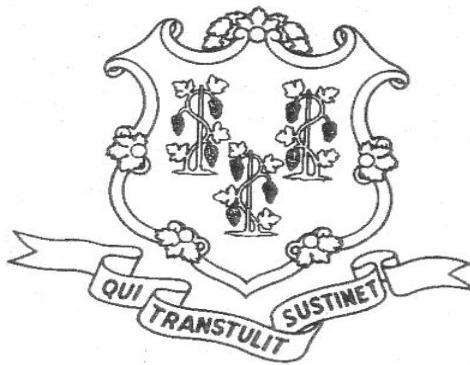


# State of Connecticut



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

Name of Facility (as licensed) Crestfield Rehabilitation Center	
Address (No. & Street, City, State, Zip Code) 565 Vernon Street, Manchester, CT 06042	
Type of Facility	
Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS)
Report for Year Beginning 10/1/2021	Report for Year Ending 9/30/2022

License Numbers:	CCNH 2344	RHNS	(Specify)	Medicare Provider 07-5013
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Medicaid Provider Numbers:	CCNH 10140	RHNS 10140	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) Crestfield Rehabilitation Center	License No. 2344	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 Crestfield Rehabilitation Center [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.

Signed (Administrator)	Date	Signed (Owner)	Date	
Printed Name (Administrator) Patricia Salisbury		Printed Name (Owner) Lawrence Santilli		
Subscribed and Sworn to before me:	State of	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
A. Report of Expenditures - Salaries & Wages	10
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B. Report of Expenditures - Professional Fees	13
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C. Expenditures Other than Salaries - Administrative and General	15
C. Expenditures Other than Salaries (Cont'd) - Administrative and General	16
Schedule C-1 - Management Services	17
C. Expenditures Other than Salaries (Cont'd) - Dietary	18
C. Expenditures Other than Salaries (Cont'd) - Laundry	19
C. Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
Depreciation Schedule	23
Amortization Schedule	24
C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C. Expenditures Other than Salaries (Cont'd) - Interest	26
C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D. Adjustments to Statement of Expenditures	28
D. Adjustments to Statement of Expenditures (Cont'd)	29
F. Statement of Revenue	30
G. Balance Sheet	31
G. Balance Sheet (Cont'd)	32
G. Balance Sheet (Cont'd)	33
G. Balance Sheet (Cont'd)	34
G. Balance Sheet (Cont'd) - Reserves and Net Worth	35
H. Changes in Total Net Worth	36
I. Preparer's/Reviewer's Certification	37

**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 Crestfield Rehabilitation Center	Period Covered:	From 10/1/2021	To 9/30/2022
Address of Facility 565 Vernon Street, Manchester, CT 06042			
Report Prepared By Athena Health Care Associates Inc	Phone Number 860-751-3900	Date 2/22/2023	
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. <b>Total Wages Paid</b>	\$		
7. Total salaries paid	\$		
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$		

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

**General Information and Questionnaire**  
**Type of Facility - Organization Structure**

Phone No. of Facility	Report for Year Ended	Page	of
860-643-5151	9/30/2022	2	37
Name of Facility (as shown on license) Crestfield Rehabilitation Center		Address (No. & Street, City, State, Zip) 565 Vernon Street, Manchester, CT 06042	
License Numbers:  CCNH 2344	RHNS	(Specify)	Medicare Provider No. 07-5013
Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)			
Type of Ownership (Check appropriate box)			
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust			
If this facility opened or closed during report year provide:		Date Opened	Date Closed
Has there been any change in ownership or operation during this report year?		<input type="radio"/> Yes <input checked="" type="radio"/> No	If "Yes," explain fully.
<hr/> <b>Administrator</b> <hr/> Name of Administrator Patricia Salisbury              Nursing Home Administrator's License No.: 1445			
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name N/A		License No.:	

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

# **General Information and Questionnaire**

## **Corporate Owners**

**General Information and Questionnaire**  
**Individual Proprietorship**

Name of Facility Crestfield Rehabilitation Center	License No. 2344	Report for Year Ended 9/30/2022	Page 3B	of 37
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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

## General Information and Questionnaire

### Related Parties\*

Name of Facility Crestfield Rehabilitation Center	License No. 2344	Report for Year Ended 9/30/2022			Page 4	of 37		
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	%**				
Athena Health Care - Insurance	135 South Road, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	<50%	Self insured Employee Health & Dental Insu	Pg 15, Ln 1a5	568,986	568,986
Athena Health Care Associates - 401(K) plan	135 South Road, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Facility Participates in group 401(K) plan			
Procare LTC	111 Executive Blvd, Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	>50%	Pharmacy	Pg 20 Ln 5a2	719,665	719,665
Athena Health Care Associates	135 South Road, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Various: See attached			
Procare LTC	111 Executive Blvd, Farmingdale, NY 11735	<input type="radio"/>	<input checked="" type="radio"/>		Note Payable - pharmacy	Pg 34	223,674	223,674
		<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 Crestfield Rehabilitation Center	License No. 2344	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.

Patient care Cons, Laundry, HSKP'g, maintenance/property costs, Admin -allocated on patient days, PT, ST, and OT allocated on % of treatments, Administrative nursing allocated on Direct Nursing hours, Management fees Allocated based on methods above for each category

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

Related company expenses were allocated on methods above except as noted in 1 above.

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 \*\*\*

12,283

\* 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 Crestfield Rehabilitation Center	License No. 2344	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 PKF O'Connor Davies	Four Corporate DR, Ste. 488, Shelton, CT
2 Marcum LLP	555 Long Wharf DR, New Haven, CT 06511
3	
4	

**Services Provided by This Firm (*describe fully*)**

1	Partnership tax returns:Disallowed	\$	14,700
2	Medicare Cost report:Allowed	\$	2,750
3		\$	
4		\$	
		Charge for Services Provided	
		\$	17,450

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

Yes       No

## Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Goldman Gruder & Woods	203-899-8900/860-567-0451
2 Murtha Cullina	860-240-6000
3 Tn of Manchester/Treasurer of CT	
4 Pilicy & Ryan	860-274-0018
5 Nicholas D'Amato	

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

- 1 200 Connecticut Ave, Norwalk, CT
- 2 185 Asylum St, Hartford, CT
- 3 66 Center St, Manchester, CT
- 4 365 Main Street, Watertown, CT
- 5

**Services Provided by This Firm (*describe fully*)**

1	Collections:Disallowed	\$	17,892
2	Annual report filing:\$80 disallowed, \$80 Allowed	\$	160
3	Conservatorship: Disallowed	\$	600
4	Conservatorship: Disallowed	\$	115
5	Employee Settlement: Disallowed	\$	9,842
			Charge for Services Provided

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Are These Charges Reflected in the Expenditure Portion of T Pg 15, Line 1e  
C V C N

## Schedule of Resident Statistics

Name of Facility Crestfield Rehabilitation Center			License No. 2344			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					155	95	60					
A. On last day of PREVIOUS report period	155	95	60									
B. On last day of THIS report period	155	95	60						155	95	60	
2. Number of Residents												
A. As of midnight of PREVIOUS report period	107	85	22		107	85	22					
B. As of midnight of THIS report period	105	85	20						105	85	20	
3. Total Number of Days Care Provided During Period												
A. Medicare	10,206	3,655	6,551		7,278	2,482	4,796		2,928	1,173	1,755	
B. Medicaid (Conn.)	23,966	23,966			18,068	18,068			5,898	5,898		
C. Medicaid (other states)												
D. Private Pay	3,533	3,248	285		2,814	2,611	203		719	637	82	
E. State SSI for RCH												
F. Other (Specify) Managed care	415	146	269		213	77	136		202	69	133	
G. Total Care Days During Period (3A thru F)	38,120	31,015	7,105		28,373	23,238	5,135		9,747	7,777	1,970	
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												
<b>5. Total Resident Days (3G + 4A + 4B)</b>	<b>38,120</b>	<b>31,015</b>	<b>7,105</b>		<b>28,373</b>	<b>23,238</b>	<b>5,135</b>		<b>9,747</b>	<b>7,777</b>	<b>1,970</b>	

## Schedule of Resident Statistics (Cont'd)

Name of Facility Crestfield Rehabilitation Center	License No. 2344	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.

	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	15	67		6	1		16	
Per Diem Rate								
a. One bed rm.	602.00	289.00		535.00	440.00	349.00		
b. Two bed rms.	602.00	289.00		410.00	380.00	349.00		
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B		TOTAL	CCNH	RHNS	(Specify)
		5,808	5,808		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments		985	985		
2. Restorative Treatments					
C. Other		15,479	11,368	4,111	
D. <b>Total Physical Therapy Treatments</b>		22,272	18,161	4,111	

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		1,344	1,344	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments		72	72	
2. Restorative Treatments				
C. Other		2,540	1,944	596
D. <b>Total Speech Therapy Treatments</b>		3,956	3,360	596

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		4,785	4,785	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments		790	790	
2. Restorative Treatments				
C. Other		16,276	11,913	4,363
D. <b>Total Occupational Therapy Treatments</b>		21,851	17,488	4,363

## Report of Expenditures - Salaries &amp; Wages

Name of Facility	License No.	Report for Year Ended		Page	of	
		2344	9/30/2022		10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes		<input type="radio"/> No		
		Total Cost and Hours				
Item		CCNH	Hours	RHNS	Hours	(Specify)
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	131,645	1,633	30,157	374		
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	169,824	6,930	38,904	1,587		
5. Dietary Service						
a. Head Dietitian	64,813	1,717	14,848	393		
b. Food Service Supervisor	54,890	1,695	12,568	388		
c. Dietary Workers	361,589	22,059	82,834	5,053		
6. Housekeeping Service						
a. Head Housekeeper	43,433	1,720	9,950	394		
b. Other Housekeeping Workers	216,594	14,393	49,618	3,297		
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	48,736	1,782	11,165	408		
b. Other Maintenance Workers	37,692	1,940	8,635	444		
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	86,070	5,633	19,717	1,290		
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	171,170	2,233	47,034	614		
b. RN						
1. Direct Care	488,489	9,516				
2. Administrative**	459,765	13,161	126,332	3,616		
c. LPN						
1. Direct Care	1,318,642	33,162	449,907	11,666		
2. Administrative**						
d. Aides and Attendants	1,755,086	71,890	446,202	23,212		
e. Physical Therapists	385,214	10,485	87,199	2,374		
f. Speech Therapists	70,590	1,916	12,521	340		
g. Occupational Therapists	209,236	5,860	52,202	1,462		
h. Recreation Workers	162,545	6,207	37,236	1,422		
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	174,180	5,345	39,902	1,225		
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	6,410,203	219,277	1,576,931	59,559		

\* 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 Crestfield Rehabilitation Center			License No. 2344		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>										
NA										
<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>										
NA										

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

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

State of Connecticut

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

CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page 12 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 III - Administrators***</b>										
Patricia Salisbury (3/1/22- 9/30/22)	95,439	21,863		Health and life ins, payroll taxes	day to day operations of facility	1,295	A2			
Phyllis Aronson (10/1/21- 2/28/22)	36,206	8,294		Health and life ins, payroll taxes	day to day operations of facility	712	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 Crestfield Rehabilitation Center	License No. 2344	Report for Year Ended 9/30/2022		Page 13	of 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	10,217	6	2,341	1	
3. Pharmacist	9,762	93	2,237	21	
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker	10,518	162	2,409	37	
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	39,054	209	8,946	48	
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**	731				
d. Administrative Services facility					
1. Infection Control Committee (Quarterly meetings)					
2. Pharmaceutical Committee (Quarterly meetings)					
3. Staff Development Committee (Once annually)					
e. Other (Specify) Medical Staff Meetings					
9. Speech Therapist					
a. Resident Care	883	3	157	1	
b. Other					
10. Occupational Therapist					
a. Resident Care					
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	110,917	801			
2. Administrative***					
b. LPN					
1. Direct Care	54,118	761			
2. Administrative***					
c. Aides	548,931	10,894			
d. Other					
12. Other (Specify) See Attached Schedule					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	785,131	12,929	16,090	108	

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

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

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

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

Name of Facility Crestfield Rehabilitation Center		License No. 2344	Report for Year Ended 9/30/2022		Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Nurse Network, 405 Park AVE, New York, NY	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Healthdrive Dental Group, 888 Worcester Street, Wellesley, MA 02482-3744	Dentist	<input type="radio"/>	<input checked="" type="radio"/>			
MAS Medical Staffing, 156 Harvye Road, Londonberry, NH	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Procare LTC, 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist/Nurse consulting	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners: Minority Interest		
Norton & Associates, 34 Elm Street, Cohasset, MA 02025	Social service Consulting	<input type="radio"/>	<input checked="" type="radio"/>			
Southern CT Vascular Center, 6 Research Drive, Suite 105, Shelton, CT 06484	lab services	<input type="radio"/>	<input checked="" type="radio"/>			
Constantine Zariphe MD, 324 Conestoga Way, Glastonbury, CT	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
MASSTEX, 3 Electronics Ave, Danvers, MA	Speech Therapy Services	<input type="radio"/>	<input checked="" type="radio"/>			
Starling Physicians, PO Box 27728, Salt Lake City Utah	Medical Director/Asst. Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
Healthdrive Audiology, 100 Crossing BLVD, Framingham, MA	audiology services	<input type="radio"/>	<input checked="" type="radio"/>			
Quest Diagnostics Chicago, 3404 Collection CTR Drive, Chicago, IL 60693	lab services	<input type="radio"/>	<input checked="" type="radio"/>			
Norton & Associates, 34 Elm Street, Cohasset, MA 02025	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Paramount Health Care, 3 Courthouse Lane, Chelmsford, MA	nurse pool	<input type="radio"/>	<input checked="" type="radio"/>			
Solomon Page Staffing, 260 Madison Ave, New York, NY	nurse pool	<input type="radio"/>	<input checked="" type="radio"/>			
Prime Time Healthcare, 15380 Weir st, Omaha, NE 68137	nurse pool	<input type="radio"/>	<input checked="" type="radio"/>			
Sambacare, 410 Melville Ave, Lakewood, NJ 08701	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Five Star Care, 410 Melville, Ave, Lakewood, NJ 08701	Nurse Pool	<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"/>			

\* Use additional sheets if necessary.

\*\* Refer to Page 4 for definition of related.

**C. Expenditures Other Than Salaries - Administrative and General**

Name of Facility Crestfield Rehabilitation Center	License No. 2344	Report for Year Ended 9/30/2022		Page 15	of 37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 166,797	133,865	32,932		
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 142,071	114,021	28,050		
4. Social Security (F.I.C.A.)	\$ 478,044	383,662	94,382		
5. Health Insurance	\$ 478,338	383,898	94,440		
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 42,597	34,187	8,410		
8. Uniform Allowance	\$				
9. Other ( <i>Specify</i> ) See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 292,268	292,268			
d. Accounting and Auditing	\$ 17,450	14,198	3,252		
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 28,609	23,277	5,332		
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$				
g. Office Supplies	\$ 85,175	69,300	15,875		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 51,339	41,770	9,569		
2. Cellular Phones	\$				
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	\$ 604,977	604,977			
<b>Subtotal</b>	\$ 2,387,665	2,095,423	292,242		

\* 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**

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

---

**Schedule of Other Taxes**

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

---

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

Name of Facility Crestfield Rehabilitation Center	License No. 2344	Report for Year Ended 9/30/2022	Page 16	of 37
Item	Total	CCNH	RHNS	(Specify)
<b><i>Subtotals Brought Forward:</i></b>	2,387,665	2,095,423	292,242	
I. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$	3,213	2,614	599
3. Gifts to Staff and Residents	\$	13,107	10,664	2,443
4. Employee Travel	\$	810	659	151
5. Education Expenses Related to Seminars and Conventions	\$	5,750	4,678	1,072
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> )	\$	15,670	12,749	2,921
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$			
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	978	796	182
4. Fund-Raising***	\$			
5. Medical Records	\$			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$			
7. Postage	\$	2,844	2,314	530
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	6,302	5,127	1,175
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$	250	203	47
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> )	\$			
12. Administrative Management Services**	\$			
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	231,249	188,148	43,101
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$	2,667,838	2,323,375	344,463

\* 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	\$ 796	\$ 182	
<b>Total Other Advertising</b>	<b>\$ 796</b>	<b>\$ 182</b>	<b>\$ -</b>

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 5,127	\$ 1,175	
<b>Total Dues</b>	<b>\$ 5,127</b>	<b>\$ 1,175</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)
Bank Charges	\$ 46,310	\$ 10,609	
Payroll processing	\$ 18,533	\$ 4,245	
Employee Physicals	\$ 14,480	\$ 3,317	
Medicare assessments	\$ 3,848	\$ 902	
Penalties	\$ 16,987	\$ 3,984	
Data processing	\$ 62,977	\$ 14,427	
Licenses	\$ 716	\$ 164	
CMS Penalty 2021-01-LTC-524	\$ 16,400	\$ 3,600	
CMS Penalty 2022-01-LTC-067	\$ 7,897	\$ 1,853	
<b>Total Other Administrative and General</b>	<b>\$ 188,148</b>	<b>\$ 43,101</b>	<b>\$ -</b>

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

Name of Facility Crestfield Rehabilitation Center	License No. 2344	Report for Year Ended 9/30/2022	Page of 17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Assoc., Inc, 135 South Rd, Farmington, CT		contract attached to prior year	see Below
Allocation of the above			Pg 16, Line 12, Pg 20, L
Athena Health Care Assoc., Inc, 135 South Rd, Farmington, CT		Admin/Gen - Other Expense	Pg 16, Line 12

**\* 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 Crestfield Rehabilitation Center	License No. 2344	Report for Year Ended 9/30/2022		Page 18   37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 318,437	259,085	59,352	
2. Non-Food Supplies	\$ 23,418	19,053	4,365	
3. Other (Specify) _____ Dishes & Utensils	\$ 8,304	6,756	1,548	
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	\$			
c. Other (Specify) _____	\$			
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 350,159</b>	<b>284,894</b>	<b>65,265</b>	
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	313	255	58	
G. Is cost of employee meals included in 2D? <input checked="" type="radio"/> Yes <input type="radio"/> No				
H. Did you receive revenue from employees? <input checked="" type="radio"/> Yes <input type="radio"/> No			If yes, specify amt.	\$657
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				pg 18, Ln 2a1
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input checked="" type="radio"/> Yes <input type="radio"/> No		If yes, specify cost.	\$3,456
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 Crestfield Rehabilitation Center	License No. 2344	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. \$	43,010	34,994	8,016	
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$				
c. Other ( <i>Specify</i> ) supplies	\$	10,803	8,790	2,013	
<b>3D. Total Laundry Expenditures (3a + b + c )</b>	\$	53,813	43,784	10,029	
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 Crestfield Rehabilitation Center	License No. 2344	Report for Year Ended 9/30/2022		Page 20	of 37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 54,798	44,584	10,214	
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )					
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 (Specify)	\$				
<b>4D. Total Housekeeping Expenditures (4a + b + c )</b>	\$	<b>54,798</b>	<b>44,584</b>	<b>10,214</b>	
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Procare	\$	<b>528,262</b>	<b>430,882</b>	<b>97,380</b>	
b. Medicine Cabinet Drugs	\$	<b>25,443</b>	<b>20,701</b>	<b>4,742</b>	
c. Medical and Therapeutic Supplies	\$	<b>283,115</b>	<b>230,347</b>	<b>52,768</b>	
d. Ambulance/Limousine***	\$	<b>18,473</b>	<b>18,473</b>		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	<b>26,601</b>	<b>21,600</b>	<b>5,001</b>	
f. X-rays and Related Radiological Procedures***	\$	<b>18,962</b>	<b>18,962</b>		
g. Dental ( <i>Not dentists who should be included under             salaries or fees</i> )	\$				
h. Laboratory***	\$	<b>11,252</b>	<b>11,252</b>		
i. Recreation	\$	<b>17,338</b>	<b>14,106</b>	<b>3,232</b>	
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (Specify)**** See Attached Schedule	\$	<b>95,754</b>	<b>77,927</b>	<b>17,827</b>	
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	<b>1,025,200</b>	<b>844,250</b>	<b>180,950</b>	

\* 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

\* 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 Crestfield Rehabilitation Center	License No. 2344	Report for Year Ended 9/30/2022			Page 22   37
Item	Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 149,405	121,558	27,847		
b. Heat	\$ 69,303	56,386	12,917		
c. Light & Power	\$ 82,880	67,432	15,448		
d. Water	\$ 28,377	23,088	5,289		
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 12,283	9,993	2,290		
f. Other ( <i>itemize</i> )	\$ 95,503	77,703	17,800		
See Attached Schedule					
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$ 437,751	356,160	81,591		
7. Depreciation ( <i>complete schedule page 23*</i> )					
a. Land Improvements	\$				
b. Building & Building Improvements	\$				
c. Non-Movable Equipment	\$				
d. Movable Equipment	\$ 27,812	17,046	10,766		
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$ 27,812	17,046	10,766		
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )					
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$ 37,312	22,869	14,443		
d. Other ( <i>Specify</i> )	\$				
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$ 37,312	22,869	14,443		
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 672,601	412,239	260,362		
10. Property Taxes					
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$ 119,251	73,089	46,162		
c. Personal property taxes	\$ 14,848	9,100	5,748		
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$ 871,824	534,343	337,481		

\* 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	Cost	Useful Life	
		Movable Category		Depreciation	
<b>Additions:</b>					
various	see attached	Administrative	\$ 15,141	10	\$ 756
various	see attached	Administrative	\$ 16,777	15	\$ 559
various	see attached	Administrative	\$ 16,499	5	\$ 1,650
various	see attached	Standard Resident	\$ 1,596	5	\$ 160
		PICK A CATEGORY			
		PICK A CATEGORY			
<b>Total additions for Movable Equipment</b>			\$ 50,013		\$ 3,125 *
<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		Cost	Useful Life		Depreciation
				Cost	Depreciation	
<b>Additions:</b>						
various	see attached		\$ 612,229	10	\$ 30,611.00	
various	see attached		\$ 2,000	2	\$ 500.00	
various	see attached		\$ 17,926.00	5	\$ 1,793.00	
various	see attached		\$ (4,708.00)	20	\$ (118.00)	
<b>Total additions for Leasehold Improvement</b>			\$ 627,447		\$ 32,786 *	
<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 Crestfield Rehabilitation Center			License No. 2344		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	9	2021	various	54,416	7,256	S/L	var	4,526	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2022	various	627,447				32,786	
C-4. Subtotal									37,312
D. <b>Total Amortization</b>									37,312

\* 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 Crestfield Rehabilitation Center	License No. 2344	Report for Year Ended 9/30/2022	Page 25	of 37																																					
<b>11. Property Questionnaire</b>																																									
<b>Part A</b> Is the property either owned by the Facility <input type="radio"/> Yes <input checked="" type="radio"/> No or leased from a Related Party?* <p style="text-align: center;">*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.</p>																																									
<table border="1"> <thead> <tr> <th>Description</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>1. Date Land Purchased</td> <td></td> </tr> <tr> <td>2. Date Structure Completed</td> <td></td> </tr> <tr> <td>3. If NOT Original Owner, Date of Purchase</td> <td>12/18/18</td> </tr> <tr> <td>4. Date of Initial Licensure</td> <td></td> </tr> <tr> <td>5. Total Licensed Bed Capacity</td> <td>155</td> </tr> <tr> <td>6. Square Footage</td> <td></td> </tr> <tr> <td>7. Acquisition Cost</td> <td></td> </tr> <tr> <td>    a. Land</td> <td></td> </tr> <tr> <td>    b. Building</td> <td></td> </tr> </tbody> </table>		Description	Total	1. Date Land Purchased		2. Date Structure Completed		3. If NOT Original Owner, Date of Purchase	12/18/18	4. Date of Initial Licensure		5. Total Licensed Bed Capacity	155	6. Square Footage		7. Acquisition Cost		a. Land		b. Building																					
Description	Total																																								
1. Date Land Purchased																																									
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a. Land																																									
b. Building																																									
<b>Part B - Owner and Related Parties</b> <table border="1"> <thead> <tr> <th></th> <th>1st Mortgage</th> <th>2nd Mortgage</th> <th>3rd Mortgage</th> <th>4th Mortgage</th> </tr> </thead> <tbody> <tr> <td>1. Financing</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>    a. Type of Financing (e.g., fixed, variable)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>    b. Date Mortgage Obtained</td> <td>12/18/18</td> <td></td> <td></td> <td></td> </tr> <tr> <td>    c. Interest Rate for the Cost Year</td> <td>6.03%</td> <td></td> <td></td> <td></td> </tr> <tr> <td>    d. Term of Mortgage (number of years)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>    e. Amount of Principal Borrowed</td> <td>5,750,000</td> <td></td> <td></td> <td></td> </tr> <tr> <td>    f. Principal balance outstanding as of</td> <td>5,347,500</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>			1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage	1. Financing					a. Type of Financing (e.g., fixed, variable)					b. Date Mortgage Obtained	12/18/18				c. Interest Rate for the Cost Year	6.03%				d. Term of Mortgage (number of years)					e. Amount of Principal Borrowed	5,750,000				f. Principal balance outstanding as of	5,347,500			
	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage																																					
1. Financing																																									
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l. Principal Outstanding on Note Paid-Off																																									
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b> <table border="1"> <thead> <tr> <th>Name and Address of Lessor</th> <th>Property Leased</th> <th>Date of Lease</th> <th>Term of Lease</th> <th>Annual Amount of Lease</th> </tr> </thead> <tbody> <tr><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>					Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease																																
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 26	of 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			Page	of
		9/30/2022			27	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)		\$	22,135	13,567	8,568	
Vendor interest						
<b>13. Total All Interest Expense (12B7 + 12C3 + 12D)</b>		\$	22,135	13,567	8,568	
14. Insurance						
a. Insurance on Property (buildings only)		\$	141,588	86,780	54,808	
b. Insurance on Automobiles		\$				
c. Insurance other than Property (as specified above)						
1. Umbrella ( <i>Blanket Coverage</i> )		\$				
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$				
<b>14d. Total Insurance Expenditures (14a + b + c)</b>		\$	141,588	86,780	54,808	
<b>15. Total All Expenditures (A-13 thru C-14)</b>		\$	14,413,461	11,727,071	2,686,390	

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

Name of Facility Crestfield Rehabilitation Center			License No. 2344	Report for Year Ended 9/30/2022		Page 28   37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS (Specify)
<b>Page 10 - Salaries and Wages</b>						
1.			Outpatient Service Costs	\$		
2.			Salaries not related to Resident Care	\$		
3.			Occupational Therapy	\$ 261,438	209,236	52,202
4.			Other - See attached Schedule	\$ 3,378	2,748	630
<b>Page 13 - Professional Fees</b>						
5.			Resident Care Physicians **	\$ 731	731	
6.			Occupational Therapy	\$		
7.			Other - See attached Schedule	\$		
<b>Pages 15 &amp; 16 - Administrative and General</b>						
8.			Discriminatory Benefits	\$		
9.			Bad Debts	\$ 292,268	292,268	
10.			Accounting	\$ 14,700	9,662	5,038
10a.			Legal	\$ 28,609	23,173	5,436
11.			Telephone	\$		
12.			Cellular Telephone	\$		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$		
14.			Gifts, flowers and coffee shops	\$ 13,107	10,664	2,443
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 *	\$ 978	796	182
19.			Income Tax / Corporate Business Tax	\$		
20.			Fund Raising / Contributions	\$		
21.			Unallowable Management Fees	\$ (193,391)	(157,346)	(36,045)
22.			Barber and Beauty	\$		
23.			Other - See attached Schedule	\$ 86,669	70,515	16,154
<b>Page 18 - Dietary Expenditures</b>						
24.			Meals to employees, guests and others who are not residents	\$ 3,456	2,812	644
<b>Page 19 - Laundry Expenditures</b>						
25.			Laundry services to employees, guests and others who are not residents	\$		
<b>Page 20 - Housekeeping Expenditures</b>						
26.			Housekeeping services to employees, guests and others who are not residents	\$		
Subtotal (Items 1 - 26)			\$ 511,943	465,259	46,684	

\* 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)
10	A12M	Marketing Salaries & Benefits	\$ 2,748	\$ 630	
<b>Total Other Salaries Adjustment</b>			<b>\$ 2,748</b>	<b>\$ 630</b>	<b>\$ -</b>

**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Fees Adjustments</b>			<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M13	Bank Fees	\$ 46,310	\$ 10,609	
16	M13	CMS Penalty 2021-01-LTC-524	\$ 16,272	\$ 3,728	
16	M13	CMS Penalty 2022-01-LTC-067	\$ 7,933	\$ 1,817	
<b>Total Other A&amp;G Adjustments</b>			<b>\$ 70,515</b>	<b>\$ 16,154</b>	<b>\$ -</b>

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
Item No.	Page No.	Line No.		2344	9/30/2022	29	37
Item Description				Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward			\$	511,943	465,259	46,684	
<b>Page 20 - Resident Care Supplies***</b>							
27.			Prescription Drugs	\$ 528,262	430,882	97,380	
28.			Ambulance/Limousine	\$ 18,473	18,473		
29.			X-rays, etc	\$ 18,962	18,962		
30.			Laboratory	\$ 11,252	11,252		
31.			Medical Supplies	\$ 15,500	12,611	2,889	
32.			Oxygen (non emergency)	\$ 26,601	21,600	5,001	
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 13,440	10,935	2,505	
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 5,160	3,163	1,997	
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	\$ 25,412	20,676	4,736	
43.			Interest Income on Account Rec.	\$ 1,183	963	220	
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$ (52,743)	(52,743)		
46.			Management Fees Indirect	\$ (46,883)	(46,883)		
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>			\$	1,076,562	915,150	161,412	

\*\*\* 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)
20	5b	Ebox	\$ 10,935	\$ 2,505	
<b>Total Other Ancillary Costs</b>			\$ 10,935	\$ 2,505	\$ -

**Schedule of Excess Movable Equipment Depreciation**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excess Moveable Equipment Depreciation	\$ 3,163	\$ 1,997	
<b>Total Excess Movable Equipment Depreciation</b>			\$ 3,163	\$ 1,997	\$ -

**Schedule of Other Property Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Property Adjustments</b>			\$ -	\$ -	\$ -

## **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 Crestfield Rehabilitation Center	License No. 2344	Report for Year Ended 9/30/2022			Page 30   37
Item		Total	CCNH	RHNS	(Specify)
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 10,388,384	10,369,064	19,320		
b. Medicaid Room and Board Contractual Allowance **	\$ (3,412,707)	(3,406,390)	(6,317)		
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 2,364,347	2,269,727	94,620		
b. Medicare Room and Board Contractual Allowance **	\$ 1,169,870	1,169,870			
4. a. Private-Pay Residents and Other	\$ 3,599,726	2,070,587	1,529,139		
b. Private-Pay Room and Board Contractual Allowance **	\$				
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 115,095	93,643	21,452		
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (115,095)	(93,643)	(21,452)		
c. Prescription Drugs - Non-Medicare	\$ 139,260	100,156	39,104		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (139,260)	(100,156)	(39,104)		
2. a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$ 185	185			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (185)	(185)			
3. a. Physical Therapy - Medicare	\$ 730,398	669,514	60,884		
b. Physical Therapy - Medicare Contractual Allowance **	\$ (567,681)	(536,832)	(30,849)		
c. Physical Therapy - Non-Medicare	\$ 499,025	424,283	74,742		
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (499,025)	(423,553)	(75,472)		
4. a. Speech Therapy - Medicare	\$ 226,870	188,443	38,427		
b. Speech Therapy - Medicare Contractual Allowance **	\$ (176,715)	(150,092)	(26,623)		
c. Speech Therapy - Non-Medicare	\$ 128,550	110,889	17,661		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (128,550)	(110,889)	(17,661)		
5. a. Occupational Therapy - Medicare	\$ 729,553	583,883	145,670		
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (581,016)	(465,004)	(116,012)		
c. Occupational Therapy - Non-Medicare	\$ 540,625	451,592	89,033		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (540,625)	(451,592)	(89,033)		
6. a. Other ( <i>Specify</i> ) - Medicare	\$				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ (91,664)	(91,664)			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 14,379,365	12,671,836	1,707,529		
<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> )	\$ 1,183	963	220		
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 53,215	43,297	9,918		
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 54,398	44,260	10,138		
<b>VI. Total All Revenue</b> (III +V)	\$ 14,433,763	12,716,096	1,717,667		

\* 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)
	<b>Total Other Resident Revenue - Medicare</b>	\$ -	\$ -	\$ -

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

Page Ref	Description	CCNH	RHNS	(Specify)
	Medicaid Retro	\$ (125,601)		
	Medicare Retro	\$ 33,937		
	<b>Total Other Resident Revenue</b>	\$ (91,664)	\$ -	\$ -

**Interest Income****Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
pg 31,L A2	Interest on AR	NA	\$ 963	\$ 220	
	<b>Total Interest Income</b>		\$ 963	\$ 220	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
	bad debt recoveries	\$ 43,297	\$ 9,918	
	<b>Total Other Revenue</b>	\$ 43,297	\$ 9,918	\$ -

**G. Balance Sheet**

Name of Facility Crestfield Rehabilitation Center	License No. 2344	Report for Year Ended 9/30/2022	Page 31	of 37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$ 2,375	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 2,992,764	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$ (19,694)	
4. Inventories			\$ 20,232	
5. Prepaid Expenses			\$ 180,077	
a. Prepaid Insurance		178,375		
b. Prepaid Expenses ( <i>itemize</i> )		1,702		
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$ 4,249	
A/R Related		4,249		
_____				
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$ 3,180,003	
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____	Net	
3. Buildings	*Historical Cost	_____	\$	
	Accum. Depreciation	_____	Net	
4. Leasehold Improvements	*Historical Cost	681,863	\$	637,295
	Accum. Depreciation	44,568	Net	
5. Non-Movable Equipment	*Historical Cost	_____	\$	
	Accum. Depreciation	_____	Net	
6. Movable Equipment	*Historical Cost	196,018	\$	113,800
	Accum. Depreciation	82,218	Net	
7. Motor Vehicles	*Historical Cost	_____	\$	
	Accum. Depreciation	_____	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$ 33,936	
See Schedule		33,936		
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$ 785,031	

\* 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	
<b>Total Prepaid Expenses</b>			\$ -

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

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

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

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

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

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

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

## G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Crestfield Rehabilitation Center	2344	9/30/2022	32   37
Account			Amount
Total Brought Forward:			\$ 3,965,034
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			\$
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$
D. Investment and Other Assets			
1. Deferred Deposits			\$
2. Escrow Deposits			\$
3. Organization Expense	*Historical Cost	Accum. Depreciation	Net
4. Goodwill (Purchased Only)			\$ 1,892,898
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> )			\$ 43,541
Deposits-Utilities	4,855		
Project Development	38,686		
See Schedule			
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$ 1,936,439
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$ 5,901,473

\* 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
		9/30/2022	33	37
		Account	Amount	
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable				\$ 3,824,422
2. Notes Payable ( <i>itemize</i> )				\$ (3,989,233)
Due from Related Party				(656,971)
Line of Credit				(3,332,262)
See Schedule				
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$ 389,598
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$
6. Accrued Payroll Taxes Payable				\$ 264,315
7. Medicare Final Settlement Payable				\$
8. Medicare Current Financing Payable				\$
9. Mortgage Payable ( <i>Current Portion</i> )				\$
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$
11. Accrued Income Taxes*				\$
12. Other Current Liabilities ( <i>itemize</i> )				\$ 1,599,894
Accrued Operating expenses		16,966		
Provider taxes due		1,582,617		
Accrued sales & use tax		311		
See Schedule				
<b>A-13. Total Current Liabilities</b> (Lines A1 thru 12)				\$ 2,088,996

\* 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 Crestfield Rehabilitation Center	License No. 2344	Report for Year Ended 9/30/2022	Page 34	of 37
Account			Amount	
Total Brought Forward:			\$ 2,088,996	
<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> )			\$ 1,410,315	
Name and Address of Lender	Amount	Loan Date		
Related Party	1,186,641	none		
procare investments	223,674			
4. Other Long-Term Liabilities ( <i>itemize</i> )			\$ 377,564	
<u>Note payable-Procare CT</u>				
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)			\$ 1,787,879	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)			\$ 3,876,875	

## G. Balance Sheet (cont'd)

### Reserves and Net Worth

Name of Facility Crestfield Rehabilitation Center	License No. 2344	Report for Year Ended 9/30/2022	Page 35	of 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				\$ 2,004,266
6. Gain or Loss for Period	10/1/2021	thru	9/30/2022	\$ 20,332
7. Total Net Worth				\$ 2,024,598
<b>C. Total Reserves and Net Worth</b>				\$ 2,024,598
<b>D. Total Liabilities, Reserves, and Net Worth</b>				\$ 5,901,473

## H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Crestfield Rehabilitation Center	2344	9/30/2022	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2021				\$ 2,038,456		
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )				\$ 14,433,763		
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )				\$ 14,413,431		
D. Net Income or Deficit				\$ 20,332		
E. Balance				\$ 2,058,788		
F. Additions						
1. Additional Capital Contributed ( <i>itemize</i> )						
2021 Expense adjmt-nurse Pool			(34,190)			
2. Other ( <i>itemize</i> )						
F-3. Total Additions				\$ (34,190)		
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>				\$ 2,024,598		

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

Name of Facility Crestfield Rehabilitation Center	License No. 2344	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	Date Signed
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Printed Name of Preparer
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Athena Health Care Associates
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Address Address 135 South Rd, Farmington, CT 06032	Phone Number 860-751-3900
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Contacted Person Regarding Additional Information Needed Regarding This Report lynn Rinaldi	Phone Number 860-751-3900
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Contact Email Address lrinaldi@athenahealthcare.com
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