State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2021

Name of Facility (as licensed) NEW HORIZONS VILLAGE	
Address (No. & Street, City, State, Zip Code) 37 BLISS MEMORIAL RD., UNIONVILLE CT 06085	
Type of Facility ☐ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☑ Other	
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH	RHNS	Other	Medicare Provider

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
NEW HORIZONS VILLAGE		9/30/2021	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for NEW HORIZONS VILLAGE [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) CAROL KIRKWOOD			Printed Name (Owner) CAROL A. FITZGERALD, CPA	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility NEW HORIZONS VILLAGE	Period Covered:		From 10/1/2020	To 9/30/2021
Address of Facility 37 BLISS MEMORIAL RD., UNIONVILLE CT 06085				
Report Prepared By CHRISTINE MURRAY	Phone Number 860-675-4711		Date 2/11/2022	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-673-8893	9/30/2021	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
NEW HORIZONS VILLAGE	37 BLISS MEMORIAL RD., UNIONVILLE CT 06085

License Numbers:	CCNH	RHNS	Other	Medicare Provider No.

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
CAROL KIRKWOOD		N/A

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

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

Name of Partners/Members	Business Address	Title	% Owned
N/A			

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General Information and Questionnaire
Corporate Owners

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

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
NEW HORIZONS, INC.	37 BLISS MEMORIAL RD., UNIONVILLE, CT 06085	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
CAROL A. FITZGERALD, CPA	37 BLISS MEMORIAL RD. UNIONVILLE CT 06085	CEO	ZERO
CHRISTINE MURRAY	37 BLISS MEMORIAL RD. UNIONVILLE CT 06085	CFO	ZERO
DIRECTORS: PLEASE SEE ATTACHED			
Names of Stockholders Owning at Least 10% of Shares			
N/A			

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General Information and Questionnaire
Individual Proprietorship

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

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
NEW HORIZONS INC.	37 BLISS MEMORIAL RD. UNIONVILLE CT 06085	○	⊙		MANAGEMENT FEE	Page 16, Line m12	200,000	200,000
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

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

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

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

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

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.

N/A

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General Information and Questionnaire
Leases (Excluding Real Property)

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

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

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

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

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General Information and Questionnaire
Accounting Basis

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The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 COHN REZNICK, LLP	350 CHURCH ST., 12 FLOOR, HARTFORD CT 06103
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	CONDUCTED AUDIT FOR FISCAL YEAR 2020	$ 24,760
2		$
3		$
4		$
		Charge for Services Provided $ 24,760

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
⊙ Yes ○ No Page 15, Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 SIEGEL, O'CONNOR, O'DONNELL & BECK, P.C.	860-757-8900
2 LAW OFFICES OF SALVATORE V. VITRANO	860-584-2800
3 WIGGIN AND DANA, LLP	203-498-4400
4	
5	

Address (*No. & Street, City, State, Zip Code*)
1 150 TRUMBULL ST., HARTFORD CT 06103
2 135 WEST ST., BRISTOL CT 06010
3 ONE CENTURY TOWER, P.O. BOX 1832, NEW HAVEN CT 06508
4
5

Services Provided by This Firm (*describe fully*)

1	PERSONNEL MATTERS	$ 2,363
2	HOUSING MATTERS	$ 12,769
3	MISCELLANEOUS LEGAL QUESTIONS	$ 282
4		$
5		$
		Charge for Services Provided $ 15,414

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
⊙ Yes ○ No Page 15, Line 1e

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total Other	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Other	Total	CCNH	RHNS	Other
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	101			101	101			101				
B. On last day of THIS report period	101			101					101			101
2. Number of Residents												
A. As of midnight of PREVIOUS report period	95			95	95			95				
B. As of midnight of THIS report period	93			93					93			93
3. Total Number of Days Care Provided During Period												
A. Medicare												
B. Medicaid (Conn.)												
C. Medicaid (other states)												
D. Private Pay												
E. State SSI for RCH												
F. Other (Specify) STATE CASH SUPPLEMENT	33,829			33,829	25,285			25,285	8,544			8,544
G. Total Care Days During Period (3A thru F)	33,829			33,829	25,285			25,285	8,544			8,544
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	33,829			33,829	25,285			25,285	8,544			8,544

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Schedule of Resident Statistics (Cont'd)

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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	Other	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Other	

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

Change in Resident Days	CCNH	RHNS	Other
1st change			
2nd change			
3rd change			
4th change			

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	Other	R.C.H.	ICF-MR
No. of Residents							93	
Per Diem Rate								
a. One bed rm.							183.82	
b. Two bed rms.							183.82	
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	Other
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. ***Total Physical Therapy Treatments***				
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. ***Total Speech Therapy Treatments***				
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. ***Total Occupational Therapy Treatments***				

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Other	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)					99,640	2,080
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)					214,456	7,061
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers						
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers					66,792	3,880
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance					80,733	2,080
b. Other Maintenance Workers					168,805	6,581
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant					132,990	2,080
b. Other Accountants					266,512	7,280
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses					76,561	1,840
b. RN						
1. Direct Care						
2. Administrative**						
c. LPN						
1. Direct Care						
2. Administrative**						
d. Aides and Attendants					2,156,643	146,684
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers						
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
Tenant Services Coordinator					63,973	2,080
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management						
n. Marketing						
o. Other (Specify)						
See Attached Schedule					404,778	20,713
A-13. Total Salary Expenditures					3,731,883	202,359

* 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)

	CCNH		RHNS		Other	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
TRANSPORTATION COORDINATOR					$ 48,329	2,080
TRANSPORTATION SCHEDULER					$ 37,345	638
VAN DRIVERS					$ 193,572	11,300
LIVERY DRIVERS (Disallowed)					$ 60,740	3,546
TEMPORARY LABOR					$ 83,209	3,149
VACATION ACCRUAL					$ (18,417)	
Total	$ -	-	$ -	-	$ 404,778	20,713

Schedule of Other Fees (Page 13)

	CCNH		RHNS		Other	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

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

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

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Other							
Section III - Administrators* **										
CAROL KIRKWOOD			99,640	Group Insurance / Pension	FACILITY MANAGER	2,080	2	N/A		
Section IV - Assistant Administrators										
N/A										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Other	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)						
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries						

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
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		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
NEW HORIZONS VILLAGE		9/30/2021	15	37

Item		Total	CCNH	RHNS	Other
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	66,576			66,576
2. Disability Insurance	$	14,514			14,514
3. Unemployment Insurance	$	14,872			14,872
4. Social Security (F.I.C.A.)	$	127,896			127,896
5. Health Insurance	$	193,057			193,057
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	(199,169)			(199,169)
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans forOwners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	57,214			57,214
d. Accounting and Auditing	$	24,760			24,760
e. Legal (*Services should be fully described on Page 7)*	$	15,414			15,414
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	113,843			113,843
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	7,972			7,972
2. Cellular Phones	$				
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	$				
Subtotal	$	436,949			436,949

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Other
Total	$ -	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	Other
Total	$ -	$ -	$ -

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
NEW HORIZONS VILLAGE		9/30/2021	16	37

Item		Total	CCNH	RHNS	Other
Subtotals Brought Forward:		436,949			436,949
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	5,919			5,919
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	21			21
5. Education Expenses Related to Seminars and Conventions	$	1,183			1,183
6. Automobile Expense (*not purchase or depreciation*)	$	21,332			21,332
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	28,539			28,539
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$				
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	2,594			2,594
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$				
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	174			174
10. Contributions***	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	119,722			119,722
12. Administrative Management Services**	$	200,000			200,000
13. Other (*Specify*)	$	71,991			71,991
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	888,424			888,424

* 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	Other
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	Other
Total Other Advertising	$ -	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	Other
Total Dues	$ -	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	Other
Total Contributions	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	Other
Livery Employee Expense			$ 1,130
Livery Vehicle Expense			$ 14,465
Livery GPS & Communication Exp			$ 11,122
Livery Software Expense			$ 7,339
Livery Marketing Expense			$ 4,018
Livery Miscellaneous			$ 2,949
Livery Gas/Fuel			$ 28,570
Livery Registration/Emissions			$ 2,398
Total Other Administrative and General	$ -	$ -	$ 71,991

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Schedule C-1 - Management Services*

Name of Facility NEW HORIZONS VILLAGE	License No.	Report for Year Ended 9/30/2021	Page 17 | of 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
NEW HORIZONS, INC. 37 BLISS MEMORIAL RD. UNIONVILLE, CT 06085	200,000	SCHEDULE ATTACHED	Page 16, Line m12

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

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

Name of Facility	License No.	Report for Year Ended	Page of
NEW HORIZONS VILLAGE		9/30/2021	18 | 37

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

2E. Dietary Questionnaire		Total	CCNH	RHNS	Other
F. Resident Meals:	Total no. of meals served per day:*				

G.	Is cost of employee meals included in 2D?	○ Yes	⊙ No	
H.	Did you receive revenue from employees?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
K.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	○ Yes	⊙ No	If yes, specify cost.
N.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

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

Name of Facility	License No.	Report for Year Ended	Page of
NEW HORIZONS VILLAGE		9/30/2021	19 | 37

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

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

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3D.

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
NEW HORIZONS VILLAGE		9/30/2021	20	37

Item			Total	CCNH	RHNS	Other
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	16,509			16,509
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	16,509			16,509
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$				
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	56,037			56,037
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$				
f. X-rays and Related Radiological Procedures***		$				
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$				
i. Recreation		$	19,677			19,677
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$				
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	75,714			75,714

* 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	Other
Total Other Resident Care	$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
NEW HORIZONS VILLAGE		9/30/2021	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	Other	Pg	Line
ADP		○	⊙		Payroll Service			23,931	16	m11
Securitas		○	⊙		Security Service			93,379	16	m11
CWPM		○	⊙		Refuse/Trash Removal			24,795	22	6a
Colonial Landscaping		○	⊙		Landscaping			40,115	22	6a
Colonial Landscaping		○	⊙		Snow Removal			68,331	22	6a
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

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

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

Name of Facility	License No.	Report for Year Ended	Page of
NEW HORIZONS VILLAGE		9/30/2021	22 | 37

Item		Total	CCNH	RHNS	Other
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	293,962			293,962
b. Heat	$	50,942			50,942
c. Light & Power	$	166,183			166,183
d. Water	$	19,773			19,773
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	21,828			21,828
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	552,688			552,688
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	13,741			13,741
b. Building & Building Improvements	$	172,151			172,151
c. Non-Movable Equipment	$	59,353			59,353
d. Movable Equipment	$	94,523			94,523
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	339,768			339,768
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$				
9. Rental payments on leased real property less real estate taxes included in item 10b	$				
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	339,768			339,768

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	Other
SEWER			$ 21,828
Total Other Repairs and Maintenance	$ -	$ -	$ 21,828

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
NEW HORIZONS VILLAGE		9/30/2021	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	769,015		769,015	731,747			13,741	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								13,741
B. **Building and Building Improvements**								
1. Acquired prior to this report period	11,218,684		11,218,684	10,839,711			72,095	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	2,493,181		2,493,181				100,056	
B-4. Subtotal								172,151
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	1,017,248		1,017,248	533,731			59,353	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								59,353

	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.	X				670,431		670,431	490,792			72,301	
b. 2017 Ford Mini Bus / 2019 Dodge C					61,039		61,039				15,259	
c. 2009 Ford E350 Van / 2011 Ford E3					(105,850)			(105,850)				
d.												
2. Movable Equipment												
a. Acquired prior to this report period					644,546		644,546	620,610			5,963	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					5,000		5,000				1,000	
D-3. Subtotal												94,523
E. ***Total Depreciation***												339,768

Schedule of Land Improvements Acquired during this report peri

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

***Ties to Page 23, Line A3**

****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Year End 2021	Lightning Protection System	$ 32,700	20	$ 1,635	
Year End 2021	Renovation Buildings 3-10	$ 716,913	25	$ 28,677	
Year End 2021	Renovation Community Building	$ 1,743,568	25	$ 69,744	
Total additions for Building Improvemen		$ 2,493,181		$ 100,056	*
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 peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Non-Movable Equipmen		$ -		$ -	*
Deletions:					
Total deletions for Non-Movable Equipmen		$ -		$ -	**

***Ties to Page 23, Line C3**

****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report peri

Acquisition Dat	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Year End 2021	Smart TV	$ 5,000	5	$ 1,000	
Total additions for Movable Equipmen		$ 5,000		$ 1,000	*
Deletions:					
Total deletions for Movable Equipmen		$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report peri

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

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
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Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
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									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
NEW HORIZONS VILLAGE		9/30/2021	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	09/30/64
2. Date Structure Completed	09/24/86
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	101
6. Square Footage	
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	FIXED			
b. Date Mortgage Obtained	01/21/20			
c. Interest Rate for the Cost Year	4.36%			
d. Term of Mortgage (number of years)	20 YEARS			
e. Amount of Principal Borrowed	2,750,000			
f. Principal balance outstanding as of 09/30/2021	2,609,517			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
NEW HORIZONS VILLAGE		9/30/2021	26 | 37

Item		Total	CCNH	RHNS	Other
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$	117,517			117,517
Name of Lender: ION Bank	Rate: 4.36%				
Address of Lender: PO Box 370, Naugatuck 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)	$	117,517			117,517

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
NEW HORIZONS VILLAGE		9/30/2021	27 | 37

Item				Total	CCNH	RHNS	Other
Subtotals Brought Forward:				117,517			117,517
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*)			$				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)			$	117,517			117,517
14. Insurance							
a. Insurance on Property (buildings only)			$	85,212			85,212
b. Insurance on Automobiles			$	31,163			31,163
c. Insurance other than Property (as specified above)							
1. Umbrella (*Blanket Coverage*)			$	17,046			17,046
2. Fire and Extended Coverage			$				
3. Other (*Specify*) Crime and Cyber Liability Insurance			$	6,746			6,746
14d. ***Total Insurance Expenditures (14a + b + c)***			$	140,167			140,167
15. ***Total All Expenditures (A-13 thru C-14)***			$	5,862,670			5,862,670

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
NEW HORIZONS VILLAGE		9/30/2021	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $	60,740			60,740
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1 c	Bad Debts $	57,213			57,213
10.			Accounting $				
10a.			Legal $	282			282
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.			Unallowable Advertising * $				
19.			Income Tax / Corporate Business Tax $				
20.	20 / 22	5c &	Fund Raising / Contributions $	31,284			31,284
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	77,528			77,528
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $				
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	227,047			227,047

* 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	Other
10	A 12o	Livery Drivers			$ 60,740
Total Other Salaries Adjustment			$ -	$ -	$ 60,740

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Other Fees Adjustments			$ -	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
15	1 g	Membership Dues			$ 618
15	1 g	Marketing Expense			$ 1,300
16	L 2	Staff Events / Programs			$ 3,619
16	m 13	Livery Employee Expense			$ 1,130
16	m 13	Livery Vehicle Expense			$ 14,465
16	m 13	Livery GPS & Communication Expense			$ 11,122
16	m 13	Livery Software Expense			$ 7,339
16	m 13	Livery Marketing Expense			$ 4,018
16	m 13	Livery Miscellaneous Expense			$ 2,949
16	m 13	Livery Gas/Fuel			$ 28,570
16	m 13	Livery Registration/Emissions			$ 2,398
Total Other A&G Adjustments			$ -	$ -	$ 77,528

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

Name of Facility	License No.	Report for Year Ended	Page of
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Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
			Subtotals Brought Forward $	227,047			227,047
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $				
28.			Ambulance/Limousine $				
29.			X-rays, etc $				
30.			Laboratory $				
31.			Medical Supplies $				
32.			Oxygen (non emergency) $				
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $				
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.	22	7 d	Depreciation on Unallowable Motor Vehicles $	75,479			75,479
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Other - Indirect $				
43.			Interest Income on Account Rec. $				
44.			Other - Miscellaneous Administrative $				
45.			Management Fees Direct $				
46.			Management Fees Indirect $				
47.			Other - Direct $				
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
49.	***Total Amount of Decrease (Items 1 - 48)***		$	302,526			302,526

*** 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.

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Other Ancillary Costs			$ -	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Other Adjustments			$ -	$ -	$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Other Adjustments			$ -	$ -	$ -

Schedule of Other - Direct Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Other Adjustments			$ -	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
NEW HORIZONS VILLAGE		9/30/2021	30 | 37

Item		Total	CCNH	RHNS	Other
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$				
b. Medicaid Room and Board Contractual Allowance **	$				
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$				
b. Medicare Room and Board Contractual Allowance **	$				
4. a. Private-Pay Residents and Other	$				
b. Private-Pay Room and Board Contractual Allowance **	$	6,072,598			6,072,598
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$				
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$				
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	$				
b. Physical Therapy - Medicare Contractual Allowance **	$				
c. Physical Therapy - Non-Medicare	$				
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$				
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$				
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	6,072,598			6,072,598
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 *(Specify)*	$	8,254			8,254
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	3,602,293			3,602,293
V. Total Other Revenue (1 thru 8)	$	3,610,547			3,610,547
VI. Total All Revenue (III +V)	$	9,683,145			9,683,145

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Other
Total Other Resident Revenue		$ -	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	Other
30 IV 4	Interest Income				$ 8,254
Total Interest Income			$ -	$ -	$ 8,254

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Other
30 IV 8	Miscellaneous Income			$ 2,954
30 IV 8	Contributions-Individual			$ 11,205
30 IV 8	Incentive/Rebate Income			$ 8,923
30 IV 8	Contributions-In Kind-CDBG (For Fixed Asset Rehabilitation Project)			$ 675,113
30 IV 8	Grant Income-DOH For Fixed Asset Rehabilitation Project)			$ 2,528,269
30 IV 8	Grant Income			$ 62,640
30 IV 8	Grant Income-Covid (Expense Disallowed)			$ 15,500
30 IV 8	Grant Income-Sunshine Wheels (Disallowed)			$ 8,328
30 IV 8	Sunshine Wheels Livery Contributions (Disallowed)			$ 95
30 IV 8	Sunshine Veyo Livery Revenue (Disallowed)			$ 163,549
30 IV 8	Sunshine Non-Veyo Livery Revenue (Disallowed)			$ 123,130
30 IV 8	FEMA Relief Funding (Expense Disallowed)			$ 2,587
Total Other Revenue		$ -	$ -	$ 3,602,293

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
NEW HORIZONS VILLAGE		9/30/2021	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 843,192
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 19,183
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 430,920
4 Inventories				$
5. Prepaid Expenses				$ 894
a. Insurance		570		
b. Telephone		324		
c.				
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,294,189
B. Fixed Assets				
1. Land				$ 168,397
2. Land Improvements	*Historical Cost	769,015		$ 23,527
	Accum. Depreciation	745,488	Net	
3. Buildings	*Historical Cost	13,711,865		$ 2,700,003
	Accum. Depreciation	11,011,862	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	1,017,248		$ 424,164
	Accum. Depreciation	593,084	Net	
6. Movable Equipment	*Historical Cost	649,546		$ 21,973
	Accum. Depreciation	627,573	Net	
7. Motor Vehicles	*Historical Cost	625,620		$ 153,118
	Accum. Depreciation	472,502	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 7,831,472
Construction in Progress		7,831,472		
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 11,322,654

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			$ -

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

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

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

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

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

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
NEW HORIZONS VILLAGE		9/30/2021	32	37

Account				Amount
			Total Brought Forward:	$ 12,616,843
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)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 12,616,843

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
NEW HORIZONS VILLAGE		9/30/2021	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 23,702
2. Notes Payable (*itemize*)					$
See Schedule					
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)					$ 98,719
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$ 93,940
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 5,129,922
Intercompany Transactions 5,065,215					
Accrued Expenses Payable 64,707					
See Schedule					
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 5,346,283

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
NEW HORIZONS VILLAGE		9/30/2021	34	37

Account	Amount
Total Brought Forward:	5,346,283
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$ 2,515,577
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$ 1,150,962
Pension FASB Long Term 1,150,962	
See Schedule	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 3,666,539
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 9,012,822

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

Name of Facility	License No.	Report for Year Ended	Page	of
NEW HORIZONS VILLAGE		9/30/2021	35	37

Account		Amount
A. **Reserves**		
1. Reserve for value of leased land		$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized		$
3. Reserve for depreciation value of leased personal property (*Equity)*		$
4. Reserve for leasehold real properties on which fair rental value is based		$
5. Reserve for funds set aside as donor restricted		$ 48,294
6. Total Reserves		$ 48,294
B. **Net Worth**		
1. Owner's Capital		$
2. Capital Stock		$
3. Paid-in Surplus		$
4. Treasury Stock		$
5. Cumulated Earnings		$
6. Gain or Loss for Period	10/1/2020 thru 9/30/2021	$ 3,555,727
7. Total Net Worth		$ 3,555,727
C. ***Total Reserves and Net Worth***		$ 3,604,021
D. ***Total Liabilities, Reserves, and Net Worth***		$ 12,616,843

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
NEW HORIZONS VILLAGE		9/30/2021	36	37

Account		Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2020	$ (224,833)
B.	Total Revenue (*From Statement of Revenue Page 30*)	$ 9,683,145
C.	Total Expenditures (*From Statement of Expenditures Page 27*)	$ 5,862,670
D.	Net Income or Deficit	$ 3,820,475
E.	Balance	$ 3,595,642
F.	Additions	
	1. Additional Capital Contributed (*itemize*)	
	2. Other (*itemize*)	
	Change in net assets with donor restrictions. 6,529	
F-3.	Total Additions	$ 6,529
G.	Deductions	
	1. Drawings of Owners/Operators/Partners (*Specify*)	$

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

	2. Other Withdrawings *(Specify)*	$

Purpose	Amount

	3. Total Deductions	$
H.	***Balance at End of Period*** 09/30/21	$ 3,602,171

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
NEW HORIZONS VILLAGE		9/30/2021	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
CHRISTINE MURRAY

Addres Address	Phone Number
37 BLISS MEMORIAL RD., UNIONVILLE CT 06085	860-675-4711

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
CHRISTINE MURRAY	860-675-4711

Contact Email Address
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