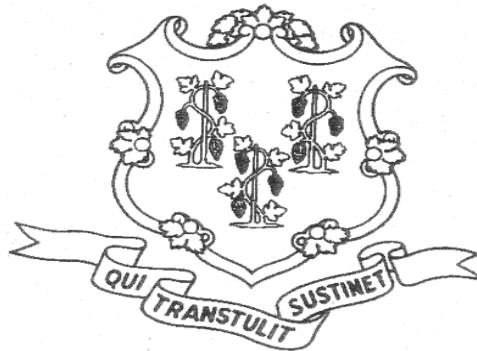


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) New Horizons Inc. d/b/a Cherry Brook HCC	
Address (No. & Street, City, State, Zip Code) 102 Dyer Avenue, Canton, CT 06019	
Type of Facility	
<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)
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH 2125C	RHNS	(Specify)	Medicare Provider 07-05396
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Medicaid Provider Numbers:	CCNH 2125C	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) New Horizons Inc. d/b/a Cherry Brook HCC	License No. 2125C	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 New Horizons Inc. d/b/a Cherry Brook HCC [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) John Zazzaro		Printed Name (Owner) Carol Fitzgerald	
Subscribed and Sworn to before me:	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public			

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC	Period Covered:		From 10/1/2020	To 9/30/2021
Address of Facility 102 Dyer Avenue, Canton, CT 06019				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900	Date 2/12/2021		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

	Phone No. of Facility 860-693-7777	Report for Year Ended 9/30/2021	Page 2
Name of Facility (as shown on license) New Horizons Inc. d/b/a Cherry Brook HCC		Address (No. & Street, City, State, Zip) 102 Dyer Avenue, Canton, CT 06019	
License Numbers:	CCNH 2125C	RHNS	(Specify)
Medicare Provider No. 07-05396			
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.
Administrator			
Name of Administrator John Zazzaro		Nursing Home Administrator's License No.:	001734
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name Not Applicable		License No.:	

General Information and Questionnaire Partners/Members

General Information and Questionnaire

Corporate Owners

General Information and Questionnaire

Individual Proprietorship

Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2021	Page of 3B 37
If this facility is owned or operated as an individual proprietorship, provide the following information:			
Owner(s) of Facility			
Not Applicable			

General Information and Questionnaire

Related Parties*

Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC	License No. 2125C	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 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			Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party	
		Yes	No	%**				
New Horizons, Inc.	37 Bliss Memorial Rd, Collinsville, CT 06085	<input type="radio"/>	<input checked="" type="radio"/>		Pension, Maintenance, legal,accounting,heal	P 15, L1a7, P22, L6a, P	930,262	730,262
New Horizons, Inc	37 Bliss Memorial Rd, Collinsville, CT 06085	<input type="radio"/>	<input checked="" type="radio"/>		Cherry Brook participates in a common 401			
		<input checked="" type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input checked="" type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input checked="" type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input checked="" type="radio"/>	<input 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 New Horizons Inc. d/b/a Cherry Brook HCC	License No. 2125C	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.

Not applicable

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

not applicable

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.

Outpatient services

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		License No.		Report for Year Ended			Page 6 of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
LEAF	<input type="radio"/>	<input checked="" type="radio"/>	Copiers	12/19/19	48 months	11,748	11,748
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	<input type="radio"/>	<input checked="" type="radio"/>	Postal Equipment	04/01/18	60 months	1,135	1,135
	<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"/>					
Is a Mileage Log Book Maintained for All Leased Vehicles ?		<input type="radio"/> Yes		<input checked="" type="radio"/> No		Total ***	12,883

* 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 New Horizons Inc. d/b/a Cherry Br	License No. 2125C	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 CohnReznick LLP 2 Marcum LLP 3 4	Address (No. & Street, City, State, Zip Code) 350 Church Street, Hartford, CT 06103 555 Long Wharf Drive, New Haven, CT 06511
--	---

Services Provided by This Firm (*describe fully*)

1 Audit & Year End Financials	\$ 35,907
2 Medicare Cost report	\$ 2,700
3	\$
4	\$
	Charge for Services Provided \$ 38,607

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

Yes No |Pg 15, Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney 1 State Marshall/Treasurer St of CT 2 Goldman, Gruder & Woods 3 Pilicy & Ryan, PC 4 Morrison/New Horizons 5	Telephone Number 203-899-8900 860-274-0018
---	--

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

1 2 200 Connecticut Ave, Norwalk, CT 3 385 Main Street, PO Box 760, Watertown, CT 06795 4 5	
---	--

Services Provided by This Firm (*describe fully*)

1 Conservatorship:Disallowed	\$ 370
2 Collections:Disallowed	\$ 30,395
3 Collections:Disallowed	\$ 345
4 COVID/Osha issues:Disallowed	\$ 296
5	\$
	Charge for Services Provided \$ 31,406

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

Yes No |Pg 15, Line 1e

Schedule of Resident Statistics

Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC			License No. 2125C				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					100	100						
A. On last day of PREVIOUS report period	100	100										
B. On last day of THIS report period	100	100							100	100		
2. Number of Residents					78	78						
A. As of midnight of PREVIOUS report period	78	78										
B. As of midnight of THIS report period	81	81							81	81		
3. Total Number of Days Care Provided During Period					2,798	2,798						
A. Medicare	4,048	4,048							1,250	1,250		
B. Medicaid (Conn.)	21,756	21,756			16,340	16,340			5,416	5,416		
C. Medicaid (other states)												
D. Private Pay	2,193	2,193			1,538	1,538			655	655		
E. State SSI for RCH												
F. Other (Specify) Managed Care	64	64			45	45			19	19		
G. Total Care Days During Period (3A thru F)	28,061	28,061			20,721	20,721			7,340	7,340		
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	22	22			22	22						
5. Total Resident Days (3G + 4A + 4B)	28,083	28,083			20,743	20,743			7,340	7,340		

Schedule of Resident Statistics (Cont'd)

Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC	License No. 2125C	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)
	CCNH	RHNS	(Specify)	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	9	63		6		3		
Per Diem Rate								
a. One bed rm.	566.90	299.19		566.00		398.88		
b. Two bed rms.	566.90	299.19		554.00		398.88		
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B		TOTAL	CCNH	RHNS	(Specify)
		8,946	8,946		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments		396	396		
2. Restorative Treatments					
C. Other		8,386	8,386		
D. Total Physical Therapy Treatments		17,728	17,728		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		1,158	1,158		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments		71	71		
2. Restorative Treatments					
C. Other		1,031	1,031		
D. Total Speech Therapy Treatments		2,260	2,260		

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		6,273	6,273		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments		596	596		
2. Restorative Treatments					
C. Other		8,462	8,462		
D. Total Occupational Therapy Treatments		15,331	15,331		

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		2125C	9/30/2021	10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes <input type="radio"/> No			
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	134,747	2,212			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	237,616	9,598			
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor	60,950	2,118			
c. Dietary Workers	353,082	23,350			
6. Housekeeping Service					
a. Head Housekeeper	62,760	2,399			
b. Other Housekeeping Workers	204,278	13,813			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	66,429	2,180			
b. Other Maintenance Workers	44,086	2,154			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers	87,238	6,222			
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	172,718	3,357			
b. RN					
1. Direct Care	633,673	14,850			
2. Administrative**	431,599	12,790			
c. LPN					
1. Direct Care	733,600	22,954			
2. Administrative**					
d. Aides and Attendants	1,342,769	63,222			
e. Physical Therapists	532,044	14,118			
f. Speech Therapists	83,860	1,818			
g. Occupational Therapists	284,938	7,371			
h. Recreation Workers	121,266	6,164			
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	176,900	5,261			
n. Marketing					
o. Other (Specify)					
See Attached Schedule					
<i>A-13. Total Salary Expenditures</i>	5,764,553	215,951			

* 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 New Horizons Inc. d/b/a Cherry Brook HCC			License No. 2125C		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)							
Section I - Operators/Owners										
Not Applicable										
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).										
Not Applicable										

* 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
New Horizons Inc. d/b/a Cherry Brook HCC				2125C		9/30/2021			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Donald Davanzo (10/1/20-9/10/21)	129,505			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	2,141	A2			
John Zazzaro (9/11/21-9/30/21)	5,242					71	A2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended		Page	of
	2125C	9/30/2021		13	37
	Total Cost and Hours				
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)					
1. Dietitian	15,391	440			
2. Dentist					
3. Pharmacist	9,420	160			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker	3,620	56			
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	47,000	161			
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**	592				
d. Administrative Services facility					
1. Infection Control Committee (Quarterly meetings)					
2. Pharmaceutical Committee (Quarterly meetings)					
3. Staff Development Committee (Once annually)					
e. Other (Specify)					
9. Speech Therapist					
a. Resident Care	7,710	22			
b. Other					
10. Occupational Therapist					
a. Resident Care					
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	829	9			
2. Administrative***					
b. LPN					
1. Direct Care	120,782	1,566			
2. Administrative***					
c. Aides	121,365	3,008			
d. Other					
12. Other (Specify)					
See Attached Schedule	1,250	12			
B-13 Total Fees Paid in Lieu of Salaries	327,959	5,433			

* 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	License No.	Report for Year Ended		Page	of
	2125C	9/30/2021		14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Michela Lux, 9 Feetwood Drive, Plainville, CT 06062	Dietician	<input type="radio"/>	<input checked="" type="radio"/>		
The Nurse Network, 653 Main Street, Plainville, CT 06479	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Gary Miller MD, 61 Bradley St, Bristol, CT 06010	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Norton & Associates, 34 Elm Street, Cohasset, MA	Social Service Fill-in position and nurse pool	<input type="radio"/>	<input checked="" type="radio"/>		
Amor Lomibao, 71 Spenser St, Winsted, CT 06098	Sub-acute Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Favorite health care staffing, PO Box 26225, Overland Park, KS 66225	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Healthdrive Audiology, 100 Crossing Blvd, Suite 300, Framingham, MA	audiology services	<input type="radio"/>	<input checked="" type="radio"/>		
MASSTEX, 3 Electronics Ave, Danvers, MA	Speech Therapy Services	<input type="radio"/>	<input checked="" type="radio"/>		
Vista Behavioral Health, LLC 152 Simsbury Rd Bldg 9 Avon, CT 06001	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
Bristol Hospital, 41 Brewster RD, Bristol, CT	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
SDX Dysphagia Experts, 21 Waterville Rd., Avon, CT 06001	Speech Therapy services	<input type="radio"/>	<input checked="" type="radio"/>		
ValueRx Pharmacy Services, 54 Tuttle Place, Middletown, CT 06457	Pharmacy Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Hospital of Special Care, PO Box 150473, Hartford, CT	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
Consulting Cardiologists, 305 Western BLVD, Glastonbury, CT	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Richard Grayson, 40 Avon Meadow Lane, Avon, CT	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
John Dempsey Hospital, 263 Farmington Ave, Farmington, CT	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Sheldon Kafer, 31 Vista Way, Bloomfield, CT 06002	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
Litchfield Hills Orthopedic, PO Box 22448, Belfast, ME	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
Quest Chicago, 3404 Collection center Drive, Chicago, IL	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
Uconn Health, 263 Farmington Ave, Farmington, CT	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
Urology Assoc of Danbury, 51-53 Kenosia Ave, Danbury, CT	Physician services	<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
		9/30/2021		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	334,056	334,056		
2. Disability Insurance	\$				
3. Unemployment Insurance	\$	51,772	51,772		
4. Social Security (F.I.C.A.)	\$	416,551	416,551		
5. Health Insurance	\$	662,867	662,867		
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$	68,377	68,377		
8. Uniform Allowance	\$				
9. Other (Specify) See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$	24,758	24,758		
d. Accounting and Auditing	\$	38,607	38,607		
e. Legal (Services should be fully described on Page 7)	\$	31,406	31,406		
f. Insurance on Lives of Owners and Operators (Specify)*	\$				
g. Office Supplies	\$	50,578	50,578		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	24,448	24,448		
2. Cellular Phones	\$	2,220	2,220		
i. Appraisal (Specify purpose and attach copy)*	\$				
j. Corporation Business Taxes (franchise tax)	\$				
k. Other Taxes (Not related to property - See Page 22)					
1. Income*	\$				
2. Other (Specify) See Attached Schedule	\$				
3. Resident Day User Fee	\$	505,215	505,215		
Subtotal		2,210,855	2,210,855		

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

(Carry Subtotals forward to next page)

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

Attachment Page 15

Schedule of Other Employee Benefits

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
	2125C	9/30/2021		16	37
Item		Total	CCNH	RHNS	(Specify)
	<i>Subtotals Brought Forward:</i>	2,210,855	2,210,855		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	1,979	1,979		
3. Gifts to Staff and Residents	\$	7,301	7,301		
4. Employee Travel	\$	703	703		
5. Education Expenses Related to Seminars and Conventions	\$	2,180	2,180		
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>)	\$	23,556	23,556		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	16,639	16,639		
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	\$	5,751	5,751		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	11,276	11,276		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	425	425		
9. Subscriptions	\$	347	347		
10. Contributions*** See Attached Schedule	\$	1,400	1,400		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$				
12. Administrative Management Services**	\$	171,600	171,600		
13. Other (<i>Specify</i>) See Attached Schedule	\$	302,122	302,122		
<i>C-14 Total Administrative & General Expenditures</i>	\$	2,756,134	2,756,134		

* Do not include Subscriptions, which should go in item 9.

** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	\$ 16,639		
Total Other Advertising	\$ 16,639	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
	\$ -		
Leading Age CT	\$ 10,926		
CAHCF	\$ 350		
Total Dues	\$ 11,276	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Donations	\$ 1,400		
Total Contributions	\$ 1,400	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
ST of CT-Annual License renewal	\$ 1,085		
Bank Charges	\$ 9,092		
Payroll Processing Fees	\$ 13,636		
Employee Physicals/background checks	\$ 3,504		
Penalty-CMS Case#2021-01-LTC-155	\$ 28,074		
Management fee-New horizons Inc	\$ 200,000		
recruitment fee	\$ 10,000		
Data Processing	\$ 36,731		
Total Other Administrative and General	\$ 302,122	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
New Horizons Inc. d/b/a Cherry Brook H	2125C	9/30/2021	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 Road Farmington, CT 06032	223,200	Contract Attached to a Prior Year	See Below
Allocation of the above	\$35,712, \$40,176	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, L 12 page 18, L 2
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	24,288	Admin/Gen - Other exp	Pg 16, Line 12
New Horizons Inc, 37 Bliss Memorial Road, Unionville, CT	200,000	Administrative Fee	Page 16, Line 13

*** 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
	2125C	9/30/2021		18 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 226,302	226,302		
2. Non-Food Supplies	\$ 28,234	28,234		
3. Other (Specify) _____ Dishes	\$			
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$			
c. Other (Specify) _____	\$			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 254,536	254,536		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	231	231		
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.	\$2,496
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				Pg 18 Line 2a1
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 New Horizons Inc. d/b/a Cherry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2021		Page of 19 37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$			
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. \$	13,074	13,074	
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$			
c. Other (Specify) Supplies	\$	6,929	6,929	
3D. Total Laundry Expenditures (3a + b + c)	\$	20,003	20,003	
3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify cost.
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify amt.
H. Where is the revenue received reported in the Cost Report?				(Page/Line Item)
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify cost.
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify amt.
K. Where is the revenue received reported in the Cost Report?				(Page/Line Item)

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3D.

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2021		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 44,346	44,346		
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 (<i>Specify</i>)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	44,346	44,346		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Procare	\$	190,106	190,106		
b. Medicine Cabinet Drugs	\$	11,978	11,978		
c. Medical and Therapeutic Supplies	\$	400,858	400,858		
d. Ambulance/Limousine***	\$	5,242	5,242		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	20,376	20,376		
f. X-rays and Related Radiological Procedures***	\$	20,601	20,601		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	28,522	28,522		
i. Recreation	\$	12,723	12,723		
j. Direct Management Services*	\$	40,176	40,176		
k. Indirect Management Services*	\$	35,712	35,712		
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	93,899	93,899		
5M. Total Resident Care Expenditures (5a - 5j)	\$	860,193	860,193		

* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Occupational Therapy Supplies	\$ 1,013		
Physical Therapy Supplies	\$ 25,517		
Medical Equip Rentals-Other	\$ 4,288		
Cable TV Services Expense	\$ 20,382		
Speech Therapy Supplies	\$ 118		
Oxygen Concentrator rentals	\$ 28,344		
Medical Equipment Rentals-Medicaid	\$ 14,237		
Total Other Resident Care	\$ 93,899	\$ -	\$ -

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 New Horizons Inc. d/b/a Cherry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2021			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 76,860	76,860				
b. Heat	\$ 38,034	38,034				
c. Light & Power	\$ 125,265	125,265				
d. Water	\$ 45,065	45,065				
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$ 12,883	12,883				
f. Other <i>(itemize)</i>	\$ 88,153	88,153				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 386,260	386,260				
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$ 29,169	29,169				
b. Building & Building Improvements	\$ 310,582	310,582				
c. Non-Movable Equipment	\$ 5,810	5,810				
d. Movable Equipment	\$ 55,680	55,680				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 401,241	401,241				
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$ 20,621	20,621				
c. Leasehold Improvements	\$					
d. Other <i>(Specify)</i>	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 20,621	20,621				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$					
10. Property Taxes						
a. Real estate taxes paid by owner	\$ 73,483	73,483				
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$ 14,518	14,518				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 509,863	509,863				

* 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 New Horizons Inc. d/b/a Cherry Brook HCC				License No. 2125C			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		
A. Land Improvements													
1. Acquired prior to this report period				321,606		321,606	188,764	S/L	Various	29,169			
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal											29,169		
B. Building and Building Improvements													
1. Acquired prior to this report period				7,701,029		7,701,029	6,247,613	S/L	Various	310,415			
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)				6,675		6,675		S/L	Various	167			
B-4. Subtotal											310,582		
C. Non-Movable Equipment													
1. Acquired prior to this report period				245,740		245,740	193,308	SL	Various	5,810			
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal											5,810		
	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals	
	Yes	No	Month	Year									
D. Movable Equipment													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a. Ford Van	x		7	2005	6,000		6,000	6,000	S/L	5 yrs			
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period			9	2018	1,054,731		1,054,731	762,843	S/L	Various	55,027		
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)			9	2019	10,742		10,742		S/L	Various	653		
D-3. Subtotal												55,680	
E. Total Depreciation												401,241	

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

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
11/30/2020	AMP Breaker	\$ 3,019	20	\$ 75
8/31/2021	Fire Door	\$ 1,990	20	\$ 50
8/31/2021	AMP Breaker	\$ 1,666	20	\$ 42
Total additions for Building Improvement		\$ 6,675		\$ 167 *
Deletions:				
Total deletions for Building Improvement		\$ -		\$ - ***

*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

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:			-	\$ -
10/31/2020	boiler motor	\$ 1,023	15	\$ 34
10/31/2020	computer equipment	2033	5	203
11/30/2020	water heater booster	5120	10	256
12/31/2020	snowblowers	1282	20	32
8/31/2021	therapy tub leg rests	1284	5	128
Total additions for Movable Equipment		\$ 10,742		\$ 653 *
Deletions:				
Total deletions for Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:			-	\$ -
1/0/1900	See attached schedule		20	\$ -
			10	0
			0	0
			0	0
Total additions for Leasehold Improvements		\$ -		\$ - *
Deletions:				
Total deletions for Leasehold Improvements		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC			License No. 2125C		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. Finance Fees-CHEFA	9	1994	30 yrs	922,570	922,570	SL			
2. Finance Fees-Farmington Bank	12	2018	10 yrs	194,356	74,504	SL		14,571	
3. Finance Fees - ION Bank	6	2021	4 yrs	72,599		SL		6,050	
B-4. Subtotal									20,621
C. Leasehold Improvements and Other									
1. Acquired prior to this report period		2020							
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									20,621

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility New Horizons Inc. d/b/a Cherry Brook	License No. 2125C	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				
2. Date Structure Completed	01/14/1993			
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure	01/14/93			
5. Total Licensed Bed Capacity	100			
6. Square Footage				
7. Acquisition Cost				
a. Land	1,000,000			
b. Building	6,039,220			

Part B - Owner and Related Parties

	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	12/10/14			
c. Interest Rate for the Cost Year	2.99%			
d. Term of Mortgage (number of years)	4			
e. Amount of Principal Borrowed	1,625,000			
f. Principal balance outstanding as of _____	1,555,136			

Complete if Mortgage was Refinanced

During Current Cost Year

g. Type of Financing (e.g., fixed, variable)	Fixed			
h. Date of Refinancing	06/02/21			
i. New Interest Rate	2.99%			
j. Term of Mortgage (number of years)	4			
k. Amount of Principal Borrowed	1,625,000			
l. Principal Outstanding on Note Paid-Off	1,653,088			

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		\$ 51391	51,391			
Name of Lender	Rate					
ION Bank	2.99%					
Address of Lender						
PO Box 370Naugatuck, CT 06770						
2. Second Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
3. Third Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
4. Fourth Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount		\$				
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$ 51,391	51,391			

(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:			51,391	51,391		
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) Vendor Interst=\$610, Bond Fees-\$16,531			\$	17,141	17,141	
13. Total All Interest Expense (12B7 + 12C3 + 12D)			\$	68,532	68,532	
14. Insurance						
a. Insurance on Property (buildings only)			\$	163,724	163,724	
b. Insurance on Automobiles			\$			
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)			\$			
2. Fire and Extended Coverage			\$			
3. Other (Specify)			\$			
14d. Total Insurance Expenditures (14a + b + c)			\$	163,724	163,724	
15. Total All Expenditures (A-13 thru C-14)			\$	11,156,103	11,156,103	

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of
Item No.	Page No.	Line No.		CCNH	RHNS	28 37
			Item Description	Total Amount of Decrease		
<i>Page 10 - Salaries and Wages</i>						
1.			Outpatient Service Costs	\$		
2.			Salaries not related to Resident Care	\$		
3.			Occupational Therapy	\$ 284,938	284,938	
4.			Other - See attached Schedule	\$ 32,987	32,987	
<i>Page 13 - Professional Fees</i>						
5.			Resident Care Physicians **	\$ 592	592	
6.			Occupational Therapy	\$		
7.			Other - See attached Schedule	\$		
<i>Pages 15 & 16 - Administrative and General</i>						
8.			Discriminatory Benefits	\$		
9.			Bad Debts	\$ 24,758	24,758	
10.			Accounting	\$ 31,406	31,406	
10a.			Legal	\$		
11.			Telephone	\$		
12.			Cellular Telephone	\$ 2,160	2,160	
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$		
14.			Gifts, flowers and coffee shops	\$ 7,301	7,301	
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 *	\$ 16,639	16,639	
19.			Income Tax / Corporate Business Tax	\$		
20.			Fund Raising / Contributions	\$ 1,400	1,400	
21.			Unallowable Management Fees	\$ 23,148	23,148	
22.			Barber and Beauty	\$		
23.			Other - See attached Schedule	\$ 238,590	238,590	
<i>Page 18 - Dietary Expenditures</i>						
24.			Meals to employees, guests and others who are not residents	\$ 11,975	11,975	
<i>Page 19 - Laundry Expenditures</i>						
25.			Laundry services to employees, guests and others who are not residents	\$		
<i>Page 20 - Housekeeping Expenditures</i>						
26.			Housekeeping services to employees, guests and others who are not residents	\$		
Subtotal (Items 1 - 26)			\$ 675,894	675,894		

* 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	\$ 32,987		
Total Other Salaries Adjustment			\$ 32,987	\$ -	\$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M13	Bank Charges	\$ 9,092		
16	M13	Management fee - New Horizons	\$ 200,000		
16	8n	Disallowed Dues	\$ 425		
various	various	Outpatient Therapy: A & G costs	369		
16	M13	Penalty: CMS 2021-01 LTC 155	28704		
Total Other A&G Adjustments			\$ 238,590	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended		Page of	
New Horizons Inc. d/b/a Cherry Brook HCC			2125C	9/30/2021		29 37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 675,894	675,894		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$ 190,106	190,106		
28.			Ambulance/Limousine	\$ 5,242	5,242		
29.			X-rays, etc	\$ 20,601	20,601		
30.			Laboratory	\$ 28,522	28,522		
31.			Medical Supplies	\$ 18,612	18,612		
32.			Oxygen (non emergency)	\$ 20,376	20,376		
33.			Occupational Therapy	\$ 1,013	1,013		
34.			Other - See Attached Schedule	\$ 33,305	33,305		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation				
			See Attached Schedule	\$ 11,260	11,260		
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	\$ 1,022	1,022		
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$ 1,271	1,271		
44.			Other - Miscellaneous Administrative	\$ 44,639	44,639		
45.			Management Fees Direct	\$ 6,313	6,313		
46.			Management Fees Indirect	\$ 5,612	5,612		
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation				
			Unallowable Building Interest - See Attached Schedule	\$ 33,365	33,365		
49. Total Amount of Decrease (Items 1 - 48)				\$ 1,097,153	1,097,153		

*** 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)
0	0		0	\$ -	
page 20	5b	Ebox		\$ 11,909	
various	various	Outpatient Therapy - Indirect Costs		\$ 326	
20	5j	Medical Equipment Rental		\$ 4,288	
22	5j	telelevision & Cable		\$ 16,782	
Total Other Ancillary Costs			\$ 33,305	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excess Moveable Equipment Depreciation	\$ 11,260		
Total Excess Movable Equipment Depreciation			\$ 11,260	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
various	various	outpatient Therapy - Capital Costs	\$ 306		
various	various	outpatient Therapy - Fair Rent	\$ 716		
Total Other Property Adjustments			\$ 1,022	\$ -	\$ -

Schedule of Other - Indirect Adjustments

Attachment Page 29

Schedule of Other - Miscellaneous Administrative Adjustments

Schedule of Other - Direct Adjustments

Schedule of Unallowable Building Interest

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended 9/30/2021			Page 30	of 37
		Item	Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 12,267,479	12,267,479				
b. Medicaid Room and Board Contractual Allowance **	\$ (6,224,986)	(6,224,986)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,457,919	1,457,919				
b. Medicare Room and Board Contractual Allowance **	\$ 206,838	206,838				
4. a. Private-Pay Residents and Other	\$ 2,041,947	2,041,947				
b. Private-Pay Room and Board Contractual Allowance **	\$ (171,375)	(171,375)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 52,299	52,299				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (50,054)	(50,054)				
c. Prescription Drugs - Non-Medicare	\$ 29,616	29,616				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (29,616)	(29,616)				
2. a. Medical Supplies - Medicare	\$ 2,419	2,419				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (2,419)	(2,419)				
c. Medical Supplies - Non-Medicare	\$ 14,939	14,939				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (14,939)	(14,939)				
3. a. Physical Therapy - Medicare	\$ 731,819	731,819				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (471,702)	(471,702)				
c. Physical Therapy - Non-Medicare	\$ 189,120	189,120				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (189,120)	(189,120)				
4. a. Speech Therapy - Medicare	\$ 183,880	183,880				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (117,763)	(117,763)				
c. Speech Therapy - Non-Medicare	\$ 48,040	48,040				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (48,040)	(48,040)				
5. a. Occupational Therapy - Medicare	\$ 603,116	603,116				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (423,719)	(423,719)				
c. Occupational Therapy - Non-Medicare	\$ 205,930	205,930				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (205,930)	(205,930)				
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$ 1,303,146	1,303,146				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 11,388,844	11,388,844				
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ 1,814	1,814				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 47,210	47,210				
V. Total Other Revenue (1 thru 8)	\$ 49,024	49,024				
VI. Total All Revenue (III +V)	\$ 11,437,868	11,437,868				

* 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)
	Total Other Resident Revenue - Medicare	\$ -	\$ -	\$ -

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

Page Ref	Description	CCNH	RHNS	(Specify)
	Misc revenues from CRF funds	\$ 1,296,953		
	0	\$ -		
	Med B medical supplies	\$ 6,193		
	Total Other Resident Revenue	\$ 1,303,146	\$ -	\$ -

Interest Income**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
pg 31, L A	Interest on A/R	N/A	\$ 1,271		
pg 31, L A	Interest on Reserve Account	N/A	\$ 543		
	Total Interest Income		\$ 1,814	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Cell Tower Income	\$ 27,498		
	Bad Debt Recoveries	\$ 17,096		
	Donations - Restricted	\$ 2,616		
	Total Other Revenue	\$ 47,210	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2021	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	907,997
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	816,130
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	17,159
5. Prepaid Expenses			\$	153,656
a. Prepaid Insurance		86,911		
b. Prepaid Expenses		66,745		
c.				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	(194,459)
8. Other Current Assets (<i>itemize</i>)			\$	7,000
A/R Facilities-Non-Related		7,000		
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,707,483
B. Fixed Assets				
1. Land			\$	1,000,000
2. Land Improvements	*Historical Cost	321,606	\$	103,673
	Accum. Depreciation	217,933	Net	
3. Buildings	*Historical Cost	7,707,704	\$	1,149,505
	Accum. Depreciation	6,558,199	Net	
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	245,740	\$	46,622
	Accum. Depreciation	199,118	Net	
6. Movable Equipment	*Historical Cost	999,323	\$	176,299
	Accum. Depreciation	823,024	Net	
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	58,414
Excluded Movable Equipment		71,933		
See Schedule		(13,519)		
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	2,534,513

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref Line Ref Description

Total Prepaid Expenses		\$ -

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

Page Ref Line Ref Description

Total Other Current Assets (Itemize)		\$ -

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

Page Ref Line Ref Description

Total Other Other Fixed Assets (Itemize)			\$ (13,519)

Schedule of Other Assets Page 32 Line D7

Page Ref Line Ref Description

Total Other Assets			\$ 449

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref Line Ref Description

Total Notes Payable			\$ -

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

Page Ref Line Ref Description

Total Other Current Liabilities (Itemize)			\$ -

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

Page Ref Line Ref Description

Total Other Current Liabilities (Itemize)			\$ -

G. Balance Sheet (cont'd)

Name of Facility New Horizons Inc. d/b/a Cherry Brook	License No. 2125C	Report for Year Ended 9/30/2021	Page 32	of 37
Account		Amount		
		Total Brought Forward:		\$ 4,241,996
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements	*Historical Cost Accum. Depreciation	Net	\$	
3. Buildings	*Historical Cost Accum. Depreciation	Net	\$	
4. Non-Movable Equipment	*Historical Cost Accum. Depreciation	Net	\$	
5. Movable Equipment	*Historical Cost Accum. Depreciation	Net	\$	
6. Motor Vehicles	*Historical Cost Accum. Depreciation	Net	\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense	*Historical Cost Accum. Depreciation	Net	\$	
4. Goodwill (Purchased Only)			\$	60,800
5. Investments Related to Resident Care (<i>itemize</i>)			\$	
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	66,549
Name and Address	Amount	Loan Date		
Deferred Finance Fees	66,549			
7. Other Assets (<i>itemize</i>) See Attached			\$	449
See Schedule	449			
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	127,798
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	4,369,794

* 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.

G. Balance Sheet (cont'd)

Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2021	Page 34	of 37
Account			Amount	
Total Brought Forward:			1,183,960	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)			\$	
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable			\$	1,555,136
3. Loans from Owners or Related Parties (<i>itemize</i>)			\$	(5,431,619)
Name and Address of Lender	Amount	Loan Date		
New Horizons Inc.	(5,431,619)			
4. Other Long-Term Liabilities (<i>itemize</i>)			\$	
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$	(3,876,483)
C. Total All Liabilities (Lines A-13 + B-5)			\$	(2,692,523)

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

Name of Facility	License No.	Report for Year Ended	Page	of
New Horizons Inc. d/b/a Cherry Brook	2125C	9/30/2021	35	37
Account				Amount
A. Reserves				
1. Reserve for value of leased land				\$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized				\$
3. Reserve for depreciation value of leased personal property (<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. Net Worth				
1. Owner's Capital				\$
2. Capital Stock				\$
3. Paid-in Surplus				\$
4. Treasury Stock				\$
5. Cumulated Earnings				\$ 6,780,552
6. Gain or Loss for Period		10/1/2020	thru	9/30/2021
				\$ 281,765
7. Total Net Worth				\$ 7,062,317
C. Total Reserves and Net Worth				\$ 7,062,317
D. Total Liabilities, Reserves, and Net Worth				\$ 4,369,794

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
New Horizons Inc. d/b/a Cherry Brook H	2125C	9/30/2021	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2020				\$ 6,780,553		
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 11,437,868		
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 11,156,103		
D. Net Income or Deficit				\$ 281,765		
E. Balance				\$ 7,062,318		
F. Additions						
1. Additional Capital Contributed (<i>itemize</i>)						
rounding				(1)		
2. Other (<i>itemize</i>)						
F-3. Total Additions				\$ (1)		
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. Balance at End of Period				\$ 7,062,317		

I. Preparer's/Reviewer's Certification

Name of Facility New Horizons Inc. d/b/a Cherry Brook	License No. 2125C	Report for Year Ended 9/30/2021	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
-----------------------	-------	-------------

Printed Name of Preparer

Athena Health Care Associates, Inc

Address	Phone Number
135 South Road Farmington, CT 06032	(860) 751-3900

Contacted Person Regarding Additional Information Needed Regarding This Report

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Lynn Rinaldi	(860) 751-3900

Contact Email Address

Contact Email Address
lrinadli@athenahealthcare.com