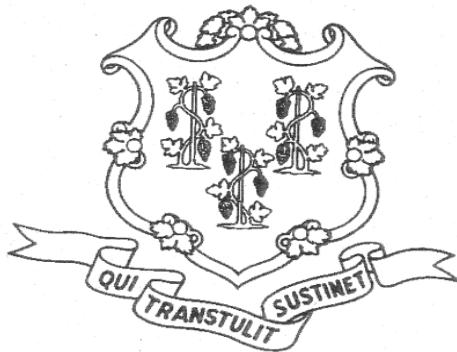


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) Healthcare Visions, Inc. d/b/a Beechwood	
Address (No. & Street, City, State, Zip Code) 31 Vauxhall Street, New London, CT 06320	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH 2077-C	RHNS	(Specify)	Medicare Provider 07-5335
------------------	----------------	------	-----------	------------------------------

Medicaid Provider Numbers:	CCNH 6221	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) Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2021	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 Healthcare Visions, Inc. d/b/a Beechwood [facility name], for the cost report period beginning October 1, 2020 and ending September 30, 2021, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)	Date	Signed (Owner)	Date
Printed Name (Administrator) William E. White		Printed Name (Owner)	
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>
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
<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 Healthcare Visions, Inc. d/b/a Beechwood	Period Covered:		From 10/1/2020	To 9/30/2021
Address of Facility 31 Vauxhall Street, New London, CT 06320				
Report Prepared By Marcum LLP	Phone Number 203-781-9600	Date 1/20/2022		
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 860-442-4363	Report for Year Ended 9/30/2021	Page 2	of 37
Name of Facility (as shown on license) Healthcare Visions, Inc. d/b/a Beechwood		Address (No. & Street, City, State, Zip ) 31 Vauxhall Street, New London, CT 06320	
License Numbers:	CCNH 2077-C	RHNS (Specify)	Medicare Provider No. 07-5335
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 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.	
N/A			
<b>Administrator</b>			
Name of Administrator William E. White		Nursing Home Administrator's License No.:	1539
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**

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2021	Page of 3A   37
If this facility is owned or operated as a corporation, provide the following information:			
Legal Name of Corporation Healthcare Visions, Inc. d/b/a Beechwood	Business Address 31 Vauxhall Street, New London, CT 06320	State(s) in Which Incorporated CT	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
William G. White	31 Vauxhall Street, New London, CT 06320	CEO	100
Diane H. White	31 Vauxhall Street, New London, CT 06320	Secretary	
William E. White	31 Vauxhall Street, New London, CT 06320	President	
Names of Stockholders Owning at Least 10% of Shares			
William G. White	31 Vauxhall Street, New London, CT 06320	CEO	100

State of Connecticut

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

CSP-3B Rev. 10/2005

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

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2021	Page of 3B   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 Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2021			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input checked="" type="radio"/> Yes <input type="radio"/> No				If "Yes," provide the Name/Address and complete the information on Page 11 of the report.				
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? <input checked="" type="radio"/> Yes <input type="radio"/> No				If "Yes," provide the following information:				
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Victorian Management, Inc.	31 Vauxhall Street, New London, CT 06320	<input type="radio"/>	<input checked="" type="radio"/>		Rental of Building	Page 22 / Line 9	341,973	229,607
Diane H. White	31 Vauxhall Street, New London, CT 06320	<input type="radio"/>	<input checked="" type="radio"/>		Rental of Parking Lot	Page 22 / Line 9	11,400	11,400
Victorian Management, Inc.	31 Vauxhall Street, New London, CT 06320	<input type="radio"/>	<input checked="" type="radio"/>		Building Depreciation	Page 22 / Line 7b	168,521	168,521
		<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.

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

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2021	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.

N/A

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

N/A

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.

State of Connecticut

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

CSP-6 Rev. 9/2002

**General Information and Questionnaire  
Leases (Excluding Real Property)**

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

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood		License No. 2077-C		Report for Year Ended 9/30/2021			Page <span style="border-left: 1px solid black; padding: 0 5px;">6</span> of <span style="border-left: 1px solid black; padding: 0 5px;">37</span>
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
Accelerated Care Plus (ACP), 13828 Collection Center, Chicago, Ill	<input type="radio"/>	<input checked="" type="radio"/>	Rehab Equipment	06/10/09	Open Ended	73	73
Elm City	<input type="radio"/>	<input checked="" type="radio"/>	Copiers		Open Ended	7,106	7,106
Aztec, 31 Vauxhall St, New London, CT 06320	<input type="radio"/>	<input checked="" type="radio"/>	Copiers	06/26/18	60 Months	3,303	3,303
Jeep	<input type="radio"/>	<input checked="" type="radio"/>	Car Lease	01/13/20	36 Months	6,328	6,328
	<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"/>					
Is a Mileage Log Book Maintained for All Leased Vehicles ?		<input type="radio"/> Yes		<input checked="" type="radio"/> No		<b>Total ***</b>	16,810

\* 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 Healthcare Visions, Inc. d/b/a Beec	License No. 2077-C	Report for Year Ended 9/30/2021	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     Yes    If "No," explain.  
previous period?     No

#### Independent Accounting Firm

Name of Accounting Firm 1    Marcum LLP 2    Laura Daniels 3    Whittlesey & Hadley, P.C. 4	Address (No. & Street, City, State, Zip Code) 555 Long Wharf Drive, 8th Floor, New Haven, CT 06511 7 Fencove Ct, Old Saybrook, CT 06475 1 Hamden Center, 2319 Whitney Ave, Suite 2a, Hamden, CT
---	--

Services Provided by This Firm (*describe fully*)

1    Medicaid & Medicare Cost Reports, Management Advisory Services(\$24,038 Disallowed on Pg 28)	\$    29,725
2    Month End Closings	\$    5,250
3    Review of Financial Statements and Preparation of Tax Returns	\$    31,276
4	\$
	Charge for Services Provided \$    66,251

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

Yes     No    |Page 15 1d

#### Legal Services Information

Name of Legal Firm or Independent Attorney 1    Murtha Cullina 2    Cushman & Wakefield 3    Stotler Hayes Group 4 5	Telephone Number 860-240-6000 201-508-5215 843-235-9871
---	--

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

1    PO Box 150435, Hartford, CT 06115	
2    107 Elm Street, Stamford, CT, 06902	
3    Georgetown S. Carolina	
4	
5	

Services Provided by This Firm (*describe fully*)

1    General Coperate Matters	\$    7,150
2    Retainer	\$    4,000
3    Collection fees (Disallowed)	\$    6,111
4	\$
5	\$
	Charge for Services Provided \$    17,261

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

Yes     No    |Page 15 1e

## Schedule of Resident Statistics

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood			License No. 2077-C				Report for Year Ended 9/30/2021				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					60	60						
A. On last day of PREVIOUS report period	60	60										
B. On last day of THIS report period	60	60							60	60		
2. Number of Residents					55	55						
A. As of midnight of PREVIOUS report period	55	55										
B. As of midnight of THIS report period	51	51							51	51		
3. Total Number of Days Care Provided During Period					2,118	2,118			1,001	1,001		
A. Medicare	3,119	3,119										
B. Medicaid (Conn.)	11,125	11,125			8,219	8,219			2,906	2,906		
C. Medicaid (other states)												
D. Private Pay	3,239	3,239			2,384	2,384			855	855		
E. State SSI for RCH												
F. Other (Specify)	112	112			81	81			31	31		
G. Total Care Days During Period (3A thru F)	17,595	17,595			12,802	12,802			4,793	4,793		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	119	119			81	81			38	38		
B. Other Bed Reserve Days												
<b>5. Total Resident Days (3G + 4A + 4B)</b>	<b>17,714</b>	<b>17,714</b>			<b>12,883</b>	<b>12,883</b>			<b>4,831</b>	<b>4,831</b>		

## Schedule of Resident Statistics (Cont'd)

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2021	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	13		31		7			
Per Diem Rate								
a. One bed rm.	Various		292.00		455.00			
b. Two bed rms.	Various		292.00		415.00			
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
		653	653	
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments		117	117	
C. Other		2,561	2,561	
D. <b>Total Physical Therapy Treatments</b>		3,331	3,331	
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B		94	94	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments		28	28	
C. Other		403	403	
D. <b>Total Speech Therapy Treatments</b>		525	525	
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B		585	585	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments		171	171	
C. Other		2,621	2,621	
D. <b>Total Occupational Therapy Treatments</b>		3,377	3,377	

## Report of Expenditures - Salaries &amp; Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		2077-C	9/30/2021	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
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)		87,347	Disallowed		
2. Administrator(s) (Complete also Sec. III of Schedule A1)		115,746	2,000		
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)		224,542	9,505		
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor					
c. Dietary Workers		316,352	14,924		
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers		204,427	10,712		
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance					
b. Other Maintenance Workers		114,962	4,854		
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers		14,599	1,913		
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		148,915	2,441		
b. RN					
1. Direct Care		574,160	13,877		
2. Administrative**		223,565	6,033		
c. LPN					
1. Direct Care		619,712	19,424		
2. Administrative**					
d. Aides and Attendants		1,095,619	53,929		
e. Physical Therapists					
f. Speech Therapists					
g. Occupational Therapists					
h. Recreation Workers		88,181	4,544		
i. Physicians					
1. Medical Director					
2. Utilization Review					
3. Resident Care***					
j. Dentists					
k. Pharmacists					
l. Podiatrists					
m. Social Workers/Case Management		71,175	1,833		
n. Marketing					
o. Other (Specify)		60,360	2,040		
See Attached Schedule					
A-13. Total Salary Expenditures		3,959,662	148,029		

\* 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 Healthcare Visions, Inc. d/b/a Beechwood			License No. 2077-C		Report for Year Ended 9/30/2021			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>										
William G. White	87,347			See Page 28	Owner/CEO	N/A	A1			
<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>										
Jody White	60,360			Group Benefits	Admissions	2,040	A12o			

\* 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	of
Healthcare Visions, Inc. d/b/a Beechwood				2077-C		9/30/2021			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section III - Administrators***</b>										
William E. White	115,746			Group Benefits	Administrator	2,000	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 Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2021		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 (For all such services complete Schedule B1)</b>					
1. Dietitian	20,692	440			
2. Dentist	4,914	Monthly			
3. Pharmacist	5,697	102			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	204,325	2,349			
b. Other					
6. Social Worker	(751)	N/A			
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	45,000	180			
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) Physiatrist	4,575	31			
9. Speech Therapist					
a. Resident Care	27,525	316			
b. Other					
10. Occupational Therapist					
a. Resident Care	202,769	2,331			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	16,220	108			
2. Administrative***					
b. LPN					
1. Direct Care	25,179	560			
2. Administrative***					
c. Aides	52,713	3,514			
d. Other					
12. Other (Specify) See Attached Schedule					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	608,858	9,931			

\* 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 Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2021		Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
HealthPro Heritage PO Box 69268, Baltimore MD 21264-9268	Physical, Occupational and Speech Therapy	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Partners Pharmacy, 50 Lawrence Road, Springfield Township, New Jersey 07081	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Yale NewHaven Health, PO Box 9403, New Haven, CT 06534	Physiatrist	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Mystic Geriatric, 3 Heron Road Mystic, CT 06355	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Kathleen Labella-17 College Street, Old Saybrook Ct	Dietician	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Republic Healthcare-Wells Fargo PO Box 202056, Dallas, Tx	RN Pool	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Norton & Associates, 97 Elm St, Cohasset, MA 02025	LPN Pool	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Genie Healthcare, 104 Interchange Plaza, Monroe NJ	LPN/Aides Pool	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
		<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"/>		
		<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	License No.	Report for Year Ended	Page	of
Healthcare Visions, Inc. d/b/a Beechwood	2077-C	9/30/2021	15	37
Item		Total	CCNH	RHNS
1. Administrative and General				(Specify)
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$	78,317	78,317	
2. Disability Insurance	\$	6,546	6,546	
3. Unemployment Insurance	\$	48,723	48,723	
4. Social Security (F.I.C.A.)	\$	292,112	292,112	
5. Health Insurance	\$	308,091	308,091	
6. Life Insurance (employees only) (not-owners and not-operators)	\$	3,889	3,889	
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$			
8. Uniform Allowance	\$			
9. Other (Specify) See Attached Schedule	\$	15,542	15,542	
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$	74,615	74,615	
d. Accounting and Auditing	\$	66,251	66,251	
e. Legal (Services should be fully described on Page 7)	\$	17,261	17,261	
f. Insurance on Lives of Owners and Operators (Specify)*	\$			
g. Office Supplies	\$	85,899	85,899	
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$	9,158	9,158	
2. Cellular Phones	\$	1,575	1,575	
i. Appraisal (Specify purpose and attach copy)*	\$			
j. Corporation Business Taxes (franchise tax)	\$	203	203	
k. Other Taxes (Not related to property - See Page 22)				
1. Income*	\$			
2. Other (Specify) See Attached Schedule	\$			
3. Resident Day User Fee	\$	303,592	303,592	
<b>Subtotal</b>	\$	1,311,774	1,311,774	

\* 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)
	0		
Participant Fees - Beneflex	\$ 595		
William G White Benefits(Disallow)	\$ 3,952		
Employee turkeys at Thanksgiving	\$ 1,491		
Flu Shots	\$ 4,614		
Employee X-Ray PPD(Disallowed)	\$ 150		
JE Adjustment(Disallowed)	\$ 690		
Employee Relations(Disallow)	\$ 1,509		
Employee Assistance Progr.	\$ 869		
401K Fees	\$ 1,672		
<b>Total</b>	<b>\$ 15,542</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Taxes**

Description	CCNH	RHNS	(Specify)
	0		
<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2021		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
	<b><i>Subtotals Brought Forward:</i></b>	1,311,774	1,311,774		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	27,185	27,185		
3. Gifts to Staff and Residents	\$	2,396	2,396		
4. Employee Travel	\$	833	833		
5. Education Expenses Related to Seminars and Conventions	\$	1,142	1,142		
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$	4,258	4,258		
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$	8,186	8,186		
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	3,952	3,952		
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	\$				
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	4,061	4,061		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	349	349		
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$	100	100		
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$	41,649	41,649		
12. Administrative Management Services**	\$				
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	64,311	64,311		
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$	1,470,196	1,470,196		

\* 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)
	0		
<b>Total Other Travel and Entertainment</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
	0		
Promotional Advertising(Disallowed)	\$ 3,952		
<b>Total Other Advertising</b>	<b>\$ 3,952</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
	0		
CAHCF	\$ 3,421		
AHCA	\$ 600		
CATRD	\$ 40		
<b>Total Dues</b>	<b>\$ 4,061</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
	0		
Donations	\$ 100		
<b>Total Contributions</b>	<b>\$ 100</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
	0		
Pre Employment Expenses	\$ 4,953		
Licensing Fees	\$ 735		
Routine Bank Charges	\$ 2,200		
Credit Card Fees	\$ 1,283		
Other Bank Charges	\$ 27		
COVID Expenses	\$ 55,113		
<b>Total Other Administrative and General</b>	<b>\$ 64,311</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 Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2021	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 #
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
	2077-C	9/30/2021		18   37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 156,403	156,403		
2. Non-Food Supplies	\$ 12,937	12,937		
3. Other (Specify) _____	\$			
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	\$			
c. Other (Specify) _____ Other Dietary Supplies	\$			
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 169,340</b>	<b>169,340</b>		
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 Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2021	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. \$	4,169	4,169	
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.			
	Amt. \$			
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.			
	Amt. \$			
4. Repair and/or purchase of linens.***	Lbs.			
	Amt. \$			
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$			
c. Other (Specify) Supplies	\$	6,504	6,504	
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	\$	10,673	10,673	
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 Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2021		Page 20	of 37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 28,632	28,632		
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )					
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel				
Amt.	\$				
C. Other ( <i>Specify</i> )	\$				
<b>4D. Total Housekeeping Expenditures (4a + b + c )</b>	\$	28,632	28,632		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Partner's Pharmacy	\$	126,116	126,116		
b. Medicine Cabinet Drugs	\$	49,946	49,946		
c. Medical and Therapeutic Supplies	\$	124,705	124,705		
d. Ambulance/Limousine***	\$	14,669	14,669		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	9,044	9,044		
f. X-rays and Related Radiological Procedures***	\$	6,780	6,780		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$	12,957	12,957		
i. Recreation	\$	2,056	2,056		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other ( <i>Specify</i> )**** See Attached Schedule	\$	11,228	11,228		
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	357,501	357,501		

\* 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 \***

\* 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 Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2021			Page 22   37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 31,375	31,375			
b. Heat	\$ 38,234	38,234			
c. Light & Power	\$ 71,562	71,562			
d. Water	\$ 32,260	32,260			
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 16,810	16,810			
f. Other ( <i>itemize</i> )	\$ 14,411	14,411			
See Attached Schedule					
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$ 204,652	204,652			
7. Depreciation ( <i>complete schedule page 23*</i> )					
a. Land Improvements	\$				
b. Building & Building Improvements	\$ 168,521	168,521			
c. Non-Movable Equipment	\$				
d. Movable Equipment	\$ 32,307	32,307			
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$ 200,828	200,828			
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )					
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$ 1,359	1,359			
d. Other ( <i>Specify</i> )	\$				
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$ 1,359	1,359			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 353,373	353,373			
10. Property Taxes					
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$ 93,604	93,604			
c. Personal property taxes	\$ 894	894			
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$ 650,058	650,058			

\* 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

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood				License No. 2077-C			Report for Year Ended 9/30/2021				Page 23	of 37
Property Item				Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals	
<b>A. Land Improvements</b>												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
<b>A-4. Subtotal</b>												
<b>B. Building and Building Improvements</b>				5,055,638		5,055,638	4,459,322	S/L	Various	168,521		
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
<b>B-4. Subtotal</b>												
<b>C. Non-Movable Equipment</b>												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
<b>C-4. Subtotal</b>												
	Is a mileage logbook maintained?	Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year		
		Yes	No									
<b>D. Movable Equipment</b>												
1. Motor Vehicles (Specify name, model and year of each vehicle)				159,495		159,495	117,578	S/L	Various	14,492		
a. Various Vehicles (See attached)		Var	Var		(87,035)		(87,035)	(87,035)				
b. Disposals												
c.												
d.												
2. Movable Equipment				218,072		218,072	149,765	S/L	Various	17,815		
a. Acquired prior to this report period		Var	Var		(21,935)		(21,935)	(21,935)				
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)												
<b>D-3. Subtotal</b>											32,307	
<b>E. Total Depreciation</b>											200,828	

**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 C3

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

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

\*\*Ties to Page 23, Line D2b

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

\*Ties to Page 24, Line C3

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

## Amortization Schedule\*

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood			License No. 2077-C		Report for Year Ended 9/30/2021			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. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	Var	Var	Various	74,015	66,749	S/L	Var	1,359	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal								1,359	
D. Total Amortization									1,359

\* 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 Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2021	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	01/01/55			
2. Date Structure Completed	01/01/55			
3. If NOT Original Owner, Date of Purchase	03/08/93			
4. Date of Initial Licensure	04/01/91			
5. Total Licensed Bed Capacity	60			
6. Square Footage	47,000			
7. Acquisition Cost				
a. Land	10,466			
b. Building	17,785			

##### 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	04/21/16			
c. Interest Rate for the Cost Year	3.83%			
d. Term of Mortgage (number of years)	18			
e. Amount of Principal Borrowed	3,659,568			
f. Principal balance outstanding as of 9/30/21	2,849,736			

##### 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 9/30/2021			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 9/30/2021			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)		\$	15,416	15,416		
Interest Expense						
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)		\$	15,416	15,416		
14. Insurance						
a. Insurance on Property (buildings only)		\$	21,861	21,861		
b. Insurance on Automobiles		\$				
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$				
2. Fire and Extended Coverage		\$	1,129	1,129		
3. Other (Specify)		\$	21,018	21,018		
Director Ins \$17,566 (Disallowed) Cyber Liability \$3,45						
14d. <b>Total Insurance Expenditures</b> (14a + b + c)		\$	44,008	44,008		
15. <b>Total All Expenditures</b> (A-13 thru C-14)		\$	7,518,996	7,518,996		

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

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood			License No. 2077-C	Report for Year Ended 9/30/2021		Page 28	of 37
Item No.	Page No.	Line No.	Item Description	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	\$ 87,347	87,347		
<b><i>Page 13 - Professional Fees</i></b>							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$ 202,769	202,769		
7.			Other - See attached Schedule	\$ (751)	(751)		
<b><i>Pages 15 &amp; 16 - Administrative and General</i></b>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 74,615	74,615		
10.	15	1d	Accounting	\$ 24,038	24,038		
10a.			Legal	\$ 6,111	6,111		
11.			Telephone	\$			
12.	15	h2	Cellular Telephone	\$ 495	495		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	l3	Gifts, flowers and coffee shops	\$ 2,396	2,396		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.	16	L4	Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$ 1,498	1,498		
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m2/3	Unallowable Advertising *	\$ 3,952	3,952		
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m10	Fund Raising / Contributions	\$ 100	100		
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 37,350	37,350		
<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)			\$ 439,920	439,920			

\* 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	A1	Owner's Salary	\$ 87,347		
<b>Total Other Salaries Adjustment</b>			\$ 87,347	\$ -	\$ -

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**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13B	6	Contracted Social Worker	\$ (751)		
<b>Total Other Fees Adjustments</b>			\$ (751)	\$ -	\$ -

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**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m8a	Chamber Dues	\$ 349		
15	1a9	William G White Benefits(Disallow)	\$ 3,952		
15	1a9	Employee Assistance Progr.	\$ 1,509		
16	m13	Credit Card Fees	\$ 1,283		
16	m13	Other Bank Charges	\$ 27		
15	1a9	Employee X-Ray PPD(Disallowed)	\$ 150		
15	1a9	JE Adjustment(Disallowed)	\$ 690		
15	1a9	William E White Insurance Expense(Disallow)	\$ 1,245		
15	1g	Office Supplies	\$ 13,616		
16	L3	Patient Relations	\$ 2,396		
16	L4	Travel	\$ 833		
16	L6	Auto Expenses	\$ 4,258		
15	Various	Owner's Benefits	\$ 7,042		
<b>Total Other A&amp;G Adjustments</b>			\$ 37,350	\$ -	\$ -

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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	
Healthcare Visions, Inc. d/b/a Beechwood			2077-C	9/30/2021		29   37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 439,920	439,920		
			<b><i>Page 20 - Resident Care Supplies***</i></b>				
27.	20	5a2	Prescription Drugs	\$ 126,116	126,116		
28.	20	5d	Ambulance/Limousine	\$ 14,669	14,669		
29.	20	5f	X-rays, etc	\$ 6,780	6,780		
30.	20	5h	Laboratory	\$ 12,957	12,957		
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 9,044	9,044		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 15,236	15,236		
			<b><i>Page 22 - Maintenance and Property</i></b>				
35.			Excess Movable Equipment Depreciation				
			See Attached Schedule	\$ 7,096	7,096		
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	\$ 23,894	23,894		
			<b><i>Page 27 - Insurance</i></b>				
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
			<b><i>Other - Miscellaneous</i></b>				
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ 1,971	1,971		
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
			<b><i>Not For Profit Providers Only</i></b>				
48.			Building/Non Movable Eq. Depreciation				
			Unallowable Building Interest -				
			See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 657,683	657,683		

\*\*\* 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	5j	Oxygen Rental-MRA(Disallow)	\$ 996		
20	5j	Oxygen Rental-Managed Care(Disallow)	\$ 483		
20	5j	Oxygen Rental - House(Disallow)	\$ 2,542		
20	5j	Splint/Brace Supplies(Disallow)	\$ 46		
20	5j	W/C Parts(Disallowed)	\$ 298		
20	5f	X-Rays Managed	\$ 2,986		
20	5h	Medicare A - Laboratory	\$ 7,885		
<b>Total Other Ancillary Costs</b>			\$ 15,236	\$ -	\$ -

**Schedule of Excess Movable Equipment Depreciation**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	B7	Motor Vehicle Depreciation Disallowance	\$ 7,096		
<b>Total Excess Movable Equipment Depreciation</b>			\$ 7,096	\$ -	\$ -

**Schedule of Other Property Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	6e	Auto Lease	\$ 6,328		
27	14c	Director & Owner Insurance	\$ 17,566		
<b>Total Other Property Adjustments</b>			\$ 23,894	\$ -	\$ -

### **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		Page of	
		9/30/2021		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> )	\$ 4,163,855	4,163,855			
b. Medicaid Room and Board Contractual Allowance **	\$ (1,308,696)	(1,308,696)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 816,750	816,750			
b. Medicare Room and Board Contractual Allowance **	\$ 366,618	366,618			
4. a. Private-Pay Residents and Other	\$ 1,992,244	1,992,244			
b. Private-Pay Room and Board Contractual Allowance **	\$ 74,475	74,475			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 62,249	62,249			
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$ 79,401	79,401			
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	\$ 216,977	216,977			
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$ 184,206	184,206			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$ 34,580	34,580			
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$ 29,131	29,131			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 216,739	216,739			
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$ 217,024	217,024			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other ( <i>Specify</i> ) - Medicare	\$ (409,357)	(409,357)			
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ (361,319)	(361,319)			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 6,374,877	6,374,877			
<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> )	\$ 1,259	1,259			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 1,087,449	1,087,449			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 1,088,708	1,088,708			
<b>VI. Total All Revenue</b> (III +V)	\$ 7,463,585	7,463,585			

\* 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 II 6a	Laboratory-Med A	\$ 7,919		
30 II 6a	Equipment Rental-Med A	\$ 810		
30 II 6a	Other Services-MCR	\$ 9,186		
30 II 6a	Contract Allow-Ancillary-MCR	\$ (401,810)		
30 II 6a	Radiology-MCR	\$ 3,939		
30 II 6a	Contract All Ancillarie-Med B	\$ (29,394)		
30 II 6a	Med B C/A 2% Sequestration	\$ (7)		
<b>Total Other Resident Revenue - Medicare</b>		<b>\$ (409,357)</b>	\$ -	\$ -

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

Page Ref	Description	CCNH	RHNS	(Specify)
30 II6b	Oxygen Sup & Rental-Title XIX	4,876		
30 II6b	Equipment Rental-MCD	623		
30 II6b	Contract Allow-MCD Ancillary	(23,256)		
30 II6b	Equip Rental-MGD	200		
30 II6b	Laboratory-MGD	5,436		
30 II6b	Other Services-MGD	4,719		
30 II6b	Contact Allowance-Ancillary-MG	(366,888)		
30 II6b	Radiology-MGD	3,116		
30 II6b	Managed Medicare Part B	13,725		
30 II6b	Managed Medicare B Contract Al	(5,036)		
30 II6b	Contract Allowance-Ancil-Hosp	\$ (197)		
30 II6b	Equipment Rental-hospice	\$ 197		
30 II6b	Cont. Adjustment Outpatient Th	\$ (42)		
30 II6b	Flu Shots	\$ 1,208		
<b>Total Other Resident Revenue</b>		<b>\$ (361,319)</b>	\$ -	\$ -

**Interest Income****Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
		N/A	0		
30 IV 5	Interest Income - Accts. Rec	\$ 60			
30 IV 5	Interest Income	\$ 1,199			
<b>Total Interest Income</b>		<b>\$ 1,259</b>	\$ -	\$ -	

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV 8	Late Fees(Disallow)	\$ 1,839		
30 IV 8	ECHO Program Income	\$ 28,200		
30 IV 8	Other Income(Disallow)	\$ 132		
30 IV 8	HHS	\$ 204,436		
30 IV 8	PPP Loan Forgiveness	\$ 849,000		
30 IV 8	Recovery Bad Debt	\$ 480		
30 IV 8	OutPatient Therapy(Moved to PY, No related CY Expense, Outpatient Closed in 2020)	\$ 3,362		
<b>Total Other Revenue</b>		<b>\$ 1,087,449</b>	\$ -	\$ -

**G. Balance Sheet**

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2021	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	208,893
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	759,957
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	7,547
4. Inventories			\$	
5. Prepaid Expenses			\$	17,872
a. Prepaid Expenses				
b. Prepaid Taxes State		1,000		
c. Prepaid State Corp Taxes		16,872		
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	19,539
Patient Refund		20,537		
Exchange Account		(998)		
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	1,013,808
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	74,015	\$	5,907
	Accum. Depreciation	68,108 Net		
5. Non-Movable Equipment	*Historical Cost		\$	
	Accum. Depreciation	Net		
6. Movable Equipment	*Historical Cost	196,137	\$	50,492
	Accum. Depreciation	145,645 Net		
7. Motor Vehicles	*Historical Cost	72,460	\$	27,425
	Accum. Depreciation	45,035 Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	(27,950)
FS vs CR NBV		(27,950)		
See Schedule				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	55,874

\* 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

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

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

## Schedule of Other Assets Page 32 Line D7

Page Ref Line Ref Description

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

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

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 of Credit Webster	\$ 23,168
	Patient Deposits	\$ (4,087)
	Patient Rec Fund	\$ 3,212
	Suspense - Flexible Spending	\$ (15,139)
	401(k) Payable	\$ (1,719)
	HUD Suspense Account	\$ (29,569)
	Customer Deposits	\$ 15,485
	State Sales Tax	\$ (250)
	Provider Tax Payable	\$ 79,708
	Accrued Expenses	24306
	Accrued Benefits	2284
<b>Total Other Current Liabilities (Itemize)</b>		\$ 97,399

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

Page Ref Line Ref Description

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2021	32	37
Account			Amount	
Total Brought Forward:				\$ 1,069,682
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				\$
2. Land Improvements	*Historical Cost	Accum. Depreciation	Net	\$
3. Buildings	*Historical Cost	5,055,638		
	Accum. Depreciation	4,627,843	Net	\$ 427,795
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>				\$ 427,795
D. Investment and Other Assets				
1. Deferred Deposits				\$
2. Escrow Deposits				\$
3. Organization Expense	*Historical Cost	Accum. Depreciation	Net	\$
4. Goodwill (Purchased Only)				\$
5. Investments Related to Resident Care ( <i>itemize</i> )				\$
6. Loans to Owners or Related Parties ( <i>itemize</i> )				\$
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>				\$ 1,497,477

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

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

\* 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 Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2021	Page 34	of 37
Account			Amount	
Total Brought Forward:			705,469	
<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> )			\$	
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities ( <i>itemize</i> )			\$ 170,601	
<u>Loan Payable Liberty Bank</u>			170,601	
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)			\$ 170,601	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)			\$ 876,070	

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

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2021	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			\$	427,795
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	427,795
<b>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	79,501
6. Gain or Loss for Period	10/1/2020	thru	9/30/2021	\$ 113,111
7. Total Net Worth			\$	193,612
<b>C. Total Reserves and Net Worth</b>				
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$ 1,497,477	

## **H. Changes in Total Net Worth**

Name of Facility Healthcare Visions, Inc. d/b/a Beechwoo	License No. 2077-C	Report for Year Ended 9/30/2021	Page 36	of 37		
<b>Account</b>				<b>Amount</b>		
A. Balance at End of Prior Period as shown on Report of 09/30/2020				\$ 139,731		
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )				\$ 7,463,585		
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )				\$ 7,350,474		
D. Net Income or Deficit				\$ 113,111		
E. Balance				\$ 252,842		
F. Additions						
1. Additional Capital Contributed ( <i>itemize</i> )						
Total Expenses per Page 27 \$ 7,518,996						
CR vs FS Depreciation (168,522)						
Total FS Expenses \$ 7,350,474						
2. Other ( <i>itemize</i> )						
Prior Year Adjustment				(59,230)		
F-3. Total Additions				\$ (59,230)		
G. Deductions						
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )				\$		
Name and Address (No., City, State, Zip )		Title	Amount			
Distribution Stockholders						
2. Other Withdrawals ( <i>Specify</i> )				\$		
Purpose		Amount				
3. Total Deductions				\$		
H. <b>Balance at End of Period</b>				\$ 193,612		

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

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2021	Page <u>37</u> of <u>37</u>
<i>Check appropriate category</i>			
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)	

### Preparer/Reviewer Certification

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
Printed Name of Preparer		
Matthew S. Bavolack		
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Contacted Person Regarding Additional Information Needed Regarding This Report Bill White		Phone Number 860-442-4363
Contact Email Address Facebook.com/BeechwoodRehav/		