		
<b>Total Other Travel and Entertainment</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
Promotional Advertising	\$ 1,438		
<b>Total Other Advertising</b>	<b>\$ 1,438</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
Chase Credit Card (Disallowed)	\$ 95		
CAHCF	\$ 350		
<b>Total Dues</b>	<b>\$ 445</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
	\$ -		
<b>Total Contributions</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
Social Services Consultant	\$ 303		
Unemployment Tax Consultant (Disallowed)	\$ 2,380		
Bank Charges	\$ 5,534		
Late Fees / Finance Charges (Disallowed)	\$ 7,416		
Facility Licenses	\$ 1,550		
<b>Total Other Administrative and General</b>	<b>\$ 17,183</b>	<b>\$ -</b>	<b>\$ -</b>

State of Connecticut

**Annual Report of Long-Term Care Facility**

CSP-17 Rev. 10/97

**Schedule C-1 - Management Services\***

Name of Facility	License No.	Report for Year Ended	Page of
Farmington Rehab Center, LLC d/b/a Am	2332	9/30/2022	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 #
N/A			

**\* 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
Farmington Rehab Center, LLC d/b/a Amberwoods of	2332	9/30/2022	18	37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 255,534	255,534		
2. Non-Food Supplies	\$ 40,673	40,673		
3. Other (Specify) _____	\$ _____			
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 474	474		
c. Other (Specify) _____	\$ 31,109	31,109		
Supplements				
Dietary Small Equipment				
2D. <b>Total Dietary Expenditures</b> (2a + b + c + d)	\$ 327,790	327,790		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				
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 meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
K. Is any revenue collected 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)				
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> 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.

## C. Expenditures Other Than Salaries (cont'd) - Laundry Basis for Allocation of Costs

(See Note on Page 5)

Name of Facility Farmington Rehab Center, LLC d/b/a Amberwoods of F:	License No. 2332	Report for Year Ended 9/30/2022	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. \$			
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)	\$	138,947	138,947	
c. Other (Specify) Laundry Supplies	\$	1,293	1,293	
<b>3D. Total Laundry Expenditures (3a + b + c )</b>	<b>\$</b>	<b>140,240</b>	<b>140,240</b>	
3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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.

**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
Farmington Rehab Center, LLC d/b/a Amberw	2332	9/30/2022		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced				
a. In-House Care	by Personnel				
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	34,600	34,600		
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. Other ( <i>Specify</i> )	\$				
<b>4D. Total Housekeeping Expenditures (4a + b + c)</b>	\$	34,600	34,600		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Pharmerica	\$	417,111	417,111		
b. Medicine Cabinet Drugs	\$				
c. Medical and Therapeutic Supplies	\$	142,157	142,157		
d. Ambulance/Limousine***	\$	1,285	1,285		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	19,326	19,326		
f. X-rays and Related Radiological Procedures***	\$	6,197	6,197		
g. Dental ( <i>Not dentists who should be included under     salaries or fees</i> )	\$				
h. Laboratory***	\$	21,455	21,455		
i. Recreation	\$	19,905	19,905		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other ( <i>Specify</i> )****	\$	25,053	25,053		
See Attached Schedule					
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	652,489	652,489		

\* 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**

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

Name of Facility Farmington Rehab Center, LLC d/b/a Amberwoods of Farmington				License No. 2332	Report for Year Ended 9/30/2022				Page of 21   37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
CWPM, PO Box 415, Plainville, CT 06062	PO Box 415, Plainville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		Trash Removal	27,035			22	6e
Jesse's Lawn Care, 30 Bonnie Drive, Farmington, CT 06032	30 Bonnie Drive, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Landscaping	29,597			22	6e
MatrixCare	Bin#32, PO Box 1414, Minneapolis, MN 55480	<input type="radio"/>	<input checked="" type="radio"/>		AR/AP Software	28,006			16	m11
Rinaldi Linen	47 Commons Court, Waterbury, CT 06704	<input type="radio"/>	<input checked="" type="radio"/>		Laundry Services	138,947			19	3b
Anthony Santino	42 Robin Hill Lane, Hamden, CT 06518	<input type="radio"/>	<input checked="" type="radio"/>		IT Consultant	25,201			16	m11
Select Mechanical Services	PO Box 918, Southington, CT 06489	<input type="radio"/>	<input checked="" type="radio"/>		HVAC Mechanical Repair	15,370			22	6a
Iris Carafaro		<input type="radio"/>	<input checked="" type="radio"/>		AR Services	22,000			16	m11
Broadway Data		<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing	16,020			16	m11
		<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 checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" 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 9/30/2022			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	69,939	69,939			
b. Heat	\$	50,357	50,357			
c. Light & Power	\$	115,631	115,631			
d. Water	\$	58,177	58,177			
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$	16,990	16,990			
f. Other ( <i>itemize</i> )	\$	73,660	73,660			
See Attached Schedule						
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$	384,754	384,754			
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$	7,768	7,768			
b. Building & Building Improvements	\$	66,599	66,599			
c. Non-Movable Equipment	\$	131	131			
d. Movable Equipment	\$	14,995	14,995			
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$	89,493	89,493			
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other ( <i>Specify</i> )	\$					
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	657,810	657,810			
10. Property Taxes						
a. Real estate taxes paid by owner	\$	142,419	142,419			
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$	1,398	1,398			
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$	891,120	891,120			

\* 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**

## Depreciation Schedule

**Schedule of Land Improvements Acquired during this report period**

\*Ties to Page 23, Line A3

\*\*Ties to Page 23, Line A2

**Schedule of Building Improvements Acquired during this report period**

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

**Schedule of Non-Movable Equipment Acquired during this report period**

\*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	Pick One	Useful Life		Depreciation
		Movable Category	Cost	Life	
<b>Additions:</b>					
12/23/2021	MatrixCare Software	Administrative	\$ 12,950	5	\$ 2,158
9/30/2022	Door & Security	Administrative	\$ 10,110	10	\$ 84
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
<b>Total additions for Movable Equipment</b>			\$ 23,060		\$ 2,243
<b>Deletions:</b>					
<b>Total deletions for Movable Equipment</b>			\$ -		\$ -

\*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	Useful		
		Cost	Life	Depreciation
<b>Additions:</b>				
<b>Total additions for Leasehold Improvement</b>		\$ -		\$ -
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ -

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Amortization Schedule\***

Name of Facility Farmington Rehab Center, LLC d/b/a Amberwoods of Farmi			License No. 2332		Report for Year Ended 9/30/2022			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. <b>Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
B. <b>Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
C. <b>Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
<b>D. Total Amortization</b>									

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

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

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

Name of Facility Farmington Rehab Center, LLC d/b/a	License No. 2332	Report for Year Ended 9/30/2022	Page 25	of 37
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#### 11. Property Questionnaire

##### Part A

Is the property either owned by the Facility  
or leased from a Related Party?\*

Yes

No

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

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

Description	Total			
1. Date Land Purchased				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase	07/07/08			
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	130			
6. Square Footage	39,341			
7. Acquisition Cost				
a. Land				
b. Building				

##### Part B - Owner and Related Parties

1st Mortgage    2nd Mortgage    3rd Mortgage    4th Mortgage

1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	12/30/11			
c. Interest Rate for the Cost Year	3.75%			
d. Term of Mortgage (number of years)	35			
e. Amount of Principal Borrowed	6,341,000			
f. Principal balance outstanding as of 9/30/2022	5,191,633			

##### 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 9/30/2022			Page of 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. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$			

(Carry Subtotals forward to next page )

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

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page 27	of 37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment	\$					
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)	\$					
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)	\$	185	185			
Other Interest Expense						
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>	\$	185	185			
14. Insurance						
a. Insurance on Property (buildings only)	\$	26,586	26,586			
b. Insurance on Automobiles	\$					
c. Insurance other than Property (as specified above)						
1. Umbrella ( <i>Blanket Coverage</i> )	\$	10,435	10,435			
2. Fire and Extended Coverage	\$					
3. Other (Specify)	\$	73,185	73,185			
Liability Insurance						
14d. <b>Total Insurance Expenditures (14a + b + c)</b>	\$	110,206	110,206			
15. <b>Total All Expenditures (A-13 thru C-14)</b>	\$	12,834,729	12,834,729			

## **D. Adjustments to Statement of Expenditures**

Name of Facility			License No.	Report for Year Ended		Page of
Item No.	Page No.	Line No.	2332	9/30/2022		28   37
				Total Amount of Decrease	CCNH	RHNS (Specify)
<b><i>Page 10 - Salaries and Wages</i></b>						
1.			Outpatient Service Costs	\$		
2.			Salaries not related to Resident Care	\$		
3.			Occupational Therapy	\$		
4.			Other - See attached Schedule	\$		
<b><i>Page 13 - Professional Fees</i></b>						
5.	13	B8e	Resident Care Physicians **	\$ 15,283	15,283	
6.	13	B10	Occupational Therapy	\$ 170,033	170,033	
7.			Other - See attached Schedule	\$		
<b><i>Pages 15 &amp; 16 - Administrative and General</i></b>						
8.			Discriminatory Benefits	\$		
9.			Bad Debts	\$		
10.			Accounting	\$		
10a.			Legal	\$ 828	828	
11.			Telephone	\$		
12.	15	1h2	Cellular Telephone	\$ 4,200	4,200	
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$		
14.			Gifts, flowers and coffee shops	\$		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$		
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$		
17.	16	L6	Automobile Expense (e.g. personal use)	\$ 778	778	
18.	16	m3	Unallowable Advertising *	\$ 1,438	1,438	
19.			Income Tax / Corporate Business Tax	\$		
20.			Fund Raising / Contributions	\$		
21.			Unallowable Management Fees	\$		
22.			Barber and Beauty	\$		
23.			Other - See attached Schedule	\$ 15,891	15,891	
<b><i>Page 18 - Dietary Expenditures</i></b>						
24.			Meals to employees, guests and others who are not residents	\$		
<b><i>Page 19 - Laundry Expenditures</i></b>						
25.			Laundry services to employees, guests and others who are not residents	\$		
<b><i>Page 20 - Housekeeping Expenditures</i></b>						
26.			Housekeeping services to employees, guests and others who are not residents	\$		
Subtotal (Items 1 - 26)			\$ 208,451	208,451		

\* 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)
<b>Total Other Salaries Adjustment</b>			\$ -	\$ -	\$ -

## Schedule of Fees Adjustments

## **Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Late Fees / Finance Charges (Disallowed)	\$ 7,416		
16	m13	Unemployment Tax Consultant (Disallowed)	\$ 2,380		
15	1a9	Other Employee Benefits (Disallowed)	\$ 6,000		
16	m8	Chase Credit Card (Disallowed)	\$ 95		
<b>Total Other A&amp;G Adjustments</b>			\$ 15,891	\$ -	\$ -

State of Connecticut

**Annual Report of Long-Term Care Facility**

CSP-29 Rev. 9/2018

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

Name of Facility				License No.	Report for Year Ended		Page	of
Farmington Rehab Center, LLC d/b/a Amberwoods of Farmington				2332	9/30/2022		29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)	
Subtotals Brought Forward				\$ 208,451	208,451			
<b>Page 20 - Resident Care Supplies***</b>								
27.	20	5a2	Prescription Drugs	\$ 417,111	417,111			
28.	20	5d	Ambulance/Limousine	\$ 1,285	1,285			
29.	20	5f	X-rays, etc	\$ 6,197	6,197			
30.	20	5h	Laboratory	\$ 21,455	21,455			
31.	20	5c	Medical Supplies	\$ 65,937	65,937			
32.	20	5e2	Oxygen (non emergency)	\$ 19,326	19,326			
33.			Occupational Therapy	\$				
34.			Other - See Attached Schedule	\$ 9,307	9,307			
<b>Page 22 - Maintenance and Property</b>								
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$				
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	\$				
<b>Page 27 - Insurance</b>								
40.			Mortgage Insurance	\$				
41.			Property Insurance	\$				
<b>Other - Miscellaneous</b>								
42.			Other - Indirect	\$				
43.			Interest Income on Account Rec.	\$				
44.			Other - Miscellaneous Administrative	\$				
45.			Management Fees Direct	\$				
46.			Management Fees Indirect	\$				
47.			Other - Direct	\$				
<b>Not For Profit Providers Only</b>								
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$				
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 749,070	749,070			

\*\*\* 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**

### Schedule of Excess Movable Equipment Depreciation

### **Schedule of Other Property Adjustments**

### **Schedule of Other - Indirect Adjustments**

Attachment Page 29

### **Schedule of Other - Miscellaneous Administrative Adjustments**

### **Schedule of Other - Direct Adjustments**

## Schedule of Unallowable Building Interest

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page 30	of 37
		Item	Total	CCNH	RHNS	(Specify)
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a.	Medicaid Residents ( <i>CT only</i> )	\$ 8,060,438	8,060,438			
b.	Medicaid Room and Board Contractual Allowance **	\$ (2,945,007)	(2,945,007)			
2. a.	Medicaid ( <i>All other states</i> )	\$				
b.	Other States Room and Board Contractual Allowance **	\$				
3. a.	Medicare Residents ( <i>all inclusive</i> )	\$ 841,832	841,832			
b.	Medicare Room and Board Contractual Allowance **	\$ 412,173	412,173			
4. a.	Private-Pay Residents and Other	\$ 5,968,244	5,968,244			
b.	Private-Pay Room and Board Contractual Allowance **	\$ (958,964)	(958,964)			
<b>II. Other Resident Revenue</b>						
1. a.	Prescription Drugs - Medicare	\$ 71,732	71,732			
b.	Prescription Drugs - Medicare Contractual Allowance **	\$				
c.	Prescription Drugs - Non-Medicare	\$ 353,337	353,337			
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	\$ 97,277	97,277			
b.	Physical Therapy - Medicare Contractual Allowance **	\$				
c.	Physical Therapy - Non-Medicare	\$ 295,869	295,869			
d.	Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a.	Speech Therapy - Medicare	\$ 36,479	36,479			
b.	Speech Therapy - Medicare Contractual Allowance **	\$				
c.	Speech Therapy - Non-Medicare	\$ 97,417	97,417			
d.	Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a.	Occupational Therapy - Medicare	\$ 131,232	131,232			
b.	Occupational Therapy - Medicare Contractual Allowance **	\$				
c.	Occupational Therapy - Non-Medicare	\$ 327,109	327,109			
d.	Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a.	Other ( <i>Specify</i> ) - Medicare	\$ (318,114)	(318,114)			
b.	Other ( <i>Specify</i> ) - Non-Medicare	\$ (949,776)	(949,776)			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)		\$ 11,521,278	11,521,278			
<b>IV. Other Revenue*</b>						
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> )	\$ (26,775)	(26,775)			
<b>V. Total Other Revenue</b> (1 thru 8)		\$ (26,775)	(26,775)			
<b>VI. Total All Revenue</b> (III +V)		\$ 11,494,503	11,494,503			

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

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

**Schedule of Other Resident Revenue - Medicare****Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
30 II6a	Lab	\$ -		
30 II6a	X-Ray	\$ 463		
30 II6a	IV Therapy	\$ 215		
30 II6a	Contractual Allowance	\$ -		
		\$ (318,792)		
<b>Total Other Resident Revenue - Medicare</b>		<b>\$ (318,114)</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Non-Medicare Resident Revenue****Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
30 II6b	Lab	\$ -		
30 II6b	X-Ray	\$ 4,454		
30 II6b	IV Therapy	\$ 1,787		
30 II6b	Contractual Allowance	\$ -		
		\$ (956,017)		
<b>Total Other Resident Revenue</b>		<b>\$ (949,776)</b>	<b>\$ -</b>	<b>\$ -</b>

**Interest Income****Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
		\$ -			
<b>Total Interest Income</b>		<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV8	Misc. Adj	\$ -		
		\$ (26,775)		
<b>Total Other Revenue</b>		<b>\$ (26,775)</b>	<b>\$ -</b>	<b>\$ -</b>

**G. Balance Sheet**

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a A	2332	9/30/2022	31	37
<b>Account</b>				<b>Amount</b>
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )				\$ 6,599
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				\$ 3,458,440
3. Other Accounts Receivable (Excluding Owners or Related Parties)				\$
4. Inventories				\$ 15,000
5. Prepaid Expenses				\$ 8,735
a. Prepaid Insurance				1,991
b. Other Prepaid Expenses				6,744
c. _____				
d. See Schedule				
6. Interest Receivable				\$
7. Medicare Final Settlement Receivable				\$
8. Other Current Assets ( <i>itemize</i> )				\$ 768,819
Goodwill				147,852
Deposits				620,967
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)				\$ 4,257,593
B. Fixed Assets				
1. Land				\$
2. Land Improvements				\$ 51,707
*Historical Cost				122,427
Accum. Depreciation				70,720 Net
3. Buildings				\$ 403,360
*Historical Cost				1,050,974
Accum. Depreciation				647,614 Net
4. Leasehold Improvements				\$
*Historical Cost				
Accum. Depreciation				Net
5. Non-Movable Equipment				\$ 7,708
*Historical Cost				53,876
Accum. Depreciation				46,168 Net
6. Movable Equipment				\$ 73,971
*Historical Cost				847,901
Accum. Depreciation				773,930 Net
7. Motor Vehicles				\$
*Historical Cost				
Accum. Depreciation				Net
8. Minor Equipment-Not Depreciable				\$
9. Other Fixed Assets ( <i>itemize</i> )				\$ (1,601)
NBV Cost Report Adj.				(1,601)
See Schedule				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)				\$ 535,145

\* 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**

Page Ref	Line Ref	Description	
<b>Total Prepaid Expenses</b>			\$ -

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

Page Ref Line Ref Description

<b>Total Other Current Assets (Itemize)</b>		\$ -

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

Page Ref Line Ref Description

			0
<b>Total Other Other Fixed Assets (Itemize)</b>			\$ -

**Schedule of Other Assets Page 32 Line D7**

Page Ref Line Ref Description

			0
<b>Total Other Assets</b>			\$ -

**Schedule of Notes Payable (Itemize) Page 33 Line A2**

**Page Ref Line Ref Description**

Page Ref	Line Ref	Description	
<b>Total Notes Payable</b>			\$ -

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

**Page Ref Line Ref Description**

Line Item	Description	
<b>Total Other Current Liabilities (Itemize)</b>		\$

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

Page Ref Line Ref Description

Total Other Current Liabilities (Itemize)	\$ -

**G. Balance Sheet (cont'd)**

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a A	2332	9/30/2022	32	37
Account				Amount
Total Brought Forward:				\$ 4,792,738
<b>C. Leasehold or like property recorded for Equity Purposes.</b>				
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				\$
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>				\$
<b>D. Investment and Other Assets</b>				
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> )				\$
Name and Address	Amount	Loan Date		
7. Other Assets ( <i>itemize</i> )				\$
See Schedule				
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>				\$
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>				\$ 4,792,738

\* 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								
Farmington Rehab Center, LLC d/b/a Ambery	2332	9/30/2022	33   37								
Account			Amount								
<b>Liabilities</b>											
A. Current Liabilities											
1. Trade Accounts Payable			\$ 2,737,614								
2. Notes Payable ( <i>itemize</i> )			\$								
_____											
_____											
_____											
See Schedule											
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )			\$								
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Name of Lender</th> <th style="text-align: left;">Purpose</th> <th style="text-align: left;">Amount</th> <th style="text-align: left;">Date Due</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>				Name of Lender	Purpose	Amount	Date Due				
Name of Lender	Purpose	Amount	Date Due								
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )			\$ 486,590								
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )			\$								
6. Accrued Payroll Taxes Payable			\$ 35,066								
7. Medicare Final Settlement Payable			\$ 5,391								
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> )			\$ 243,487								
Resident Trust 51,947											
Accrued Expenses 16,039											
Accrued Provider Tax 175,501 See Schedule											
<b>A-13. Total Current Liabilities</b> (Lines A1 thru 12)			<b>\$ 3,508,148</b>								

\* 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 Farmington Rehab Center, LLC d/b/a Ambulatory Care Center	License No. 2332	Report for Year Ended 9/30/2022	Page 34	of 37
Account				Amount
Total Brought Forward:				3,508,148
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$ 2,996,029
Name and Address of Lender	Amount	Loan Date		
	2,996,029			
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$ 1
<u>Rounding</u>				1
<u>See Schedule</u>				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 2,996,030
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 6,504,178

## G. Balance Sheet (cont'd)

### Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a	2332	9/30/2022	35	37
Account				Amount
<b>A. Reserves</b>				
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 ( <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			\$	
<b>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(371,214)
6. Gain or Loss for Period	10/1/2021	thru	9/30/2022	\$ <span style="color: red;">(1,340,226)</span>
7. Total Net Worth			\$	(1,711,440)
<b>C. Total Reserves and Net Worth</b>				\$ <span style="color: red;">(1,711,440)</span>
<b>D. Total Liabilities, Reserves, and Net Worth</b>				\$ 4,792,738

## H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Farmington Rehab Center, LLC d/b/a Ar	2332	9/30/2022	36	37
Account				Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2021				\$ (1,778,276)
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )				\$ 11,494,503
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )				\$ 12,834,729
D. Net Income or Deficit				\$ (1,340,226)
E. Balance				\$ (3,118,502)
F. Additions				
1. Additional Capital Contributed ( <i>itemize</i> )				
2. Other ( <i>itemize</i> )				
Prior Period Adjustments			1,407,062	
F-3. Total Additions				\$ 1,407,062
G. Deductions				
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )				\$
Name and Address (No., City, State, Zip)		Title	Amount	
2. Other Withdrawings ( <i>Specify</i> )				\$
Purpose		Amount		
3. Total Deductions				\$
H. <b>Balance at End of Period</b>				\$ (1,711,440)
09/30/22				

## I. Preparer's/Reviewer's Certification

Name of Facility Farmington Rehab Center, LLC d/b/a	License No. 2332	Report for Year Ended 9/30/2022	Page 37	of 37
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*Check appropriate category*

<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)
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### Preparer/Reviewer Certification

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

Signature of Preparer 	Title President	Date Signed 02/14/2023
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Printed Name of Preparer Stephen Bernier
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Address 7 Eastview Drive, Simsbury, CT 06070	Phone Number 203-808-8197
---	------------------------------

Contacted Person Regarding Additional Information Needed Regarding This Report Simon Yisroel	Phone Number 347-254-5765
---	------------------------------

Contact Email Address <a href="mailto:simonyisroel@yahoo.com">simonyisroel@yahoo.com</a>
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