State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2016

Name of Facility (as licensed) Colonial Health & Rehab Center of Plainfield, LLC		
Address (No. & Street, City, State, Zip Code) 16 Windsor Ave., Plainfield, CT 06374		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2387			2387

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	07-5310		

For Department Use Only

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

Table of Contents

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2016	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 Colonial Health & Rehab Center of Plainfield, LLC [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 2016, 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) Curtis Rodowicz			Printed Name (Owner)	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1A Rev. 6/95

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 Colonial Health & Rehab Center of Plainfield, LLC	Period Covered:		From 10/1/2015	To 9/30/2016
Address of Facility 16 Windsor Ave., Plainfield, CT 06374				
Report Prepared By CJLC LLC	Phone Number 860-610-9009		Date 2/14/2017	

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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-2 Rev. 10/2005

General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-564-4081	9/30/2016	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Colonial Health & Rehab Center of Plainfield, LLC	16 Windsor Ave., Plainfield, CT 06374

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2387			2387

Type of Facility (Check appropriate box(es))

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

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.:
Curtis Rodowicz	001775

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

Name	License No.:

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3 Rev. 10/2005

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2016	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
Colonial Health & Rehab Center of Plainfield, LLC	16 Windsor Ave., Plainfield, CT 06374	CT

Name of Partners/Members	Business Address	Title	% Owned
Curtis Rodowicz	318 E. Haddam Colchester Tpke, East Haddam, CT 06423	President	50%
Robert Darigan	74 Lennys Lane, Hampton, CT 06247	Vice President	50%

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3A Rev. 10/2005

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plainfiel	2387	9/30/2016	3A	37

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

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
N/A			
Names of Stockholders Owning at Least 10% of Shares			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2016	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility
N/A

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-4 Rev. 10/2005

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2016	4	37

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	%**				
The Law Firm of Joseph Rodowicz, LLC	13730 Whispering Lakes Lane, Palm Beach Gardens, FL 33418	⊙	○		1199 Contract Negotiations, DPH Hearings and Appeals, DSS Appeals	15/1e	820	820
See attachment to pages 11 & 12 for detailed information for related parties		○	⊙					
Rosemarie Roowicz d/b/a Keystone Ergonomics	13730 Whispering Lakes Lane, Palm Beach Gardens, FL 33418	⊙	○		Medical management: WC, Ergonomic Inspections, OSHA		28,800	28,800
Deborah Darigan d/b/a Barr-Nunn, LLC	74 Lennys Lane, Hampton, CT 06247	⊙	○		Medical Record Management		14,220	14,220
Colonial Health & Rehab Management, LLC	13730 Whispering Lakes Lane, Palm Beach Gardens, FL 33418	○	⊙		Management Services	16/m12	212,108	212,108
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-5 Rev. 9/2002

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plainfield, I	2387	9/30/2016	5	37

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.

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

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

⊙ Yes ○ No If "No," explain fully why such allocation was not made.

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	of
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2016	6	37

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
Ricoh USA, Inc. 70 Valley Stream Parkway, Malvern, PA 19355	○	◉	Copier	04/18/13	1 year	7,706	7,706
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
						Total ***	7,706

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

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 6/95

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of	2387	9/30/2016	7	37

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 CJLC LLC	225 Pitkin Street, East Hartford, CT 06108
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Medicaid and Medicare Cost Report, Audited Financial Statements, Tax Services	$ 16,000
2		$
3		$
4		$
		Charge for Services Provided: $ 16,000

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

⊙ Yes ○ No — Pg 15/1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Murtha Cullina LLP	
2	
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)
1 PO Box 150435, Hartford, CT 06115
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	Consultative Services: Survey, IDR	$ 1,463
2	Various (Disallowed on Page 28/10)	$ 44,495
3		$
4		$
5		$
		Charge for Services Provided: $ 45,958

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

⊙ Yes ○ No — Pg 15/1e

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 9/2002

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2016	8	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												
A. On last day of PREVIOUS report period	90	90			90	90			90	90		
B. On last day of THIS report period	90	90			90	90			90	90		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	90	90			90	90			90	90		
B. As of midnight of THIS report period	90	90			90	90			90	90		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,823	4,823			3,867	3,867			956	956		
B. Medicaid (Conn.)	22,537	22,537			16,668	16,668			5,869	5,869		
C. Medicaid (other states)												
D. Private Pay	2,917	2,917			2,129	2,129			788	788		
E. State SSI for RCH												
F. Other (Specify) Hospice/Managed	964	964			732	732			232	232		
G. Total Care Days During Period (3A thru F)	31,241	31,241			23,396	23,396			7,845	7,845		
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)**	31,241	31,241			23,396	23,396			7,845	7,845		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plainfield	2387	9/30/2016	9	37

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						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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

Change in Resident Days	CCNH	RHNS	(Specify)
1st change			
2nd change			
3rd change			
4th change			

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-IID
No. of Residents	11	73		5				
Per Diem Rate								
a. One bed rm.	537.60	236.76		370.00				
b. Two bed rms.				350.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	4,919	4,919		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	58	58		
D. ***Total Physical Therapy Treatments***	4,977	4,977		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	1,006	1,006		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	5	5		
D. ***Total Speech Therapy Treatments***	1,011	1,011		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	5,257	5,257		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	85	85		
D. ***Total Occupational Therapy Treatments***	5,342	5,342		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2016	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
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)	115,328	1,760				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	219,423	7,228				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	269,885	14,629				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	162,799	8,735				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	120,760	2,893				
b. Other Maintenance Workers						
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	34,861	2,002				
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	107,198	1,698				
b. RN						
1. Direct Care	437,963	8,031				
2. Administrative**	242,952	4,808				
c. LPN						
1. Direct Care	754,010	21,083				
2. Administrative**						
d. Aides and Attendants	1,355,815	60,341				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	107,948	3,355				
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	45,328	1,275				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	94,020	2,826				
A-13. Total Salary Expenditures	4,068,290	140,662				

* 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		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Admissions	$ 94,020	2,826				
Total	$ 94,020	2,826	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

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	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2016	11	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										
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).										
See Attachment										

* 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
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2016	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* **										
Curtis Rodowicz (10/1/15 to 9/30/16)	115,328				Administrator	1,760	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2016	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						
2. Dentist	10,206	Contract				
3. Pharmacist	9,360	144				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	337,300	7,471				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	33,000	216				
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)						
Physician	5,570	85				
9. Speech Therapist						
a. Resident Care	53,578	1,185				
b. Other						
10. Occupational Therapist						
a. Resident Care	351,445	7,272				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	22,847	181				
2. Administrative***						
b. LPN						
1. Direct Care	22,901	461				
2. Administrative***						
c. Aides	2,844	98				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	849,051	17,112				

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2016	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
HealthPro Therapy Service, LLC 10600 York Road, Suite 105, Cockeysville, MD	PT, ST, OT	○	⊙	
Healthdrive 88 Worcester St, Wellesley, MA 02482	Dental Consultant	○	⊙	
Pro Health Pysicians P.O. Box 150483, Hartford, CT 06115	Medical Director	○	⊙	
Pro Health Pysicians P.O. Box 150483, Hartford, CT 06115	Physician Fees	○	⊙	
Superior Scheduling & Consulting 1326 SW Sultan Drive, Port St. Lucie, FL 34953	Facility Scheduling	○	⊙	
Partners Pharmacy of CT PO Box 9689, Uniondale, NY 11555	Pharmacist	○	⊙	
Mobile X USA 109 Rhode Island Rd., Lakeville, MA 02347	Diagnostics	○	⊙	
US Laboratory 2 Jonathan Dr., Brockton, MA 02301	Phlebotomist	○	⊙	
		○	⊙	
		○	○	
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		○	○	
		○	○	

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plainfield, LL	2387	9/30/2016	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	108,857	108,857		
2. Disability Insurance	$	15,930	15,930		
3. Unemployment Insurance	$	109,118	109,118		
4. Social Security (F.I.C.A.)	$	308,249	308,249		
5. Health Insurance	$	665,087	665,087		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	252,195	252,195		
(not-owners and not-operators)					
8. Uniform Allowance	$	5,718	5,718		
9. Other (*Specify*)	$	4,246	4,246		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	23,029	23,029		
d. Accounting and Auditing	$	16,000	16,000		
e. Legal (*Services should be fully described on Page 7)*	$	45,958	45,958		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$	11,996	11,996		
g. Office Supplies	$	17,839	17,839		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	6,927	6,927		
2. Cellular Phones	$				
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$	409	409		
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	547,677	547,677		
Subtotal	$	2,139,234	2,139,234		

* 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	(Specify)
Other employee benefits	$ 4,246		
Total	$ 4,246	$ -	$ -

Schedule of Other Taxes

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

State of Connecticut
Annual Report of Long-Term Care Facility
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
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2016	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,139,234	2,139,234		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	7,072	7,072		
3. Gifts to Staff and Residents	$	10,040	10,040		
4. Employee Travel	$	3,204	3,204		
5. Education Expenses Related to Seminars and Conventions	$	4,573	4,573		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$	3,296	3,296		
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	5,002	5,002		
2. Advertising Telephone Directory (*all such expenses*)***	$	7,406	7,406		
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	$	5,389	5,389		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$				
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	8,122	8,122		
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	99,618	99,618		
12. Administrative Management Services**	$	212,108	212,108		
13. Other (*Specify*) See Attached Schedule	$	109,087	109,087		
C-14 Total Administrative & General Expenditures	$	2,614,151	2,614,151		

* 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)
A & G Meal & Entertainment	$ 3,296		
Total Other Travel and Entertainment	$ 3,296	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Total Other Advertising	$ -	$ -	$ -

Schedule of Dues

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

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
A & G Late Fees	$ 2,224		
A & G Background checks	$ 2,548		
A & G Bochures and Forms	$ 346		
License & Permit fees	$ 1,200		
Bank fees	$ 7,306		
Community awarness	$ 18,169		
Software Maintenance	$ 77,294		
Total Other Administrative and General	$ 109,087	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Colonial Health & Rehab Center of Plainf	2387	9/30/2016	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 #
Colonial Health & Rehab Management, LLC	212,108	Management Services	16/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.**

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-18 Rev. 9/2002

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
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2016	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	205,845	205,845		
2. Non-Food Supplies	$	18,216	18,216		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	124,424	124,424		
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	348,486	348,486		

2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals:	Total no. of meals served per day:*				

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	⊙ Yes	○ No	If yes, specify amt.
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
P.	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.
** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-19 Rev. 9/2002

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
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2016	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. $	11,934	11,934		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	35,788	35,788		
c. Management Services**	$				
d. Other (*Specify*) Laundry Supplies	$	2,786	2,786		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	50,507	50,507		

3F.	Laundry Questionnaire			
G.	Is cost of employee laundry included in 3E?	○ Yes	⊙ No	If yes, specify cost.
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 laundry provided to persons other than employees or residents included in 3E?	○ Yes	⊙ No	If yes, specify cost.
K.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
L.	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 3E.

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-20 Rev. 9/2002

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
Colonial Health & Rehab Center of Plainfield, I	2387	9/30/2016	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	27,224	27,224		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	36,163	36,163		
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	63,387	63,387		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	171,906	171,906		
b. Medicine Cabinet Drugs		$	11,757	11,757		
c. Medical and Therapeutic Supplies		$	37,178	37,178		
d. Ambulance/Limousine***		$	2,719	2,719		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	14,984	14,984		
f. X-rays and Related Radiological Procedures***		$	11,408	11,408		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	14,625	14,625		
i. Recreation		$				
j. Other (Specify)**** See Attached Schedule		$	196,725	196,725		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	461,303	461,303		

* 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)
PT supplies	$ 1,742		
OT supplies	$ 3,299		
IV solution	$ 36,735		
Central Supp-Personal supplies	$ 42,404		
Incontinent Care Diapers	$ 48,841		
Wound Care Medicare A	$ 10,301		
Equipment Rental Wound Care	$ 16,407		
Nursing supplies	$ 21,268		
Equipment over $100	$ 1,167		
Cable Television	$ 8,047		
Resident expense	$ 3,517		
Internet	$ 2,998		
Total Other Resident Care	$ 196,725	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 10/2001

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

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2016	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Healthcare Services Group, Inc.	3220 Tillman Drive, Bansalem, PA 19020	○	⊙		Dietary Services			124,424	18	2b
Healthcare Services Group, Inc.	3220 Tillman Drive, Bansalem, PA 19020	○	⊙		Laundry Services			35,788	19	3b
Healthcare Services Group, Inc.	3220 Tillman Drive, Bansalem, PA 19020	○	⊙		Housekeeping Services			36,163	20	4b
Integnity Health Care Management	33 Chesterfield Road, Amston, CT 06231	○	⊙		A/R Billing Services			70,818	16	m11
Point Click Care	6975 Creditview Road, Unit 4, Mississauga,	○	⊙		Software Provider			28,800	16	m11
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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).

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Colonial Health & Rehab Center of Plainfield,	2387	9/30/2016	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	63,089	63,089		
b. Heat	$	39,690	39,690		
c. Light & Power	$	86,071	86,071		
d. Water	$	19,873	19,873		
e. Equipment Lease (*Provide detail on page 6*)	$	7,706	7,706		
f. Other (*itemize*)	$	40,665	40,665		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	257,094	257,094		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	27,156	27,156		
d. Movable Equipment	$	96,617	96,617		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	123,773	123,773		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	21,413	21,413		
c. Leasehold Improvements	$	20,464	20,464		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	41,878	41,878		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	402,534	402,534		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	90,298	90,298		
c. Personal property taxes	$	17,936	17,936		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	676,418	676,418		

* 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	(Specify)
Plant Garbage	$ 28,718		
Equipment rental	$ 11,947		
Total Other Repairs and Maintenance	$ 40,665	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-23 Rev. 10/2006

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2016	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								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	160,584		160,584	32,647	SL	Var	23,292	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	41,224						3,864	
C-4. Subtotal								27,156

	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.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			Var	Var	506,406		506,406	130,664	SL	Var	92,057	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					35,366						4,560	
D-3. Subtotal												96,617
E. ***Total Depreciation***												123,773

Colonial Health & Rehab Center of Plainfield, LLC
9/30/2016

Schedule of Land Improvements Acquired during this report period

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

***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:					
Total additions for Building Improvements		$ -		$ -	*
Deletions:					
Total deletions for Building Improvements		$ -		$ -	**

***Ties to Page 23, Line B3**

****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Various	See Attached	$ 41,224	7	$ 3,864	
Total additions for Non-Movable Equipment		$ 41,224		$ 3,864	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Varous	See Attached	$ 26,139	5	$ 3,239	
		$ 9,227	3	$ 1,321	
Total additions for Movable Equipment		$ 35,366		$ 4,560	*
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:					
Various	See Attached	98,175	39	$ 2,219	
		54,603	15	$ 2,181	
Total additions for Leasehold Improvement		$ 152,778		$ 4,400	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2016	24	37

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	Var	Var	Var	626,509	23,094	SL	Var	16,065	
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)				152,778				4,400	
C-4. Subtotal									20,464
D. ***Total Amortization***									20,464

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-25 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Pla	2387	9/30/2016	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	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	12/29/2012
4. Date of Initial Licensure	7/13/1983
5. Total Licensed Bed Capacity	90
6. Square Footage	37,000
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				
c. Interest Rate for the Cost Year	3.35%			
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of 9/30/2016	3,506,854			
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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-26 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended			Page of
Colonial Health & Rehab Center of Pl	2387	9/30/2016			26 | 37

Item	Total	CCNH	RHNS	(Specify)
12. Interest				
A. Building, Land Improvement & Non-Movable Equipment				
1. First Mortgage $				
Name of Lender / Rate				
Address of Lender				
2. Second Mortgage $				
Name of Lender / Rate				
Address of Lender				
3. Third Mortgage $				
Name of Lender / Rate				
Address of Lender				
4. Fourth Mortgage $				
Name of Lender / Rate				
Address of Lender				
B. CHEFA Loan Information				
1. Original Loan Amount $				
2. Loan Origination Date				
3. Interest Rate %				
4. Term				
5. CHEFA Interest Expense				
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $				

(*Carry Subtotals forward to next page*)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-27 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Colonial Health & Rehab Center of	2387	9/30/2016	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				
12. C. Movable Equipment				
1. Automotive Equipment $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*) $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
B. Item / Rate / Amount				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $				
12. D. Other Interest Expense (*Specify*) $	107,571	107,571		
Interest Expense				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	107,571	107,571		
14. Insurance				
a. Insurance on Property (buildings only) $	86,065	86,065		
b. Insurance on Automobiles $	213	213		
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)*** $	86,278	86,278		
15. ***Total All Expenditures (A-13 thru C-14)*** $	9,582,536	9,582,536		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-28 Rev. 9/2002

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2016	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	B10a	Occupational Therapy $	351,445	351,445		
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.	15	1a9	Discriminatory Benefits $	4,246	4,246		
9.	15	1c	Bad Debts $	23,029	23,029		
10.	15	1e	Accounting & Legal $	44,496	44,496		
11.			Telephone $				
12.			Cellular Telephone $				
13.	15	1f	Life insurance premiums on the life of Owners, Partners, Operators $	11,996	11,996		
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 $	159	159		
20.			Fund Raising / Contributions $				
21.	16	m12	Unallowable Management Fees $	212,108	212,108		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	24,035	24,035		
Page 18 - Dietary Expenditures							
24.	30	IV1	Meals to employees, guests and others who are not residents $	388	388		
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) $	671,902	671,902		

* 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)
Total Other Salaries Adjustment			$ -	$ -	$ -

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	L7	A & G Meal & Entertainment	$ 3,296		
16	m13	A & G Late Fees	$ 2,224		
16	m13	A & G Bochures and Forms	$ 346		
16	m13	Community awarness	$ 18,169		
Total Other A&G Adjustments			$ 24,035	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-29 Rev. 10/2006

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

Name of Facility	License No.	Report for Year Ended	Page of
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2016	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	671,902	671,902		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $	171,906	171,906		
28.	20	5d	Ambulance/Limousine $	2,719	2,719		
29.	20	5f	X-rays, etc $	11,408	11,408		
30.	20	5h	Laboratory $	14,625	14,625		
31.			Medical Supplies $				
32.	20	5e2	Oxygen (non emergency) $	14,984	14,984		
33.	20	5j	Occupational Therapy $	3,299	3,299		
34.			Other - See Attached Schedule $	99,394	99,394		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Research or Experimental Activities $				
43.			Radio and Television Revenue $				
44.			Vending Machine Revenue $				
45.			Purchase Discounts and Allowances $				
46.			Duplications of functions or services $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest $				
48.			Interest Income on Accounts Rec $				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $				
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.	***Total Amount of Decrease (Items 1 - 50)*** $			990,237	990,237		

*** 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

Colonial Health & Rehab Center of Plainfield, LLC
9/30/2016

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV solution	$ 36,735		
20	5j	Incontinent Care Diapers	$ 48,841		
20	5j	Wound Care Medicare A	$ 10,301		
20	5j	Resident expense	$ 3,517		
Total Other Ancillary Costs			$ 99,394	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

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

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plain	2387	9/30/2016	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	7,881,019	7,881,019		
b. Medicaid Room and Board Contractual Allowance **	$	(2,408,813)	(2,408,813)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	2,834,685	2,834,685		
b. Medicare Room and Board Contractual Allowance **	$	(49,363)	(49,363)		
4. a. Private-Pay Residents and Other	$	1,166,151	1,166,151		
b. Private-Pay Room and Board Contractual Allowance **	$	(105,658)	(105,658)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	193,032	193,032		
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$	11,530	11,530		
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	$	838,295	838,295		
b. Physical Therapy - Medicare Contractual Allowance **	$				
c. Physical Therapy - Non-Medicare	$	49,090	49,090		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	138,600	138,600		
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$	1,400	1,400		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	962,400	962,400		
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$	50,900	50,900		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	(1,797,305)	(1,797,305)		
b. Other *(Specify)* - Non-Medicare	$	38	38		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	9,766,001	9,766,001		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	388	388		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	29	29		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$				
V. Total Other Revenue (1 thru 8)	$	417	417		
VI. Total All Revenue (III +V)	$	9,766,418	9,766,418		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30/II6a	Medical Supply-Med A	$ (527)		
30/II6a	X-Ray -Medicare A	$ 10,205		
30/II6a	Lab Revenue-Medicare A	$ 10,357		
30/II6a	Contractual Allow-Med A Ancill	$ (1,604,884)		
30/II6a	Contractual Allow - Med B	$ (207,402)		
30/II6a	Contractual Allow-Med B Seq 2%	$ (5,054)		
Total Other Resident Revenue - Medicare		$ (1,797,305)	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30/II6b	X-ray Medicaid	$ 9		
30/II6b	X-ray Managed Care	$ 9		
30/II6b	Lab Revenue - Medicaid	$ (7)		
30/II6b	Lab Revenue Managed Care	$ 27		
Total Other Resident Revenue		$ 38	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30/IV5	Interest Income		$ 29		
Total Interest Income			$ 29	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
Total Other Revenue		$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-31 Rev. 6/95

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plai	2387	9/30/2016	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 443,056
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,064,690
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 68,813
a. Prepaid Insurance P&L		22,038		
b. Prepaid Insurance Workers Comp		18,199		
c. Prepaid RE Tax Expense		25,489		
d. Prepaid PP Taxes		3,086		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 206,641
HUD Tax		16,230		
HUD Insurance		63,334		
HUD Replacement Reserves		127,077		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,783,200
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	779,288		$ 735,730
	Accum. Depreciation	43,558	Net	
5. Non-Movable Equipment	*Historical Cost	201,808		$ 142,005
	Accum. Depreciation	59,803	Net	
6. Movable Equipment	*Historical Cost	541,772		$ 314,490
	Accum. Depreciation	227,281	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 42,827
Capitalized Finance Costs		42,827		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 1,235,052

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

(*Carry Total forward to next page*)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-32 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plai	2387	9/30/2016	32	37

Account				Amount
			Total Brought Forward:	$ 3,018,252
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*)				$ 50,000
Security Deposits - Long Term		50,000		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 50,000
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 3,068,252

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-33 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plainfield,	2387	9/30/2016	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 1,530,003
	2. Notes Payable (*itemize*)				$
	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*)				$ 305,756
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 64,087
	7. Medicare Final Settlement Payable				$
	8. Medicare Current Financing Payable				$
	9. Mortgage Payable (*Current Portion*)				$
	10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
	11. Accrued Income Taxes*				$
	12. Other Current Liabilities (*itemize*)				$ 599,759
	401-K / Pension / Health	2,497	American Express	5,613	
	Union Dues Withheld	(100)			
	Line of Credit -AR (SCM)	590,581			
	Home Depot Credit	1,167			
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 2,499,606

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

(Carry Total forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plainfie	2387	9/30/2016	34	37

Account	Amount
Total Brought Forward:	2,499,606
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ 101,892

Name and Address of Lender	Amount	Loan Date
Various	101,892	

4. Other Long-Term Liabilities (*itemize*)	$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 101,892
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 2,601,498

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-35 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Pl	2387	9/30/2016	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	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$ 5,016
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 277,856
	6. Gain or Loss for Period 10/1/2015 thru 9/30/2016	$ 183,882
	7. Total Net Worth	$ 466,754
C.	***Total Reserves and Net Worth***	$ 466,754
D.	***Total Liabilities, Reserves, and Net Worth***	$ 3,068,252

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-36 Rev. 6/95

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plain	2387	9/30/2016	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015			$ 297,734
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 9,766,418
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 9,582,536
D.	Net Income or Deficit			$ 183,882
E.	Balance			$ 481,616
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
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*** 09/30/16			$ 481,616

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-37 Rev. 9/2002

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of	2387	9/30/2016	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
CJLC LLC

Address	Phone Number
225 Pitkin Street, East Hartford, CT 06108	860-610-9009